

Proposed HHS Notice of Benefit and Payment Parameters for 2019 Fact Sheet

In the HHS Notice of Benefit and Payment Parameters for 2019 proposed rule released today, CMS proposes standards for issuers and Exchanges, generally for plan years beginning on or after January 1, 2019.

This proposed rule is intended to increase flexibility in the individual market, improve program integrity, and reduce regulatory burdens associated with the Patient Protection and Affordable Care Act in the individual and small group markets. The rule includes proposals that would provide states with more options in how the essential health benefits (EHBs) are defined for their state, enhance the role of states related to qualified health plan (QHP) certification, and provide states with additional flexibility in the operation and establishment of Exchanges, particularly the Small Business Health Options Program (SHOP) Exchanges. In addition, we propose to permit states to reduce the magnitude of risk adjustment transfers in the small group market to minimize unnecessary burden. Finally, the rule proposes other changes that would streamline the Exchange consumer experience and the individual and small group markets as a whole.

The actions in this proposed rule build on other actions CMS has taken to strengthen the health insurance markets in recent months, such as a recent request for information (RFI) seeking public comment on ways to stabilize the individual and small group health insurance markets, promote consumer choice, enhance affordability, and return regulatory authority to the states.¹

This fact sheet highlights certain elements of the proposed rule. In addition to the elements described below, we also seek comment on other proposals to reduce regulatory burdens, streamline state and issuer requirements, and simplify eligibility and enrollment processes for consumers, such as by providing greater flexibility to agents, brokers, and allowing issuers to select their own third-party entities for conducting direct enrollment operational readiness reviews, and removing the actuarial value standard for stand-alone dental plans.

Exchange and Qualified Health Plan Provisions:

Essential Health Benefits

We propose to provide states with additional flexibility in how they select their essential health benefits (EHBs) benchmark plans for benefit years 2019 and beyond, and outline potential future directions for defining EHBs. Specifically, we propose to allow states to select a new EHB-benchmark plan on an annual basis, which would allow states to update their EHB-benchmark plan on a schedule that works for the state, rather than one set by HHS. We also propose to provide states with substantially more options in what they can select as an EHB-benchmark plan. Instead of being limited to 10 options, states would be allowed to: 1) choose from the 50 EHB-benchmark plans that other states used for the 2017 plan year; 2) replace one or more EHB categories of benefits under its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or 3) otherwise select a set of benefits to become its EHB-benchmark plan, provided

¹ Available at: <https://www.gpo.gov/fdsys/pkg/FR-2017-06-27/pdf/2017-13417.pdf>. For the press release regarding the RFI, see <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-06-08.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending>.

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that the new EHB-benchmark plan does not provide more benefits than a set of comparison plans and is equal to the scope of benefits provided under a typical employer plan, as required by the PPACA.

State-based Exchanges (SBEs)

We seek to provide incentives for innovation by SBEs, and seek comment on ways that we can support such efforts through program flexibilities. We also propose to explore strategies to make the State-based Exchange on the Federal platform (SBE-FP) a more appealing and viable option for states, and seek comment on options for SBE-FP flexibility.

Small Business Health Options Program (SHOP)

We propose to remove several SHOP requirements as they relate to enrollment through an online SHOP Exchange and introduce an approach for the SHOP Exchanges through which groups could enroll through a SHOP QHP issuer or a SHOP-registered agent or broker. The Federally-facilitated SHOPs (FF-SHOPs) and SBE-FP for SHOPs would take advantage of this enrollment approach for plan years beginning on or after January 1, 2018. If the proposals of this rule were to become final, the changes would become effective as of the effective date of this rule. State-based Exchanges would be given the flexibility to maintain current operations of their online SHOP enrollment platforms, or take advantage of the proposed regulatory flexibilities to design a SHOP that best meets the needs of the small group market in their state. The Small Business Health Care Tax Credit would continue to be available to employers who enroll their small group in a SHOP plan.

Qualified Health Plan (QHP) Certification Standards

We propose to further expand the role of states in the QHP certification process for Federally-facilitated Exchanges (FFE), including FFEs where the state performs plan management functions. Specifically, we propose to rely on states for additional review areas, including accreditation requirements, compliance plans, quality improvement strategy reporting, and service area. We believe this would reduce burden on issuers from duplicative review at both the state and federal level. We seek comment on additional areas of review for which it would be appropriate for the FFEs to rely on state reviews for QHP certification and seek comment from states on their interest in taking on a larger role in QHP certification in FFEs and any potential benefits and unintended consequences of this approach.

We also propose to eliminate requirements for SBE-FPs to enforce FFE standards for network adequacy and essential community providers, instead allowing states to establish their own standards, which we believe would further empower SBE-FPs to use their QHP certification authority to encourage issuers to stay in the Exchange, enter the Exchange for the first time, or expand into additional service areas.

We are also proposing to eliminate the meaningful difference requirement for QHPs. The meaningful difference standard was implemented to make it easier for consumers to understand differences between plans, and choose the right plan option for them. However, with fewer issuers participating in the Exchange, and fewer plans for consumers to choose from, we propose to remove these standards, as we no longer believe the requirement is necessary.

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Standardized Options

We are not proposing to specify standardized options or to provide differential display of standardized options on HealthCare.gov for 2019. We have heard concerns that providing differential display for these plans may limit enrollment in coverage with plan designs that do not match the standardized options, removing incentives for issuers to offer coverage with innovative plan designs. Agents and brokers and issuers that assist consumers with QHP selection and enrollment would also be relieved of the requirement to differentially display these plans.

