



PCG Memorandum on Proposed Exchange Guidance for 2019

Proposed Notice of Benefit and Payment Parameters for 2019, the 2019 Draft Letter to Issuers in the Federally-facilitated Exchanges, and accompanying guidance

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EXECUTIVE SUMMARY

Addendum to the Executive Summary

On November 27, 2017, the Centers for Medicare & Medicaid Services (CMS) released its annual [Draft Letter to Issuers in the Federally-facilitated Exchanges](#) (Letter) for the 2019 plan year. As is typical, the draft Letter provides operational and technical guidance relative to Qualified Health Plan (QHP) certification to issuers seeking to offer QHPs and Standalone Dental Plans on Federally-Facilitated Exchanges (FEEs) and State-Based Exchanges on the Federal Platform (SBE-FPs). At the same time, CMS also released guidance on the [rate review timeline](#) and [other key dates](#) for certification of QHPs for the 2019 plan year.

This year's draft Letter is brief compared to prior years' Letters. It largely refers readers to policies outlined in the 2018 Letter. CMS also reiterated many of the changes proposed in the Proposed Notice of Benefit and Payment Parameters (NBPP) for 2019, including related to state responsibilities for reviewing plan compliance with certification criteria, eliminating standardized plans, and changes to the Small Business Health Options Program (SHOP) and standalone dental plans. All of these proposals are outlined in detail below.

This summary focuses on notable proposed policy changes from prior years as well as the timeline for certification of 2019 QHPs. We have inserted proposed changes included in the Letter into our summary of the proposed NBPP in red.

The summary focuses on the standards and process for certification of QHPs. Other topics addressed by the Letter that may be of interest include:

- Transparency in coverage;
- QHP oversight; and
- Consumer support, including guidance related to the Summary of Benefit and Coverage.

Comments on the Letter are due on December 11, 2017.

Original Executive Summary

The Centers for Medicare & Medicaid Services (CMS) released its annual [Proposed Notice of Benefit and Payment Parameters \(NBPP\) for 2019](#) on October 27, 2017.¹ As is typical, the NBPP for 2019 addresses a breadth of issues relative to health plan regulation, Exchange operations (including financial parameters), and premium stabilization programs. However, as the first NBPP released by the new administration, the direction of this year's NBPP is a stark departure from prior years. The stated goals of the NBPP are to increase state flexibility, decrease regulation of insurance plans, and improve program integrity. While most changes are proposed to be effective starting with the 2019 plan year, some major changes (including related to the Small Business Health Options Program) would be effective immediately.

The proposed rule includes a combination of typical changes along with major direction changes, including:

- Changes to the process and options for states seeking to change their Essential Health Benefit (EHB) benchmarks;
- The elimination of the newly introduced standardized "Simple Choice" plans;
- New flexibility in rate review; and
- Limiting the role of Small Business Health Options Programs (SHOPs).

Regulators across the country will be reviewing the changes outlined in these proposed regulations to understand how the changes proposed to Qualified Health Plan (QHP) certification, health insurance regulation, and Exchange operations, specifically, would impact their regulation of health plans and the markets in their states. In

¹ CMS released a [Draft 2019 Actuarial Value Calculator](#) also on October 27, 2017.

an effort to support states as they analyze the impact of the changes proposed in the NBPP for 2019, we have created this summary of notable changes relative to those topics.

Top of mind for states will likely be their additional responsibilities proposed in the NBPP for 2019. Under the proposal, states would take on an increased role in oversight and have new decisions to contemplate, including:

- Whether to select a new EHB benchmark plan and states' increased responsibilities in deciding whether substitutions across EHB categories will be permitted and monitoring the appropriateness of those substitutions;
- States' increased responsibilities relative to QHP certification;
- Whether to adopt a state-specific threshold for reviewing premium increases and whether to avail of the flexibility related to rate filing deadlines and posting dates;
- Whether and how to monitor student health insurance plan rates;
- Whether to request adjustments to the medical loss ratio rebate threshold in the state; and
- Whether to request an adjustment to the risk adjustment transfer amount.

