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CMS Finalizes 2019 Marketplace Benefit and Payment Policies

OVERVIEW

On April 9th, the Centers for Medicare and Medicaid Services (CMS) released the Final Benefit and Payment Parameters for the 2019 plan year. The rule will make significant changes to benefit and payment guidelines for plans participating in the Affordable Care Act (ACA) Health Insurance Marketplaces. Many provisions of the final rule are intended to carry out President Trump's January 20, 2017 Executive Order to exercise all authority available by law to waive, grant exemptions from, or delay the implementation of any provision of the ACA that would impose a cost or regulatory burden on any state or health care stakeholder.

In cases where a current regulatory requirement is removed, it is expected that the Federally Facilitated Exchanges (FFEs) will modify policies accordingly, but State-Based Exchanges (SBEs), such as New York and California, may often elect to continue with their previous policies.

This document summarizes several major provisions of the rule. The rule is available here.

ESSENTIAL HEALTH BENEFITS (EHB)

The ACA requires that non-grandfathered plans provide 10 categories of EHBs. Under current regulation, states are required to set an EHB-benchmark plan from among the following 10 plans operating in the state: the three largest small group plans, the three largest state employee health plans, the three largest federal employee health plan options, or the largest Health Maintenance Organization offered in the state's commercial market.

The rule will provide states with more flexibility in selecting their EHB-benchmark for plan year 2020. States will be allowed to:

- Choose from 50 EHB-benchmark plans used by other states in 2017;
- Replace one or more categories of EHB benefits with the same categories of EHB benefits from another state's 2017 EHB-benchmark plan; or
- Build their own set of benefits that may qualify as an EHB-benchmark plan if it meets scope of benefit requirements.

States may also allow plans to substitute benefits across EHB categories. A state's EHB-benchmark plan cannot be more generous than the most generous of: the state's 2017 EHB-benchmark plan and the options available for the 2017 EHB-benchmark.

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MEANINGFUL DIFFERENCE

Under current regulation, QHPs are required to contain at least one "meaningful difference" from other plans in the service area and metal-level so that consumers can easily identify differences between plans. The rule will eliminate this requirement for Federally Funded Exchanges (FFEs), with the goal of increasing plan offerings in areas where there are limited coverage options.

INDIVIDUAL MANDATE EXEMPTION

Under current regulation, an individual is exempt from the individual mandate if the lowest cost bronze plan available costs more than the required contribution percentage for self-only coverage. For service areas that do not have a bronze-level plan in 2018, CMS will allow lack of affordable coverage exemptions from the individual mandate based on projected income using the lowest cost Exchange metal-level plan in that service area.

The expanded affordable coverage exemption goes into effect for 2018, in advance of the Tax Cut and Job Act's repeal of the individual mandate penalty in 2019.

RISK ADJUSTMENT

The final rule will adjust and recalibrate the risk adjustment model for 2019 using 2014 and 2015 MarketScan data and 2016 enrollee-level External Data Gathering Environment server data. CMS believes these data sources will bring stability to the market by more accurately reflecting risk.

The risk adjustment transfer amount is currently calculated by reference to the total average statewide premium. The new rule continues to reduce this average amount by 14% to remove administrative components of premium that do not vary with changes in risk. In addition, the final regulation will allow states to request reductions in the amount transferred by up to 50% in the small group market, if it can be established that conditions in the state make the existing federal methodology inappropriate and over-compensate for differences in measured risk. Such reductions in the federal transfer amount would begin in 2020.

In response to a comment about New York's actions in 2017 to reduce net transfers through a state mechanism separate from the federal mechanism, CMS asserted that states, under their general authority to regulate insurance markets, may conduct such activities using their own resources.

CMS will also implement a number of technical changes to HHS-Risk Adjustment Data Validation requirements.

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ADVANCED PREMIUM TAX CREDITS (APTC)

To verify APTC eligibility, CMS will generate annual income inconsistences for consumers who attest to projected annual income that differs from the amount documented by the Internal Revenue Service, Social Security Administration, or other trusted data sources, rather than accept the consumer's attestation. The new check will only apply to households whose income is below 100% of the Federal Poverty Level (FPL) and whose self-projected income is 100%-400% of FPL.

Under current regulation, Exchanges must send an explicit notice to the tax filer before discontinuing an APTC for an enrollee who failed to file a tax return, which explains the issue and the opportunity to reconcile the APTC that was paid. The final rule eliminates the requirement that Exchanges send an explicit notice of the issue before discontinuing the ineligible APTC. FFE enrollees are expected to receive general notices of potential discontinuation.

SPECIAL ENROLLMENT PERIOD (SEP)

The final rule will update several SEP requirements:

- *Dependents* - The rule will standardize the enrollment options for dependents, regardless of whether the dependent is an existing QHP enrollee or a new dependent of an existing QHP enrollee. If an enrollee qualifies for a SEP, the Exchange must also allow the enrollee's dependents to change to another QHP with the same level of coverage (or one metal-level higher or lower, if no such QHP is available). In the case of a birth, adoption, foster care, child support, or court order SEP, the Exchange must ensure that coverage starts on the date of the life event or allow the individual to select a coverage effective date in the month following plan selection.
- *Pregnant Women* - The rule adds a SEP for women who lose pregnancy-related CHIP coverage.
- *Prior Coverage* – Consumers who lived in a service area without a QHP will be exempt from the prior coverage requirement that applies to certain SEPs.

TERMINATION EFFECTIVE DATES

Under current regulations, enrollees are required to give 14 days of notice prior to termination of Exchange coverage. The rule will allow enrollees to request same-day or prospective coverage termination dates.

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MEDICAL LOSS RATIO (MLR)

The rule will ease several MLR reporting requirements by allowing plans to report a standardized amount equal to 0.8% of the plan's earned premium each year for a minimum of three consecutive MLR reporting years instead of reporting actual Quality Improvement Activity (QIA) expenses. Plans will continue to have the option of tracking and reporting QIA expenses. This can be expected to have a slightly inflationary impact on MLR measures, improving the profitability of plans at or near the minimum MLR threshold that spend less than 0.8% on QIA activities.

NAVIGATORS

Under current regulation, each Exchange must have at least two Navigator entities, one of which must be a community and consumer-focused nonprofit and both of which maintain a physician presence in the Exchange's service area. CMS will eliminate these requirements.