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2019 NOTICE OF BENEFIT AND PAYMENT PARAMETERS

DRAFT RULE

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On November 2, 2017 HHS published its Draft Notice of Benefit and Payment Parameters for 2019.[1] The Notice contains rules and parameters that would apply to the individual and small group health insurance markets in 2019, and modifications to previously promulgated rules. This document represents a summary of our interpretation of the Notice but does not constitute, nor is it a substitute for, legal advice.

1.Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019; Proposed Rule," November 2, 2017 https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf

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HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

1. Fair Health Insurance Premiums (§147.102)

- In accordance with the proposed SHOP changes described later, HHS is proposing to no longer require SHOPs to offer average enrollee premiums as a premium billing option

2. Guaranteed Availability of Coverage (§147.104)

- HHS is proposing to clarify that the exceptions to the limited open enrollment periods listed under §147.104(b)(2)(i) are only applicable to coverage offered outside of the Exchange for the individual market
- HHS is proposing to exempt qualified individuals from prior coverage requirements that apply to certain special enrollment periods if, for at least one of the 60 days prior to the date of their qualifying event, they lived in a service area in which no QHPs were available through the Exchange
  - This exemption would also apply to individuals who enroll in coverage off-Exchange, regardless of availability of off-Exchange coverage
- HHS is seeking comment regarding off-Exchange special enrollment periods and whether special enrollment periods for an individual who gains a dependent or becomes a new dependent according to the circumstances described under §155.420(d)(2)(i) (i.e., marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order) should apply to new and existing dependents (as is the current practice in the Exchange), or instead apply to only new dependents (consistent with HIPAA group market regulations), or if another approach should be considered

STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT

1. Sequestration

- In accordance with the Office of Management and Budget (OMB) Report to Congress on the Joint Committee Reductions for Fiscal Year 2018, payments made from the reinsurance program using fiscal year 2018 resources would be sequestered at a rate of 6.6%
  - The second contribution collection deadline of the transitional reinsurance fee is November 15, 2017, which falls in fiscal year 2018
  - Sequestered funds would become available in fiscal year 2019

2. Provisions and Parameters for the Permanent Risk Adjustment Program (§153.20, §153.320, §153.610, §153.630)

- For the 2019 benefit year, HHS is proposing to recalibrate the risk adjustment model with an equally weighted blend of coefficients produced using each 2014, 2015, and 2016 data, instead of solely using 2016 data as outlined in the 2018 Payment Notice
  - MarketScan data would be used to develop the 2014 and 2015 coefficients; the EDGE data would be used to develop the 2016 coefficients
  - The 2019 benefit year risk adjustment model coefficients included in the Proposed Rule are solely based on 2014 and 2015 MarketScan data, but HHS intends to incorporate the 2016 EDGE data to develop the final risk adjustment model coefficients

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- HHS expects to include final 2019 benefit year risk adjustment model coefficients with the Final Rule, but seeks comment on whether the final coefficient should be published under separate guidance in Spring 2018
  - Additional time may be needed to analyze the 2016 EDGE data if significant demographic or distributional differences are noted between MarketScan and the EDGE data, in which case HHS seeks comment on whether to update the risk adjustment model coefficients for 2019 or to align the coefficients more so with the 2016 EDGE data
- The two severity-only RXCs would be removed from the 2019 benefit year risk adjustment model
  - RXC 11 (Ammonia Detoxicants) and RXC 12 (Diuretics, Loop and Select Potassium-Sparing)
- The 2018 high-cost risk pool adjustment parameters (i.e., $1 million threshold with an issuer coinsurance rate of 40%) would be maintained for the 2019 benefit year
  - HHS seeks comment on alternative methods for reimbursing issuers for exceptionally high-cost enrollees through the high-cost risk pool adjustment
- The current cost-sharing reduction adjustment factors would be used for the 2019 benefit year
  - HHS anticipates updating the cost-sharing reduction adjustment factors for the 2020 benefit year
- The current risk adjustment payment transfer formula would be used for the 2019 benefit year
  - A slight technical modification was made to specify that the statewide average premium is defined as the unadjusted statewide average premium reduced by 14%
  - Additional transfers would be added to reflect the payments and charges assessed under the high-cost risk pool adjustment
- States would be allowed to apply an adjustment to the average statewide premium in the calculation of the risk adjustment transfer amounts to reduce the average statewide premium by up to 50% in the small group market beginning for the 2019 benefit year
  - States would be required to submit proposals for an adjustment within 30 calendar days after the proposed HHS notice of benefit and payment parameters for the applicable benefit year has been published
  - HHS would make final determinations by March 1 of the benefit year prior to the applicable benefit year (e.g., for the 2019 benefit year, HHS would make final determinations by March 1, 2018)
- HHS is seeking comment on whether to allow states to apply an adjustment to the average statewide premium in the calculation of the risk adjustment transfer amounts to reduce the average statewide premium in the individual market, similar to the proposed adjustments states would be allowed to make in the small group market, and how such an adjustment could be justified
- HHS is proposing to evaluate material statistical deviations in error rates in applying error rates to risk scores, beginning with the 2017 benefit year risk adjustment data validation
  - An issuer's risk score would be adjusted when an issuer's error rate materially deviates from a "central tendency" to reflect the difference between the mean error rate or the confidence interval around the population's "central tendency" and the calculated error rate, instead of the full error rate
  - If all error rates in a state risk pool for a particular benefit year do not deviate materially from the national "central tendency" of error rates, no adjustment would be applied to issuers' risk scores
- The error rate derived from the risk adjustment data validation process would be used to adjust payment transfers for an issuer's final benefit year for issuers that exit a state market during or at the end of the benefit year being audited
  - This would require retroactive adjustments to payment transfer estimates market-wide for a given benefit year