States will also be interested in the feedback that CMS is seeking via the proposed NBPP for 2019. In addition to seeking comments on all proposals and the issues flagged below, CMS is seeking input on how it can promote innovative coverage strategies including:

- Value-based insurance design, including: drug tiering; strategies to address overutilization of high-cost health care services; innovative network designs; and strategies to promote preventive care and wellness;
- Using cost sharing to incentivize more cost-effective enrollee behavior and higher quality outcomes; and
- Promoting the use of Health Savings Accounts, including by promoting enrollment in high-deductible health plans via healthcare.gov display.

CMS is also seeking input on how to promote State-Based Exchanges (SBEs) – including how it can provide technical assistance and make regulatory changes to allow SBEs to more easily utilize commercial platforms - and SBEs on the Federal Platform (SBE-FPs), including by: streamlining requirements; providing more operational guidance and greater decision-making authority; and allowing for access to greater data and opportunities for branding. Comments are also sought relative to promoting program integrity, including via shortened periods for reporting eligibility data.

CMS also noted that it plans to consider future rulemaking relative to drug costs and price transparency as well as relative to eligibility standards for Exchanges and financial assistance programs.

For a full discussion of the notable changes relative to Exchange operations, QHP certification, and health insurance regulation, please see below.

Other topics addressed by the NBPP but not included in this summary include:

- **Enrollment and eligibility rules**, including related to notifications, data-matching, verifying access to employer-sponsored insurance for those applying for premium tax credits, eligibility redeterminations and terminations;
- Eligibility requirements for certain **Special Enrollment Periods**, including aligning standards for new dependents and allowing for exemptions from the prior coverage requirements;
- **Assisters**, including eliminating standards around the selection of Navigators and requirements for all assisters;
- **Direct enrollment**, including changing the standards for readiness reviews for third-party entities performing direct enrollment;
- The **Risk Adjustment** program, including relative to sequestration, recalibrating parameters for the methodology and recalibrating the formula, adjusting the data used, changes to data validation

requirements, and allowing states to request changes to their transfer amounts in their state; CMS also proposed a \$0.14 per member per month risk adjustment user fee;

- The **Medical Loss Ratio** standards, including amendments relative to quality improvement expenses and simplifying the state waiver process; CMS is also seeking input on the treatment of taxes in the MLR rebate calculations; and
- The **Individual Mandate**, including the required contribution percentage and eligibility standards for exemptions.

Comments on the proposed NBPP for 2019 are due on November 27, 2017.

Please contact us for more information about the issues not included in this summary as well as those outlined below.

NOTABLE CHANGES PROPOSED

Exchange User Fees

CMS is proposing to maintain the user fee on Federally-Facilitated Exchange (FFE) issuers at 3.5 percent of premiums generated through FFE sales in 2019. This is the same user fee rate that has been utilized since 2014. However, given the changes proposed to the SHOP (as outlined below), CMS is proposing not to collect a user fee from SHOP plans.

CMS has proposed a 3 percent user fee for issuers on the SBE-FPs. This is the same amount that has been proposed since the implementation of the SBE-FP, though it was prorated for both 2017 and 2018.

Maximum Annual Limit on Cost Sharing

As CMS does annually, it has proposed updated maximum annual limits on cost sharing (which are increasing by 7 percent) in the NBPP for 2019 as follows:

	2018		2019	
	Self-Only	Other than Self-Only	Self-Only	Other than Self-Only
Maximum Annual Limit on Cost Sharing	\$7,350	\$14,700	\$7,900	\$15,800
Reduced Annual Limit on Cost Sharing for Individuals between 100% and 150% of the Federal Poverty Level (FPL)	\$2,450	\$4,900	\$2,600	\$5,200
Reduced Annual Limit on Cost Sharing for Individuals between 150% and 200% of the FPL	\$2,450	\$4,900	\$2,600	\$5,200
Reduced Annual Limit on Cost Sharing for Individuals between 200% and 250% of the FPL	\$5,800	\$11,700	\$6,300	\$12,600

The draft Letter reiterates that:

- CMS will continue to enforce requirements related to cost-sharing reduction (CSR) Silver plan variations, including the requirement that carriers adjust maximum annual limits on cost sharing for those plan variations; and
- Payments to issuers for CSRs are subject to appropriation.

