American Hospital Association

Special Bulletin

Monday, October 30, 2017

CMS Issues Proposed Notice of Benefit and Payment Parameters for 2019

The Centers for Medicare & Medicaid Services (CMS) Oct. 27 issued a proposed rule that would implement the standards governing health insurance issuers and the Health Insurance Marketplaces for 2019. In the rule, CMS proposes the benefit and payment parameters for qualified health plan (QHP) issuers selling in the marketplaces, as well as policies intended to increase state flexibility and reduce regulatory burden.

CMS proposes, among other changes, to give states additional flexibility to define the essential health benefit (EHB) standards and a larger oversight role of the QHP standards. The agency also would make significant changes to the Navigator Program, the rate review process and the medical loss ratio (MLR) standards. CMS's proposal would maintain the Federally-facilitated Marketplace user fee rate of 3.5 percent and the State-based Marketplace on the federal platform user fee rate of 3 percent, and set the maximum annual limit on cost sharing for 2019 at $7,900 for individual coverage and $15,800 for family coverage. More information on these and other major provisions follows.

The AHA appreciates that many of the proposed changes could reduce the regulatory burden on health plans and give states added flexibilities. However, we are concerned that a number of the proposed changes could increase health care costs for consumers and reduce their access to critical services and providers, including if states decrease the comprehensiveness of coverage through changes to the EHBs.

The proposed policy changes that could most affect hospitals and health systems include those related to potential changes to the EHB standards, network adequacy rules, the Navigator Program and the MLR. Providers with health plans will want to review carefully the broader array of policy proposals, such as those related to rate review, the risk-adjustment model, standardized plan options and the QHP certification standards, among others.

MAJOR PROVISIONS

Essential Health Benefits: CMS proposes to give states additional flexibility in defining EHBs for plans sold for 2019 and beyond. The agency proposes to permit states to change their benchmark plan on an annual basis and would allow them to select from a broader range of benchmark plans, including those used by other states. States would still be required to meet statutory requirements that the EHB package equals the benefits provided under a typical employer plan.

QHP Network Adequacy Standards: CMS proposes to continue its commitment to grant states greater flexibility and oversight over how QHP issuers develop their provider networks. The proposed rule would allow states using the federally-facilitated exchange (FFE) to set their own network adequacy rules, including minimum contracting with essential community providers, and to rely on a state's review process of those networks if CMS determines their process is sufficient.

QHP Certification Standards: CMS proposes a number of other changes to the QHP certification process for the FFE to expand states' oversight role. The agency proposes for states to assume responsibility for reviewing QHP adherence to accreditation, compliance, quality improvement and service area requirements. CMS also proposes to eliminate the "meaningful difference" requirement, which is intended to reduce consumer confusion by prohibiting insurers from offering multiple plans that are essentially the same (e.g., not meaningfully different). CMS suggests that this requirement is no longer necessary given the limited choice available in many markets. CMS seeks comment on additional ways in which states can have a larger role in QHP certification.

Medical Loss Ratio: CMS proposes to increase flexibility for health plans and states with regard to the MLR requirements. The MLR measures how much of the premium dollars goes toward health care services. CMS proposes a streamlined application process for states to adjust the 80 percent MLR standard for the individual market, if the state can demonstrate that a lower MLR standard could stabilize the individual market. The agency also proposes to allow plans to claim a standardized amount for quality improvement activities (QIA), proposed at 0.8 percent of the issuers' earned premium, which, according to CMS, would alleviate a significant reporting burden for issuers.

Navigator Program: CMS proposes significant changes to Navigator Program requirements, including to allow states to contract with only one Navigator entity (current rules require two), to no longer require that at least one Navigator entity be a community and consumer-focused nonprofit group, and to no longer require that Navigator entities maintain a physical presence in the exchange service area. CMS acknowledges that these changes may reduce the availability of in-person consumer assistance.

Rate Review: CMS proposes a number of changes related to rate review that the agency expects will reduce the regulatory burden on states and health plans. The proposed changes would increase the threshold for premium rate increases that require plans to submit a narrative justification to 15 percent from 10 percent. The agency also proposes to allow states to post proposed and final rate increases on a rolling basis instead of all at the same time and reduce the amount of advanced notice that states must give CMS about the posting of rate increases from 30 days to five business days, among other changes.

Special Enrollment Periods (SEPs): In addition to experiencing a qualifying event, individuals must demonstrate that they had qualifying health coverage for a certain period of time to be eligible for several SEPs, such as the SEP for permanent move. In other words, an individual would not qualify for the permanent move SEP if they did not have qualifying coverage for one or more days during the 60 days prior to the move. CMS proposes to exempt individuals who did not have access to a health plan because they lived in a market without any QHPs on the exchange from this requirement. CMS also proposes to create a new SEP for women who lose coverage through the Children's Health Insurance Program (CHIP) post-pregnancy, among other changes to the SEPs.

Standardized Plan Options: CMS proposes to neither define any standardized plans for 2019 nor provide differential display of standardized plans on HealthCare.gov. CMS believes that such plans may discourage innovative plan design.

Risk Adjustment: CMS proposes several changes to the Health and Human Services risk adjustment model, including to recalibrate the 2019 model using a combination of 2014 and 2015 MarketScan® data and the 2016 enrollee-level EDGE data and to allow states to reduce the size of risk adjustment transfers in the small group market, among other changes. The agency also proposes several changes to the risk adjustment data validation audits.

Program Integrity: The agency proposes to focus on individuals who may be overstating their income in order to qualify for advanced premium tax credits. Specifically, the agency is concerned that some individuals with incomes below 100 percent of poverty are overstating their income and inappropriately qualifying for marketplace tax credits and cost-sharing reductions.

Minimum Essential Coverage (MEC) Designation for CHIP Buy-in Programs: The agency proposes to designate automatically CHIP buy-in programs that provide identical coverage to the state's CHIP program as MEC without going through an application process.

Small Business Health Options Program (SHOP): CMS proposes for the federally-facilitated SHOP to no longer provide employee eligibility, premium aggregation, or

online enrollment functions. Instead, small employers would rely on agents, brokers and health plans for these services. The SHOP would continue, however, to provide small employers with an eligibility determination for tax credits, certify QHPs, display QHP information via a website, provide a premium calculator to estimate plan prices and offer a call center for consumer questions. States operating their own exchanges could chose the role of their own SHOP moving forward.

Solicitation of Other Ideas: In preparation of future policymaking, CMS identifies several areas for stakeholder input, including how to:

- Promote innovation within state-based exchanges;
- Make the partnership exchange model (State-based Exchange on the Federal platform) a more appealing option for states;
- Encourage value-based insurance design, including ways to enable health plans to use cost-sharing to incentivize consumer behaviors;
- Promote enrollment in high deductible health plans;
- Increase enrollee reporting of changes in circumstances that may change their eligibility for premium tax credits and CSRs;
- Further modify the MLR standards; and
- Increase flexibility in determining provider network adequacy.

NEXT STEPS

Comments on the proposed rule are due by Nov. 27. For more information, contact Molly Smith, AHA vice president for coverage and State Issues Forum, at mollysmith@aha.org.