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- Issuers with 500 billable member months or fewer who submit data to an EDGE server would not be required to hire an initial validation auditor, or submit initial validation audit results, beginning with the 2017 benefit year risk adjustment validation
  - Such issuers would have their risk scores adjusted by a default error rate equal to the lower of either the national average negative error rate or the average negative error rate within a state
- The application of the materiality threshold associated with the risk adjustment data validation process would be postponed until the 2018 benefit year
  - Issuers with total premiums of less than $15 million in the 2018 benefit year would not be required to conduct a risk adjustment data validation each year, but would be subject to random, targeted sampling
  - The error rate for an issuer not subject to an initial validation audit would either be a national average negative error rate, an average negative error rate within the State or an error rate from prior audits
- The risk adjustment data validation sampling methodology would change beginning with the 2017 benefit year data validation so that the initial data validation audit sample will only include enrollees from state risk pools in which there was more than one issuer and where HHS conducted risk adjustment on behalf of the state
- For purposes of risk adjustment validation audits, HHS is proposing that a provider may submit a mental or behavioral health assessment for validation of a mental or behavioral health diagnosis when state or Federal privacy laws prohibit a provider from submitting a full mental or behavioral health record
  - Issuers may be required to obtain written consent from the patient in order for providers to release a mental or behavioral health record or assessment
- HHS is proposing to clarify that it has the authority to impose civil money penalties for issuers of all risk adjustment covered plans that engage in misconduct or substantial non-compliance of risk adjustment data validation standards, or issuers that intentionally or recklessly misrepresent or falsify information that is provided to HHS
- Risk adjustment data validation would be included as a method of discovering materially incorrect EDGE server data submissions, with adjustments being applied to the applicable benefit year transfer amounts instead of subsequent benefit year risk scores
  - In cases where there is a material impact on risk adjustment transfers for a particular market, HHS would calculate the dollar value of differences in risk adjustment transfers and adjust other issuers' risk adjustment transfer amounts accordingly to balance the market
- A risk adjustment user fee of $1.68 per billable member per year is proposed for the 2019 benefit year, pro-rated on a monthly basis
  - This is unchanged relative to the 2018 benefit year risk adjustment user fee

HEALTH INSURANCE ISSUER RATE INCREASES; DISCLOSURE AND REVIEW REQUIREMENTS

1. Applicability (§154.103)

- Starting with plan or policy years effective January 1, 2019, HHS proposes to exempt student health insurance coverage from Federal rate review requirements
- States would continue to have flexibility to review student rate increases; in states that do not have an Effective Rate Review Program, HHS would monitor compliance with applicable market rating reforms based on complaints and targeted market conduct examinations

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2. Rate Increases Subject to Review (§154.200)