Stand-Alone Dental Plans (SADPs)

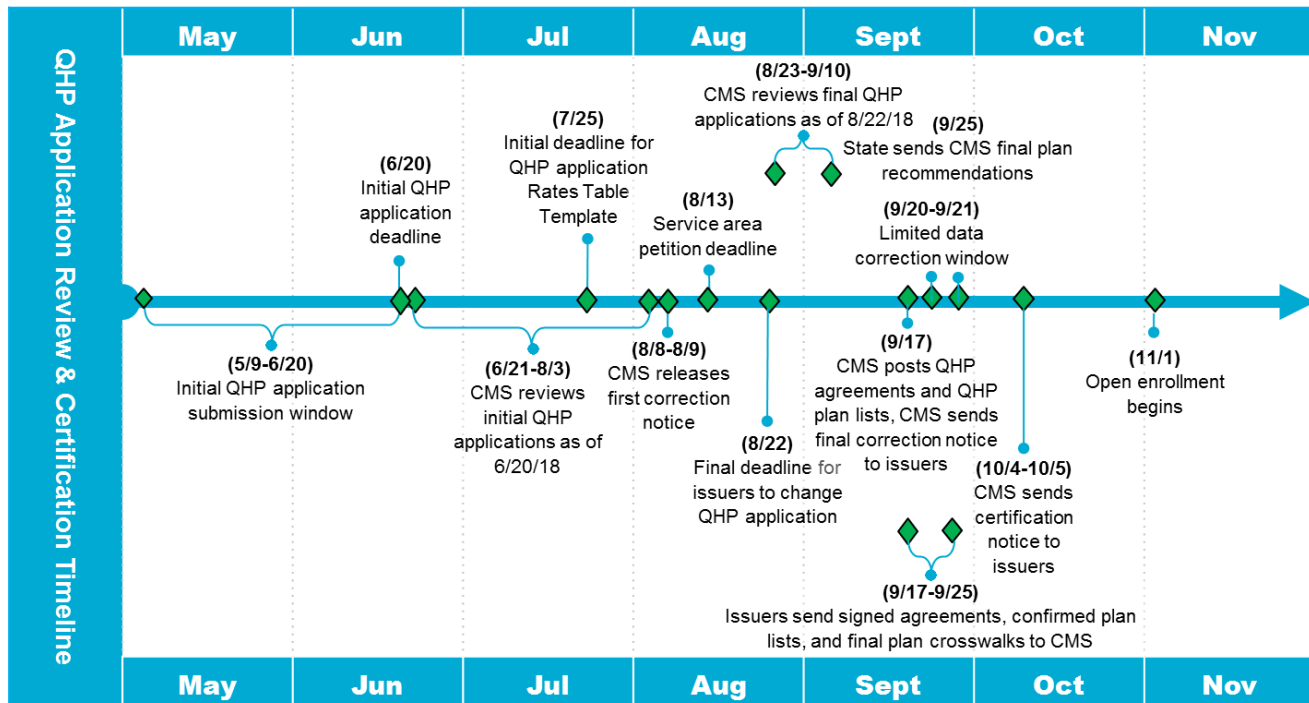
No changes were proposed to the maximum annual limits on cost sharing for SADPs.² However, the NBPP and Letter do propose to remove the actuarial levels (high and low) for SADPs.

²² The maximum annual limit on SADP cost sharing is currently \$350.00 for one child and \$700 for two or more.

QHP Certification

Draft 2019 Plan Certification Timeline for the FFEs

The draft Letter along with the [Proposed Key Dates for Calendar Year 2018 guidance](#) set forth the proposed QHP certification timeline, with additional time built into the latter part of the review period. CMS proposals defer to states to set their own deadlines within the parameters of the CMS required transfer deadlines for form, binder, and rate filings. SERFF transfer deadlines would again correspond with HIOS transfer deadlines and all plans submitted to the state for certification, including off-Exchange SADPs, would be transferred by CMS deadlines set forth in the timeline below.



The 2019 draft Letter includes an additional requirement that all issuers register for the CCIIO Plan Management Community to receive communications regarding applications as well as correction and certification notices. CMS will release information in the Spring of 2018 about how to register for the Plan Management Community.

Reliance on State Reviews of Proposed QHPs

The NBPP for 2019 and the draft Letter propose a number of changes related to QHP certification. CMS proposes to build upon the changes it made with last spring's [Market Stabilization Regulations](#).

The approach for 2019 U.S. Office of Personnel Management (OPM) certification of Multi-State Plan options remains unchanged from that used in 2018. Please refer to the [2018 Letter to Issuers](#) for more information.

