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CMS releases annual health insurance exchanges final rule

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On April 9, 2018, the Centers for Medicare & Medicaid Services (CMS) released the Benefit and Payment Parameters final rule for 2019 (2019 Payment Notice) applicable to qualified health plans (QHPs) offered on health insurance exchanges.[1] Although the Trump Administration had previously issued regulations and guidance related to the health insurance marketplaces (for example, the market stabilization rule) this is the first time that it has completed the annual payment notice rulemaking cycle, given that that the 2018 payment notice was issued by the Obama Administration. While the focus of the annual payment notice rulemaking cycle is on QHPs offered on exchanges, it often also addresses federal regulations that apply across the health insurance markets, as the 2019 Payment Notice does.

The regulatory changes made in the 2019 Payment Notice reflect the Trump Administration's stated objectives of enhancing flexibility, affordability, program integrity, and market stability, while reducing the regulatory burden of the Affordable Care Act (ACA). Health insurance issuers and state regulators will have to move quickly to respond to the changes in policy, as the 2019 Payment Notice was issued later relative to prior years.

The changes in policy reflected in the 2019 Payment Notice include:

- **Essential health benefits (EHBs)**: Under the ACA, non-grandfathered individual and small group market plans, including exchange plans, must cover 10 categories of EHBs. The 2019 Payment Notice gives states increased flexibility to define the items and services that constitute each of these categories of EHBs. Beginning with plan year 2020, CMS is allowing states on an annual basis to pick from three options when setting their EHB-benchmark plans: (1) choose one of the 50 benchmark plans that states used in plan year 2017; (2) replace one or more of the 10 statutorily required EHB categories of items and services under the state's benchmark plan used in plan year 2017 with the same category or categories of items and services from another state's benchmark plan used in plan year 2017; or (3) select an entirely new set of benefits as the state's benchmark plan. These options are subject to two scope-of-benefit requirements. First, a state's benchmark plan must provide benefits that are at least equal to the scope of benefits provided under a typical employer plan. A typical employer plan is defined as one of the state's 10 benchmark plan options in plan year 2017 or one of the state's five largest group health insurance products by enrollment in plan year

[1] The document, copy available here, was released by the Department of Health and Human Services, but has yet to be published by the Office of the Federal Register. Minor changes could be made.

2017, assuming such products meet certain additional conditions. Second, a state's benchmark plan must not be more generous than the most generous comparison plan, which is defined to include the state's benchmark plan in plan year 2017 and the state's three largest small group health plans by enrollment in plan year 2017.

- **Medical loss ratio (MLR)**: Under the ACA, health insurance issuers must spend a proportion of premium revenues on clinical services and quality improvement relative to their total costs and profits or issue rebates to enrollees; this requirement is known as the MLR requirement. The 2019 Payment Notice, will, among other things, give CMS the authority to allow a state to lower its individual market MLR if the state shows that a lower MLR would help stabilize its individual market.

- **Rate review**: Under the ACA, health insurance issuers must submit information to regulators about proposed premium rate increases. CMS, in partnership with states, reviews any proposed rate premium increases above a threshold to ensure the increases are not "unreasonable." The 2019 Payment Notice makes certain changes to the rate review process, including, most significantly, increasing the "unreasonable" premium increase threshold from its current rate of 10 percent to 15 percent.

- **Network adequacy**: To be certified as a QHP, a plan must meet a network adequacy requirement. Under the 2019 Payment Notice, CMS will continue to defer to state review of network adequacy when a state has the authority and means to enforce standards that are at least equal to the federal "reasonable access standard." For a state that does not have such authority and means, CMS will rely on an issuer's accreditation or the submission of an access plan as part of the issuer's QHP application.

- **Risk adjustment program**: Under the ACA, to protect against potential effects of adverse selection, the risk adjustment program transfers funds from QHPs with relatively low risk enrollees to QHPs with relatively high risk enrollees. Under the 2019 Payment Notice, CMS made technical changes to how issuers' risk scores are calculated. Additionally, beginning in plan year 2020, in states where the federal government operates the risk adjustment program, CMS will allow state regulators to request a percentage adjustment of up to 50 percent in the individual, small group, or merged market if the state regulator can demonstrate that state-specific factors warrant such an adjustment.

- **Meaningful difference standard and standardized plan options**: CMS is eliminating the meaningful difference standard, which required QHPs to be meaningfully different from other QHPs offered by the same issuer within a service area and metal level tier. CMS is also eliminating standardized plan options for plan year 2019, including by not specifying standardized options on HealthCare.gov, the federal exchange webportal.

- **Small business health options programs (SHOPs)**: CMS is no longer requiring SHOPs, the small group market exchanges, to provide employee eligibility, premium aggregation, or online enrollment functionality. While this change in policy is codified in the 2019 Payment Notice, CMS implemented the change in plan year 2018.

- **Hardship exemption**: Although the individual mandate has been repealed by Congress beginning in plan year 2019, CMS is expanding the scope of the hardship exemption from the mandate for years where the mandate remains in force. Under the 2019 Payment Notice, for plan year 2018, affordable coverage, which is used to determine whether an individual is eligible for a hardship exemption, will be based on the individual's projected income using the lowest-cost metal level plan offered through an exchange when there is no bronze level plan available in the individual's service area. In conjunction with the 2019 Payment Notice, CMS

released guidance that further expands the hardship exemption to include a person who lives in a county where: no QHPs are offered (i.e., a bare county); only one issuer offers QHPs and such circumstance renders the person incapable of obtaining coverage; or all QHPs include abortion coverage and such coverage is contrary to the person's beliefs.

- **Special enrollment periods (SEPs)**: CMS made three changes to SEPs by: (1) aligning enrollment options for dependents who are newly enrolling in coverage through an SEP and who are added to an application with current enrollees; (2) making women who lose access to pregnancy-related Children's Health Insurance Program coverage eligible for a 60-day SEP; and (3) clarifying that the prior coverage requirement for SEP eligibility does not apply if an individual is moving from a bare county.
- **Eligibility Verification**: CMS is imposing increased exchange subsidy verification requirements for individuals with data matching issues who attest to income over 100 percent of the federal poverty level.

It remains to be seen whether such changes in policy will help mitigate concerns about future premium spikes or issuers exiting the exchanges. While some experts have contended these changes could generally diminish access by consumers to health care items and services, others argue that they could increase access by making plans more affordable.

If you have any questions about the 2019 Payment Notice, please feel free to contact any of the listed lawyers.

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