- HHS is proposing to increase the default threshold for review from 10 percent to 15 percent in recognition of significant rate increases in recent years
- No changes are proposed regarding the rate filing requirements
  - All single risk pool issuers must submit a Part I Unified Rate Review Template with each submission
  - If there is an increase of any size the submission must include a Part III Actuarial Memorandum
  - Submissions that are subject to review must include a Part II Consumer Justification Narrative
- States would be able to submit proposals to HHS for state-specific thresholds; HHS proposes to require states submit proposals only if the state-specific threshold being requested is higher than the Federal threshold
  - Requests for a higher threshold would need to be based on factors impacting rate increases in that state that are available by August of the preceding year
  - Future guidance on the process for submission will be issued to be effective for rate filings submitted on or after January 1, 2019
  - HHS proposes to eliminate the requirement for the Secretary to publish a notice annually indicating which threshold applies to each state
    - CMS would continue to post state specific thresholds on its website for states that request a higher threshold than the Federal default
    - States would be responsible to communicate stricter thresholds

3. Submission of Rate Filing Justification (§154.215)

- The proposed change to this section makes a technical correction to a regulation citation

4. Timing of Providing the Rate Filing Justification (§154.220)

- States with Effective Rate Review Programs would be allowed to set a rate filing deadline that differs from the uniform Federal deadline for issuers that only offer non-QHPs

5. Determinations of Effective Rate Review Programs (§154.301)

- Under the proposal, states would only need to provide five business days notice to HHS rather than 30 days if it intends to make rate filing information public prior to the date set by the Secretary
- The uniform posting date of rate filing information is proposed to be eliminated, allowing states to post on a rolling basis

EXCHANGE ESTABLISHMENT STANDARDS

1. Standardized Options (§155.20)

- First introduced in the 2017 Payment Notice as the "Simple Choice" plans, a standardized option is a QHP offered through the individual Exchange with a standard cost sharing structure specified by HHS
- Citing the need to encourage plans to continue to innovate on plan design, and the fact that the preferential display of standard options was stifling innovation, HHS is proposing not to specify any standard options for 2019 and to provide no preferential display

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2. General Standards Related to Establishment of an Exchange

Flexibility for State-based Exchanges and State-based Exchanges on the Federal Platform (§155.106 and §155.200)

- Currently, 11 states and DC operate their own Exchanges, five states use the SBE-FP model, and 34 states utilize the FFE
- HHS is seeking to expand SBEs and is seeking comment on how to accomplish this, as well as ways to expand SBE-FPs where states retain plan management and consumer assistance activities

Election to Operate a State-based Exchange after 2014 (§155.106)

- HHS is proposing to reflect changes to the operation of the SHOP Exchanges in regulation, and will no longer allow states to elect to operate an SBE-FP for SHOP
  - States that are currently operating an SBE-FP for SHOP, which include Kentucky and Nevada, could maintain their existing SBE-FPs for SHOP

Additional Required Benefits (§155.170)

- Benefits mandated by state action prior to or on December 31, 2011 could be considered EHBs and would not require state defrayal, however, states would have to continue to cover the cost of state mandated benefits enacted after December 31, 2011, even if embedded in the state's new EHB benchmark plans.

3. General Functions of an Exchange

Functions of an Exchange (§155.200)

- The requirements that states operating an SBE-FP enforce FFE standards for network adequacy and essential community providers would be eliminated, and instead states would be allowed to set these standards
- In 2019 and later, states determined to have an adequate review process would be allowed to determine network adequacy

Navigator Program Standards (§155.210)

- To maximize state flexibility, HHS is proposing to remove 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, non-profit group
- The requirement that each Navigator entity maintain a physical presence in the Exchange service area would also be eliminated

Standards for Third Party Entities to Perform Audits of Agents, Brokers, and Issuers Participating in Direct Enrollment (§155.221)

- Issuers, in addition to agents and brokers, participating in direct enrollment who engage third-party entities would be required to conduct operational readiness reviews
- Agents, brokers and issuers that participate in direct enrollment would be allowed to select their own third-party entities to conduct onboarding operational readiness reviews and audits
- Third-party entities would have to meet certain requirements established in proposed regulation but would not need to be pre-approved by HHS
  - Such an entity would be considered a downstream and delegated entity of the agent, broker, or issuer and subject to experience, privacy, security, and conflict of interest standards

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4. Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Eligibility Standards (§155.305)

- The requirement that a tax filer be notified directly of the potential for the consumer to be determined ineligible for APTCs if they failed to file and reconcile an income tax return for the year would be eliminated
  - HHS believes this is already being accomplished through other notification processes
  - Additionally, the consumer has the right to appeal the determination and keep APTCs in place during the appeal