The NBPP and draft Letter propose that CMS will continue to rely on state reviews of **network adequacy** in states that have the authority and means to enforce standards that are at least equal to the "reasonable access" standard. As was the case for the 2018 plan year, in states that do not have such authority and / or means, CMS will rely on issuer accreditation from an accrediting entity recognized by the U.S. Department of Health and Human Services (HHS)³ to ensure network adequacy. Issuers that are not accredited would be required to

³ This includes the National Committee for Quality Assurance, URAC, and the Accreditation Association for Ambulatory Health Care.

submit, as part of their QHP filing, an access plan that demonstrates that the issuer has standards and procedures in place to maintain an adequate network consistent with the [National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act](#).

As in past Letters, CMS is examining modifications to the network breadth analysis. The changes proposed are to make the network breadth analysis county specific, to change the terms used to describe the network's breadth, and to obtain data directly from the issuers that is machine-readable, instead of using the Federal network template. States participating in this program are encouraged to comment on these proposed modifications.

CMS will also continue to allow insurers to write-in **Essential Community Providers (ECPs)** not on the CMS list and to maintain the reduced 20 percent threshold as the percentage of available ECPs that must be included in provider networks as provided for in the Market Stabilization regulations. As in prior years, carriers that do not meet the 20 percent standard will need to submit a narrative justification demonstrating that their networks provide for an adequate level of services for individuals that are low-income or medically-underserved and explaining how they plan to increase ECP participation for future years. The narrative justification must include:

- The number of contracts offered to ECPs for the applicable plan year;
- The number of additional contracts an issuer expects to offer and the timeframe of those planned negotiations;
- The names of the specific ECPs to which the issuer has offered contracts that are still pending; and
- Contingency plans for how the issuer's provider network, as currently designed, would provide adequate care to enrollees who might otherwise be cared for by relevant ECP types that are missing from the issuer's provider network.

As provided for in the [Guidance to States on Review of QHP Standards for Federally-Facilitated Exchanges for Plan Years 2018 and Later](#), CMS will also continue to rely on state reviews as follows:

- In all states, of **licensure and good standing**;
- In states with Effective Rate Review Programs, **rate outlier analyses**; and
- In plan management states, of:
 - **Service area**;
 - **Prescription drug formulary outliers**; and
 - **Non-discrimination in cost sharing**.

For 2019, CMS proposes to expand its reliance on state reviews to include reviews of:

- **Accreditation** requirements;
- **Compliance** reviews;
- **Minimum geographic area** of a plan's proposed service area; and
- **Quality Improvement Strategy** reporting.

CMS is specifically seeking comment on whether states are already performing these reviews and whether they should defer to states for other reviews. The NBPP also requests comments on the potential benefits, challenges, and unintended consequences of increasing the state role in this manner and what the impact may be on insurers with plans in multiple states. If this proposal is finalized, CMS intends to provide further guidance.

CMS will continue to review plan data that relates to Federal funds and plan display, including related to cost-sharing reductions, data integrity (which remains unchanged from 2018) and plan crosswalks.

State-Based Exchanges on the Federal Platform

CMS proposes to eliminate the requirement that SBE-FPs enforce FFE standards for network adequacy, ECPs, and meaningful difference. SBE-FPs would be able to decide how to implement those standards.

Meaningful Difference

CMS proposes to eliminate the **meaningful difference** QHP certification requirement.

Quality Reporting and Improvement

As outlined in the NBPP **and reiterated in the draft Letter**, CMS is considering giving states a larger role in the **quality improvement compliance review** process and anticipates releasing more information on QIS requirements in the 2019 QIS Technical Guidance and User Guide.

Essential Health Benefits

State Benchmark Plans

The NBPP proposes significant changes to the process and options for states to select Essential Health Benefits (EHB) that will apply in the state as of 2019. The state-led benchmark approach will be maintained. However, starting in 2019, states would have the *option* of changing their benchmark plan on an annual basis.

States would also have new options to select from. In addition to the option of maintaining their 2017 benchmark plan, states could change the benchmark by selecting between the following options:

- The EHB benchmark that another state had in place in 2017;
- Replacing one or more benchmark categories from its 2017 benchmark with the same category from another state's 2017 benchmark plan; and
- Designing a set of benefits, as long as it is not more generous than the state's 2017 benchmark or the other options for the state's benchmark plan in 2017 (based on an actuarial certification).