SADP Actuarial Value

We are proposing to remove the actuarial value (AV) standard for stand-alone dental plans (SADPs). This would provide SADP issuers with greater flexibility. The proposal is intended to allow issuers to offer plans with a greater variation in both premiums and cost sharing. Consumers will benefit by having a greater range of SADPs from which to choose.

Navigator Program

We propose to provide Exchanges with more flexibility in the operation of Navigator programs, by removing the requirements that each Exchange must have at least two Navigator entities, and that one of these entities must be a community and consumer-focused nonprofit group. Also, we propose to remove the requirement that each Navigator entity maintain a physical presence in the Exchange service area.

Payment Parameter Provisions:

Risk Adjustment

We propose to amend the HHS risk adjustment model in the following ways: 1) we propose to use the 2014 and 2015 MarketScan® data and the 2016 enrollee-level EDGE data to recalibrate the 2019 risk adjustment model in order to provide more stability and predictability for issuers; 2) we propose to permit states to reduce the magnitude of risk adjustment transfers in the small group market to minimize unnecessary burden; and 3) we propose to remove two severity-only drug classes from the model.

Risk Adjustment Data Validation (RADV) Audits

HHS performs RADV audits to validate the accuracy of the diagnosis codes submitted by issuers to the EDGE server for the risk adjustment transfer calculation. In this proposed rule, we propose a simplified approach to making payment adjustments as a result of RADV error rates; how payment adjustments would apply to exiting issuers who participate in RADV; the minimum data elements required for validation of mental or behavioral health diagnoses to address state law privacy concerns; and to apply the RADV materiality threshold beginning with the 2018 benefit year, instead of 2017.

FFE and SBE-FP User Fees

We propose to maintain the user fee rates at 3.5 percent of premium for FFEs, and propose to set the user fee for SBE-FPs at 3.0 percent of premium for the 2019 benefit year. This represents an increase for SBE-FP states from 2.0 percent established for the 2018 benefit year.

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Eligibility and Enrollment Provisions:

Special Enrollment Periods (SEPs)

We propose to align the enrollment options for all dependents who are newly enrolling in Exchange coverage through an SEP and are being added to an application with current enrollees. For consumers newly gaining or becoming a dependent and enrolling through the birth, adoption, foster care placement, or court order SEPs, we propose to amend and standardize the alternate coverage start date options available under all of these SEPs. We also propose to allow pregnant women who are receiving health care services through Children’s Health Insurance Program (CHIP) coverage for their unborn child to qualify for a loss of coverage SEP upon losing access to this coverage. Finally, we propose to exempt consumers from the prior coverage requirement that applies to certain special enrollment periods if they lived in a service area without qualified health plans available through an Exchange.

Verification for Eligibility for Insurance Affordability Programs

To promote program integrity, we propose to newly generate annual income inconsistencies for certain consumers who attest to income that is higher than the amount found in income data received from the Exchange’s trusted data sources (IRS and the SSA, or other current income data sources) by more than a reasonable threshold amount. This new check would only be for households for which trusted data sources reflect income below 100% FPL, because an accurate eligibility determination is critical for consumers near this threshold to ensure that APTC is not paid on behalf of consumers who are statutorily ineligible. We also propose to modify the requirements for Exchanges to verify eligibility for and enrollment in qualifying employer-sponsored coverage, such that Exchanges would continue to have the option to conduct an alternative process to sampling for benefit years through 2019.

Exemptions

We propose that Exchanges can make a determination of lack of affordable coverage based on projected income using the lowest cost Exchange metal level plan offered through the Exchange when there is no bronze level plan available in the service area.

Termination Effective Dates

We propose to make it simpler for consumers to terminate coverage through the Exchanges, by allowing enrollees to request same-day or prospective coverage termination dates by removing the 14-day “reasonable notice” and “newly eligible for Medicaid/CHIP/BHP” rules.

Market Reform Provisions:

Rate Review

We propose several changes related to rate review that would recognize the primary role of state regulators in the rate review process, and would reduce regulatory burden for states and issuers, including: 1) eliminating the requirement that proposed and final rate increases must be posted at a uniform time, instead allowing states with Effective Rate Review Programs to publish proposed and final rate increases on a rolling basis; 2) exempting student health insurance coverage from the federal rate review process; 3) allowing states with Effective Rate Review Programs to have different submission deadlines for issuers that only offer non-QHPs; 4) reducing the advanced notification that states must give CMS about the posting of rate increases from 30 days to 5 business days; and 5) increasing the default threshold for rate increases subject to review to 15 percent from 10 percent.

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Medical Loss Ratio (MLR)

We propose to reduce the burden associated with the Quality Improvement Activity (QIA) reporting requirements by allowing issuers the option to either continue tracking and reporting actual QIA expenses or report a standardized amount equal to 0.8 percent of the issuer's earned premium for the year without having to separately track such expenses. We also propose to reduce the burden on states associated with requesting adjustments to the 80 percent MLR standard in the individual market by simplifying the application process and by making it easier for the Secretary to grant state requests.

Minimum Essential Coverage (MEC) Designation for CHIP Buy-in Programs

We propose to categorically designate CHIP buy-in programs that provide identical coverage to the state's Title XXI CHIP program as MEC without going through an application process. This proposal would streamline processes and alleviate burdens on states.