Verification Processes Related to Eligibility for Insurance Affordability Programs (§155.320)

- With respect to income inconsistencies, HHS is proposing to require Exchanges to obtain additional documentation of projected income where individuals attest to income between 100% and 400% of FPL but IRS and SSA data indicate income less than 100% FPL
  - In instances where the individual fails to provide such documentation, the Exchange will rely on IRS and SSA data to determine eligibility for APTCs and CSRs
  - Exchanges would be allowed to use thresholds in determining when to override a consumer's projected income
- With respect to eligibility for employer sponsored coverage, Exchanges would be allowed to continue to use an HHS approved alternative process to sampling through plan year 2019, and may request that HHS approve an alternative means for verifying enrollment

Annual Eligibility Redetermination (§155.335)

- HHS is seeking ways to encourage Exchange enrollees to report changes in their circumstances within 30 days of the change

5. Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

Special Enrollment Periods (§155.420)

- HHS is proposing to treat situations where a dependent gains access to an SEP through becoming a dependent and due to loss of minimum essential coverage similarly
  - In both cases, the dependent may be added to the enrollee's current QHP or enroll in a new QHP at any metal level
  - The current enrollee would only be allowed to choose a new QHP if they also qualify for an SEP
- The enrollment dates for all SEPs based on gaining or becoming a dependent, with the exception of gaining or becoming a dependent through marriage, would be aligned
  - Options include making the effective date the date of the qualifying event, the first of the month following the qualifying event, or the first of the month following plan selection
- Women receiving coverage through CHIP coverage for their unborn child would be treated as having minimum essential coverage for the purposes of qualifying for SEPs

Effective Dates for Termination (§155.430)

- HHS is proposing to change the termination date from either the termination date specified by the enrollee, 14 days following the request for termination by the enrollee, or an intermediate date, to be the date of the enrollee's request for termination

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6. Eligibility Standards for Exemptions (§155.605)

Hardship Exemptions (§155.605(d))

- Individuals can qualify for hardship exemptions if coverage is unaffordable
- The standard for affordability is based on the lowest-cost bronze plan available through the Exchange in the individual market in the rating areas where the individual resides
- Bronze plans are not available in every rating region, so HHS is proposing to use the lowest cost Exchange metal level plan available

Required Contribution Percentages (§155.605(e)(3))

- HHS is following the methodology for establishing the change in the required contribution in 2014 and has calculated a required contribution percentage of 8.3% of income for the hardship exemption
  - The proposed percentage is 8.05% for 2018

7. Exchange Functions: Small Business Health Options Program

- HHS is proposing to allow SHOPs to operate in a "leaner" fashion for plan years beginning on or after January 1, 2018
- SBEs would have the flexibility to operate a SHOP as they choose as long as the SHOP operates in accordance with applicable State and Federal laws
- All of the proposed changes would be implemented in the FF-SHOP and SBE-FPs for plan years beginning January 1, 2018 but would not become effective until the Proposed Rule is finalized
  - HHS seeks comment on how to best ease the transition for employers enrolling between when rates become available for plan years beginning in 2018 and when the proposed changes would become effective, as there could be a disruption in processing premium payments and enrollments for these employers

Functions of a SHOP for Plan Years Beginning on or After January 1, 2018 (§155.706)

- SHOPs would continue to be required to assist qualified small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State, and would certify plans for sale through the SHOP, by continuing to provide the following items:
  - An internet web site displaying QHP information
  - A premium calculator that generates prices of available QHPs (the prices would no longer be required to reflect employer contributions)
  - A viewable list of all QHPs available in a given area
  - A call center to respond to questions related to the SHOP
  - SHOP eligibility determinations for small employers
- Small employers would enroll in a SHOP QHP by working with a SHOP-registered agent or broker or directly with a QHP issuer participating in the SHOP, but employers would make premium payments directly to the QHP issuers instead of to the SHOP
- SHOPs would continue to provide employers the option to offer a choice of plans to their employees
  - Employers that would like to offer their employees a choice of plans across issuers would work directly with the issuers to enroll
- Under the proposal, SHOPs would no longer be required to calculate an employer's minimum participation rate
  - QHP issuers would be permitted to use their established practices to calculate a group's participation rate as allowed under State law so long as they comply with 147.104
  - Minimum participation levels would continue to be calculated at the employer level, across all issuers
  - SHOP issuers would still be required to adhere to any minimum participation rate established by a SHOP