The requirement that the EHB be equal in scope to a typical employer plan would still apply and must be supported by an actuarial certification and report.⁴ However, the "typical employer plan" could be a plan in any state. CMS is seeking comment on whether to require that the "typical employer plan" have some enrollment in the state in question.

The state would be required to host a "reasonable" public notice and comment period prior to selecting a new benchmark, but reasonableness would be determined by the state. CMS seeks comments regarding whether specific standards for the public notice and comment period should apply.

States would be required to notify CMS of new benchmark plan selections and submit required documentation by March 16, 2018 for 2019 and July 1, 2018 for 2020. In any year that a state does not select an EHB benchmark or their proposal does not meet requirements (including notifying CMS by the deadlines and providing required documentation), their existing selection would remain. Documentation that must be submitted with selections includes:

- Evidence of compliance with the 10 EHB categories and other requirements;
- The option used to select the benchmark;
- An actuarial certification that the benchmark is equal in scope to a typical employer plan (unless the benchmark is a 2017 benchmark from another state);
- An actuarial certification that the benchmark does not exceed generosity of comparable plans if the state designs its own benchmark;
- A description of the benchmark's benefits and limitations; and
- Information necessary for CMS to operationalize the benchmark plan (including a summary chart).

CMS is seeking comment on whether to delay the effective date of these changes to 2020.

⁴ CMS also released [guidance](#) regarding the methodology for comparing the benchmark to typical employer plans.

The requirement that states defray the cost of any benefits in excess of the EHBs based on state mandated benefits adopted after December 31, 2011 remains (even if those benefits are included in the new benchmark plan). CMS is seeking comments on how this requirement might be reworked to increase state flexibility while remaining broadly cost-effective (such as by allowing the state to make changes to its mandated benefits without defraying the cost if it can prove that doing so is budget neutral).

CMS is also considering establishing a uniform national default definition of EHB; if the cost of the state benchmark exceeded the cost for the national default, the state would have to defray that cost as well. CMS would publish more guidance on this requirement. CMS is also considering instituting a national benchmark plan standard for prescription drug coverage.

Insurer Substitutions

CMS also proposes to provide more flexibility for insurers seeking to make substitutions relative to the EHB benchmark plan. In addition to being able to make substitutions of benefits within the same EHB category, the NBPP proposes to allow insurers to substitute benefits across categories as long as the substituted benefit is actuarially equivalent to the benefit being replaced and a prescription drug benefit is not being replaced. The insurer must still ensure an appropriate balance across the EHB categories and benefits for a diverse segment of the population, as assessed by the state. States may prohibit or further restrict such substitutions. CMS seeks comments on whether additional flexibility or additional standards are needed as well as examples of substitutions of interest to carriers.

Standardized Options

The NBPP for 2019 **and the draft 2019 Letter** propose to eliminate the standardized plans that were introduced for the 2017 plan year. CMS is not proposing a standard plan design for 2019 and it will not provide differential display for standardized plans.

Rate Review

Student Health Plans

The NBPP proposes to exempt student health plans from rate review beginning in 2019, though states could still choose to review rates.

Reasonable Review Threshold

The NBPP **and draft Letter** also propose to increase the threshold for rate increases that will be subject to a reasonableness review from 10 percent to 15 percent. States could select a different threshold; only higher state thresholds would require CMS approval. CMS will issue future guidance regarding such requests. CMS will only provide notice of states that apply higher thresholds.

Timeline

The draft Letter and the [draft bulletin on the rate review process](#) outline key dates for the rate review process for 2019 QHPs:

Activity	Date
Submission deadline for issuers in a state without an Effective Rate Review Program to submit proposed rate filing justifications for single risk pool coverage into the URR module of HIOS.	6/1/18
Submission deadline for issuers in a state with an Effective Rate Review Program to submit proposed rate filing justifications for single risk pool coverage into the URR module of HIOS.	7/25/18
Target date on which CMS will post preliminary rate changes.	8/1/18
Deadline for all rate filing justifications for single risk pool coverage <u>that includes a QHP</u> to be in a final status in the URR system.	8/22/18
Deadline for all rate filing justifications for single risk pool coverage <u>that includes only non-QHPs</u> to be in a final status in the URR system.	10/15/18
Target date on which CMS will post <u>all</u> final rate changes.	11/1/18

CMS is also proposing to allow Effective Rate Review Program (ERRP) states to set different deadlines for rate filings from insurers *only* filing non-QHPs. The NBPP also proposes to shorten the amount of advance notice ERRP states must provide if they will make rate filing information public prior to the date specified by CMS (from 30 days to five business days). ERRP states may also post rates on a rolling basis; states doing so and prior to the date specified for posting by CMS only need provide notice to CMS once. CMS will continue to post rates on a uniform basis.