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- The FF-SHOP would no longer provide premium aggregation services and would no longer facilitate the collection of premium, however, state-based SHOPs could continue to provide these services if they would like

Eligibility Determination Process for SHOP for Plan years Beginning on or After January 1, 2018 (§155.716)

- In order for coverage to qualify as being offered through a SHOP, an employer would be required to:
  - Obtain from a SHOP a favorable determination of eligibility to participate in the SHOP
  - Enroll in a QHP offered by a SHOP issuer
  - Choose to have enrollment identified as being through the SHOP
- Employers would be allowed to purchase a QHP prior to obtaining a determination of SHOP eligibility, and subsequently confirming with the issuer the status of the enrollment as being through the SHOP once the determination is obtained
  - Issuers would be expected to establish processes to ensure SHOP enrollments are accurately identified
  - Employers applying for the small business health care tax credit would need to obtain an eligibility determination from the SHOP in the taxable year in which they intend to apply for the credit
  - While employers would be encouraged to determine SHOP eligibility as soon as possible, HHS is considering establishing a time limit between when an employer purchases a QHP and when they must obtain a determination for SHOP eligibility, and seeks comment on what this time limit should be
- SHOPs would be required to determine employer eligibility to participate in the SHOP, but SHOPs would no longer be required to determine employee eligibility to enroll
- SHOPs would be required to address inconsistencies in employer eligibility information received from sources other than those used in the employer eligibility process
- SHOPs would be required to notify employers of a denial or termination of the employer's eligibility to participate in the SHOP
- SHOPs would continue to handle appeals related to employer eligibility in the SHOP, but employer group members seeking an appeal related to their SHOP coverage would file an appeal directly with the issuer or other applicable avenues allowed under State and Federal law
- SHOPs would be required to investigate complaints from employer group members who were denied a SHOP special enrollment period
- HHS is proposing that an employer's eligibility to participate in the SHOP would remain valid until an employer makes a change under 155.710(b) that could end its eligibility
  - The employer would be required to submit a new application to determine SHOP eligibility or withdraw from participating in the SHOP
  - SHOPs would no longer be required to notify an issuer when an employer withdraws from a SHOP; disenrollment processes would be handled directly between the employer and the issuer or their agent or broker
- HHS is considering requiring employers to reapply to determine their SHOP eligibility on an annual basis

Record Retention and IRS Reporting for Plan Years Beginning on or After January 1, 2018 (§155.721)

- SHOPs would be required to maintain records for employer eligibility for ten years but would no longer be required to maintain employee-level information since employee-level information will no longer be required to be collected by SHOPs
- HHS is proposing to require SHOPs to send the IRS information about employers that were determined to be eligible to purchase a SHOP QHP only upon the request of the IRS

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Enrollment Periods Under SHOP for Plan Years Beginning on or After January 1, 2018 (§155.726)

- For SHOPs that implement the proposed approach, enrollment timelines, deadlines, and coverage effective dates in SHOPs would be set by employer and QHP issuers consistent with applicable State and Federal laws
  - Enrollment and disenrollment processes would be addressed directly between the employer and the issuer or agent/broker
  - QHP issuers, rather than the SHOP, would be required to:
    - Administer special enrollment periods
    - Set any requirements around renewals, annual employer election periods, and an annual employee open enrollment period
    - Determine, in conjunction with employers, the enrollment timelines, deadlines, and coverage effective dates for newly qualified employees
- State-based SHOPs would be permitted to continue establishing their own timelines, deadlines, and coverage effective dates in processing group enrollments
  - State based SHOPs that maintain current enrollment functions would be encouraged to set termination guidelines and distribute notices for terminations based on nonpayment of premiums or loss of employee eligibility unless State law requires QHP issuers send the notices
- Issuers would still be required to adhere to the guaranteed availability requirements and special enrollment requirements
- State-based SHOPs that continue to provide online enrollment functionality would be required to ensure that enrollment transactions are sent to QHP issuers in accordance with 155.725

Application Standards for SHOP for Plan Years Beginning on or After January 1, 2018 (§155.731)