Small Business Health Options Program (SHOP)

The NBPP proposes to codify CMS's announcement from last spring that it would allow for "leaner" SHOPS. SHOPS would no longer be required to directly facilitate enrollment and the FF-SHOP would eliminate its enrollment functionality.

SHOPS would continue to be required to:

- Certify SHOP plans;
- Operate a website that displays SHOP plan;
- Provide a premium calculator for employers;
- Have a call center to answer SHOP questions; and
- Make employer eligibility determinations and terminations.

Employee choice would be continued (employers could view plan options on the SHOP and enroll in plans and pay premiums directly with insurers). Insurers would be required to spread minimum participation rates across all plan selections.

SHOPS *could* (and the FF-SHOP would) eliminate the following functions:

- Employee eligibility and termination (and related notices);
- Enrollment; and

- Premium payment and aggregation.

The NBPP [and Letter](#) also propose to eliminate SHOP-specific requirements related to enrollment timelines, deadlines, and coverage effective dates, [and the Letter states that guidance from the 2018 Letter would no longer apply to SHOP QHPs for the 2019 plan year.](#)

Instead, enrollment could happen directly through an insurer (with assistance of a SHOP-registered agent or broker as desired) and still be considered a SHOP enrollment for purposes of the small business health care tax credit as long as the employer applies to the SHOP for an eligibility determination (though that can be done after enrollment). For enrollments that are identified as SHOP enrollments, SHOP insurer and Special Enrollment Period rules would also still apply. In leaner SHOPs, payments would be made directly to insurers and insurers would no longer be required to offer average (“composite”) premiums.

State-Based SHOPs could decide whether or not to implement this leaner structure.

If finalized, these changes would be effective immediately and impact plans with effective dates on or after January 1, **2018**, but would only apply upon new enrollments or renewals. Those groups that have purchased plans effective in 2017 can continue to pay premiums through SHOPs until their current plan year ends. CMS seeks input on how to ensure a smooth transition.

At the same time as releasing the proposed NBPP, CMS released [accompanying guidance](#) regarding proposed changes to the SHOP. This guidance provides that – in order to avoid transition challenges that could result if a 2018 plan is purchased via the SHOP prior to the effective date of the rule but later transitions to direct payment to insurers – SHOPs (and SHOP insurers and agents / brokers) may begin operating according to the leaner manner for all 2018 enrollments immediately while the rule is pending. Insurers that begin direct enrollment and premium payment now will avoid user fees; those that choose not to while the rule is pending must inform HHS of their intent not to do so as soon as possible.

If this proposal is finalized, states will not be able to request approval of SBE-FP SHOPs going forward, though existing SBE-FP SHOPs in Kentucky and Nevada could continue to rely on the remaining functionality of the FF-SHOP.

Minimum Essential Coverage

The NBPP proposes that Children’s Health Insurance Program (CHIP) buy-in plans that provide identical coverage to the state CHIP plan will be considered Minimum Essential Coverage (MEC). CMS also proposes that other buy-in programs could submit an application to CMS to be considered MEC. CMS seeks comment on whether those applications should be evaluated based on whether the plans “substantially resemble” the state CHIP plan instead of based on whether the buy-in complies with “substantially all” of the requirements of Title I of the ACA as well as whether buy-ins that provide greater coverage and buy-in programs to other public programs should automatically be deemed MEC. CMS also seeks feedback on whether considering these buy-ins to be MEC will impact the individual market risk pool.

PCG's team of regulatory experts can help you assess the implications of regulatory changes for your state or entity. Contact Lisa Kaplan Howe (lkaplanhowe@pcgus.com) or Margot Thistle (mthistle@pcgus.com) for more information.



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