- HHS would modify the SHOP's information collection requirements related to the model single employer application to include only:
  - The employer's name and addresses of the employer's locations
  - Information sufficient to confirm that the employer is a small employer
  - The Employer Identification Number
  - Sufficient information to confirm that employer is, at a minimum, offering coverage to all full-time employees through a QHP in the SHOP

Termination of SHOP Enrollment or Coverage (§155.735)

- Termination of coverage would be completed by issuers and no longer be a responsibility of SHOPs
  - SHOPs maintaining current enrollment functions would be encouraged to set termination guidelines and distribute notices

HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

1. FFE User Fee for the 2019 Benefit Year (§156.50)

- The user fee rate for issuers offering coverage through the FFE in 2019 is proposed to be 3.5% of premium, unchanged from the 2014-2018 fee

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- The user fee rate for issuers offering coverage through the SBE-FP in 2019 is proposed to be 3.0% of premium
  - HHS phased the 3.0% expected cost in, charging 1.5% of premium in 2017 and 2.0% of premium in 2018
- Since HHS proposes to end employee eligibility, premium aggregation, and online enrollment functionality through the FF-SHOPs for FFE and SBE-FP SHOP issuers, the SHOP user fee is proposed to be eliminated

2. Essential Health Benefits Package

- HHS proposes to provide states with more flexibility in their selection of an EHB package starting in 2019, but are seeking comment as to whether the change in policy should be delayed until 2020
- HHS is also considering establishing a Federal default definition of EHB in the future, but would allow states to adopt their own EHB benchmark plan, provided they defray the costs that exceed the Federal default

State Selection of Benchmark Plan for Plan Years Beginning on or After January 1, 2019 (§156.111(a))

- Current EHB requirements under §156.110 would sunset at the end of 2018, and states would be provided three new options, in addition to current benchmark options:
  - Option 1: A state may select the EHB benchmark plan that another state used for plan year 2017
  - Option 2: A state may replace one or more EHB categories of benefits in its 2017 EHB benchmark plan with another state's 2017 benchmark plan benefits for that same category
  - Options 3: Select a set of custom benefits to serve as the benchmark plan as long as they do not exceed the value of the most generous of a) the state's 2017 benchmark plan or b) any of the three largest small group products in the state (by enrollment), supplemented as necessary, that were available to the state as benchmark plan options in 2017
- Under the options above, a state selecting a new benchmark plan would be required to defray the cost of any benefit included in the new benchmark plan that was mandated by the state after December 31, 2011
- A state's EHB selection would need to be equal in scope to what is provided under a "typical employer plan"
  - Selecting another state's 2017 benchmark plan would be considered to satisfy this requirement
  - States selecting a set of benefits under the Option 3 would be provided flexibility by utilizing a Federal definition of a typical employer plan, as either:
    - One with enrollment of at least 5,000 enrollees in the small or large group market, in one or more states
    - A self insured group health plan with enrolment of at least 5,000 enrollees
- HHS seeks comment on its draft example of an acceptable methodology for comparing benefits of a state's proposed EHB benchmark plan to that of a typical employer plan
- The selected benchmark plan could not be unduly weighted towards any of the ten categories of benefits, and would need to provide benefits for diverse segments of the population
- States would need to provide reasonable public notice and opportunity for comment on any new benchmark plan
- States would need to notify HHS and submit standard documentation outlining the new benchmark plan; documents for the 2019 plan year would need to be submitted by March 16, 2018 and documents for the 2020 plan year would need to be submitted by July 1, 2018
- States selecting Options 2 or 3 would need to submit an actuarial certification affirming the selected benchmark plan is equal in scope to benefits provided under a typical employer plan

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Provision of EHB (§156.115)

- States, at their discretion, would be able to allow greater flexibility to issuers to make EHB substitutions, not only within the same EHB category as allowed for previously, but also between EHB categories, as long as the substituted benefit is actuarially equivalent to the benefit being replaced and is not a prescription drug benefit
  - Substitutions must continue to provide a balance among EHB categories, and benefits for diverse segments of the population

Premium Adjustment Percentage (§156.130)

- The maximum annual limitation for cost sharing, the required contribution percentage for minimum essential coverage (MEC), and the large employer penalty are adjusted annually by the percentage by which average per capita premium for health insurance for the prior year exceeds the average per capita premium for health insurance for 2013
  - The 2019 adjustment percentage was calculated to be 25.2%, based on the projected increase of 2018 premium over 2013 premium in the National Health Expenditure Accounts (NHEA) for employer-sponsored coverage
- Maximum out-of-pocket (MOOP) limits for 2019 are proposed to be $7,900 for self-only and $15,800 for other than self-only coverage

Reduced Maximum Annual Limitation on Cost Sharing (§156.130)

Exhibit 1: MOOP limits for CSR plans are proposed to be as follows:

FPL	AV	REDUCTION IN MOOP	2019 MOOP SELF-ONLY	2019 MOOP OTHER THAN SELF-ONLY
100–150%	0.94	2/3	$2,600	$5,200
150–200%	0.87	2/3	$2,600	$5,200
200–250%	0.73	1/5	$6,300	$12,600

Applications to Stand Alone Dental Plans Inside the Exchange (§156.150)

- Issuers would no longer need to meet the prescribed low and high actuarial values for pediatric dental plans, and instead could offer any plan of benefits as long as the plan covers the pediatric dental EHBs and meets the annual limitations on cost sharing

3. Qualified Health Plan Minimum Certification Standards

Qualified Health Plan Certification

- HHS proposes to rely on states' reviews of network adequacy in states that utilize the FFE, if the state has the authority to enforce standards that are at least equal to the "reasonable access standard" and the means to assess issuer network adequacy
- For states that don't have the authority and means to conduct network adequacy reviews, starting in 2019 they would be able to rely on the issuer's accreditation from NCQA, URAC, or AAAHC
  - Unaccredited issuers would be required to submit an access plan as part of their QHP application to demonstrate they have procedures in place consistent with the NAIC Health Benefit Plan Network Access and Adequacy Model Act
- The 20% essential community provider (ECP) standard would be continued, and issuers would be able to use the ECP write-in process to identify ECPs not on the HHS list of available ECPs

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- Starting in 2019 HHS would expand the role of states in the QHP certification process, including FFEs where the state performs plan management, and defer to the states for:
  - Accreditation requirements (§156.275)
  - Compliance reviews (§156.715)
  - Minimum geographic area of the plan's service area (§155.1055)
  - Quality improvement strategy reporting (§156.1130)

Meaningful Difference Standard for Qualified Health Plans in the Federally-facilitated Exchanges (§156.298)

- Meaningful difference standards for QHPs offered through the FFE or SBE-FP exchanges would be eliminated
  - HHS cites reduced participation in exchanges, and fewer plans to choose from as eliminating the need for this requirement, and allowing more options would encourage plan design innovation

Other Considerations

- HHS is seeking comment on ways to foster market driven programs that improve the management and costs of care, including value-based benefit designs that incentivize cost-effective enrollee behavior, that contribute to better health outcomes, and that lower rates
  - HHS has particular interest in value-based insurance designs that focus on cost effective drug tiering structures
  - HHS is looking for ways to encourage issuers to offer HDHPs paired with HSAs, and ways to promote such plans on Healthcare.gov
- HHS is interested in knowing if there are current regulations that discourage or prohibit such plan designs

4. Minimum Essential Coverage

Other Coverage that Qualifies as Minimum Essential Coverage (§156.602)

- HHS proposes to define coverage under a CHIP buy-in program as minimum essential coverage if the CHIP buy-in program provides coverage identical to that under the state's CHIP program
- HHS seeks comments on whether CHIP buy-in programs that provide greater coverage than the state's CHIP program should be deemed minimum essential coverage without requiring the state to submit an application to HHS

Requirements for Recognition as Minimum Essential Coverage (§156.604)

- HHS seeks comments on whether a new standard of review should be created so that CHIP buy-in programs that "substantially resemble" the state's CHIP program could qualify as minimum essential coverage, which would be less stringent than the current "substantially all" standard

5. Quality Rating System (§156.1120)

- HHS is not proposing any changes to the Quality Rating System at this time, but continues to evaluate methods that would account for social risk factors
  - HHS seeks comment on types of social risk factors (e.g., low income, race, ethnicity, geographic area of residence) that would be most appropriate, as well as data sources and methods to account for them in quality reporting

6. Direct Enrollment with QHP Issuer in a Manner Considered to be Through the Exchange (§156.1230)

- Prior to accepting direct enrollment, QHP issuers would be required to engage a third party to demonstrate operational readiness and compliance

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EMPLOYER INTERACTION WITH EXCHANGES AND SHOP PARTICIPATION

1. Qualified Employer Participation Process in a SHOP for Plan Years Beginning on or After January 1, 2018 (§157.206)

- In accordance with the proposed SHOP changes, HHS is proposing to add §157.206, which largely reflects current provisions associated with §157.205 (which would only apply to plan years prior to January 1, 2018), with some exceptions:
  - Employers would be required to submit a new application to the SHOP if the employer makes a change that could end its eligibility, or if the employer withdraws from participation in the SHOP
  - Employers would be required to notify a QHP issuer of an unfavorable eligibility determination
  - Employers would be required to promptly notify issuers of QHPs in which their members are enrolled if coverage is to be terminated through the SHOP
  - §157.206 would apply to plan years beginning on or after January 1, 2018

ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

1. Reporting of Federal and State Taxes (§158.162)

- HHS is seeking comment as to whether employment taxes, such as Federal Insurance Contributions Act (FICA) tax, should be excluded from premium in the MLR and rebate calculations starting with the 2017 reporting year to be filed by July 31, 2018 with the intent to improve market stability
  - HHS also seeks comment on whether employment tax data should instead be reported separately as an informational item to inform a later decision regarding amendment of the MLR and rebate calculations

2. Allocation of Expenses (§158.170)

- Issuers electing to include 0.8% of premium for quality improvement activity (QIA) expenses in their MLR numerator, as proposed in the next section related to the formula for calculating MLR, would be required to indicate this election when describing the allocation method used for QIA expenses
  - If the issuer chooses to instead report actual QIA expenses, they must continue to comply with the current allocation of expense requirements

3. Formula for Calculating an Issuer's Medical Loss Ratio (§158.221)

- Rather than requiring issuers to track and report actual QIA expenditures issuers would be allowed to include 0.8% of earned premium in the numerator of their MLR calculation in the relevant State and market as QIA expenses, an amount consistent with the average QIA expenses incurred as a percent of premium in 2012 through 2015
  - Issuers would have the option to continue to report actual expenses
- HHS estimates that this change would reduce MLR rebate payments by approximately $23 million based on 2015 MLR data

4. Potential Adjustment to the MLR for a State's Individual Market

- Currently states may request a state-specific MLR standard that is less than 80% in the individual market, subject to a number of requirements including a reasonable likelihood that application of the 80% MLR may destabilize the individual market in that state

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Standard for Adjustment to the Medical Loss Ratio (§158.301)

- Would allow HHS to adjust the individual market MLR for any state where there is a reasonable likelihood that the adjustment would help stabilize the individual market in that state
- Assuming that 22 states would apply for the MLR standard adjustment, HHS estimates this would reduce MLR rebates or increase premiums paid between $52 million (75% MLR standard) to $64 million (70% MLR standard) annually based on 2015 MLR data

Information Regarding the State's Individual Health Insurance Market (§158.321)

- States seeking an adjustment to their MLR would no longer be required to describe its MLR standard and formula for assessing compliance, its market withdrawal requirements, and the mechanisms available to provide consumers with options for alternate coverage
- Many of the application requirements related to enrollment and financial information for each issuer in the market would be reduced or eliminated
- Data requirements for categories of on-Exchange, off-Exchange, grandfathered and transitional health plans would be added
- Reporting would be required only on those issuers that are actively marketing their products
- States would be required to provide information on issuer notices of those who are beginning to offer coverage; this would be in addition to the information currently required on market exits

Proposal for Adjusted Medical Loss Ratio (§158.332)

- Requirements for states to justify how the proposed adjustment was determined, to estimate rebates with and without the adjustment, and to explain how an adjustment would permit issuers to adjust current practices in order to meet an 80% MLR as soon as practicable would be removed
- States would be required to explain how the adjusted MLR would help stabilize the individual market

Criteria for Assessing Request for Adjustment to the Medical Loss Ratio (§158.330)

- Several changes would be made to the criteria for assessing the request to focus on whether the adjustment would help stabilize the individual market
  - Criteria related to issuers likely to exit the market would be replaced with criteria focused on improving access and the capacity of new and existing issuers to write more coverage

Treatment as a Public Document (§158.341)

- Since some documents may not be able to be posted directly on Federal web sites (e.g., spreadsheets containing data that is not accessible for individuals with visual impairments), the Secretary's website would be required to include instructions on how to publicly access information on requests for adjustment to the MLR

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