# PCG Memorandum on Final Exchange Guidance for 2019

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

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## EXECUTIVE SUMMARY

On April 9, 2018, the Centers for Medicare & Medicaid Services (CMS) released the long-awaited final Exchange guidance for the 2019 plan year – the final Notice of Benefit and Payment Parameters for 2019 (NBPP) and the final Letter to Issuers in the Federally-facilitated Exchanges (Letter). Together, the NBPP and Letter set forth changes to rules and operational and technical guidance for health plan regulation, Exchange operations (including plan certification and financial parameters), and premium stabilization programs. Most–but not all–of the changes take effect for the 2019 plan year.

The final guidance includes relatively limited changes from the proposed guidance – mainly in the form of tweaks rather than any significant overhauls. Similar to the proposed NBPP and Letter, the final guidance includes a combination of typical changes from prior years along with major directional 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 need to review the final changes in short order as they prepare to begin the process of certifying Qualified Health Plans (QHPs) for the 2019 plan year. In an effort to support states as they analyze the final NBPP and Letter for 2019, we have created this summary of notable changes from prior years. 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 relative to financial assistance;
- Special Enrollment Periods;
- Requirements for assisters, including Navigators; and
- Direct enrollment standards.

At the same time, CMS also released guidance regarding new hardship exemptions from the individual mandate (which remains in effect until 2019) – including for individuals with no or limited access to QHPs, related to abortion coverage, and for other “personal circumstances.” In addition to outlining the new exemptions, the guidance explains the duration of each exemption and how to apply.

CMS also released guidance extending transitional plans that are exempt from certain Affordable Care Act requirements (often referred to as “grandmothered plans”). States may allow these policies to be renewed as late as October 1, 2019, as long as coverage ends by December 31, 2019.

# NOTABLE CHANGES

## Exchange User Fees

CMS maintained 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 to the SHOP (as outlined below), CMS will not to collect a user fee from SHOP plans.

CMS maintained a 3 percent user fee for issuers on the State-Based Exchanges on the Federal Platform (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

CMS updated the maximum annual limits on cost sharing (which are increasing by 7 percent) 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 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)

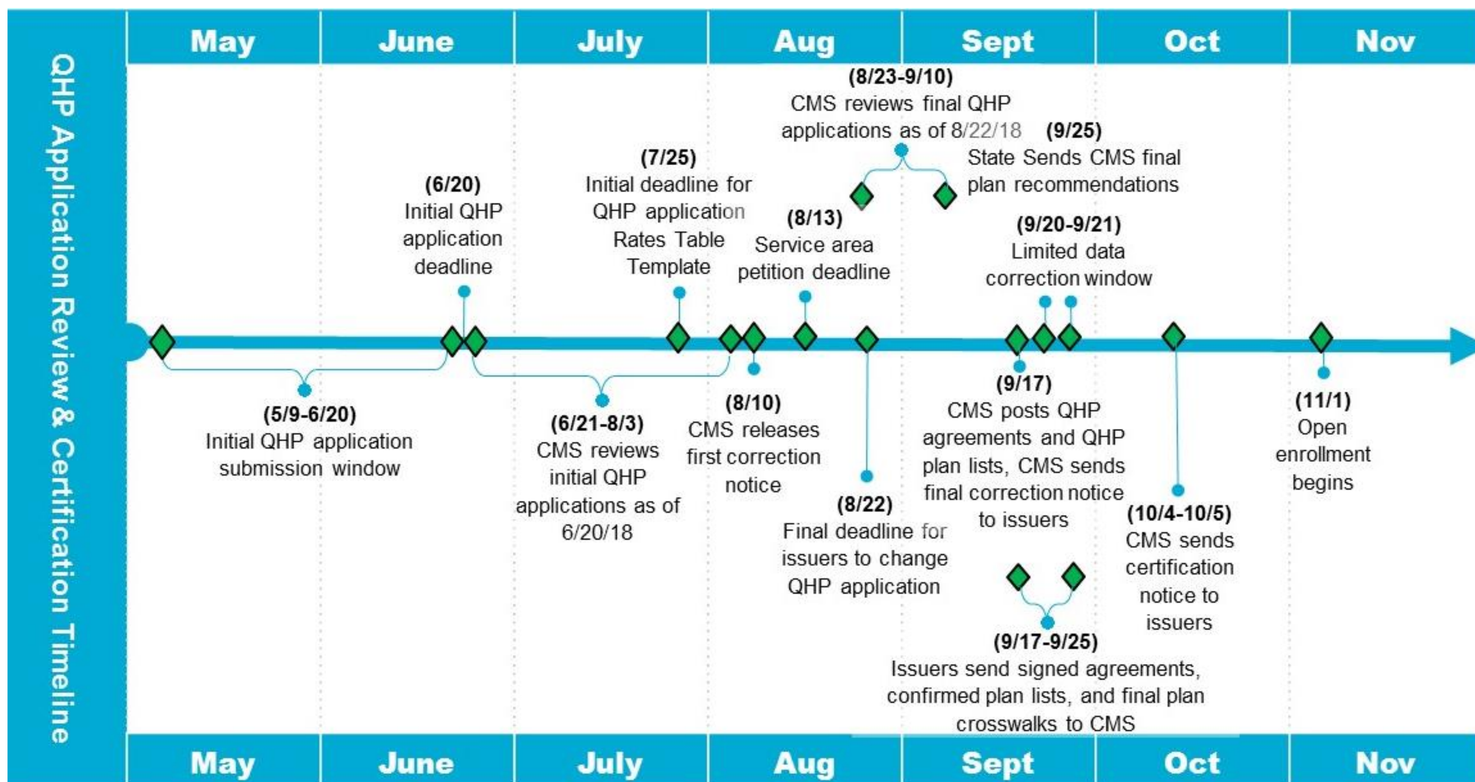
No changes were made to the maximum annual limits on cost sharing for SADPs.[1] However, CMS eliminated the actuarial levels (high and low) for SADPs. SADPs may be filed at any actuarial value level as long as they meet the annual limitations on cost sharing.

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

## QHP Certification

*2019 Plan Certification Timeline for the FFEs*

The Letter sets forth the QHP certification timeline for 2019 plans, with additional time built into the latter part of the review period. CMS will 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 will again correspond with the Health Insurance Oversight System (HIOS) transfer deadlines. All plans submitted to the state for certification, including off-Exchange SADPs, will be transferred by CMS deadlines set forth in the timeline below.




All issuers must register with the Center for Consumer Information and Insurance Oversight (CCIIO) Plan Management Community to receive communications regarding applications as well as correction and certification notices. CMS will release information this Spring about how to register for the Plan Management Community.

*Reliance on State Reviews of Proposed QHPs*

CMS will continue to rely on state reviews of **network adequacy** under the same standards as used for 2018 QHPs, and will maintain the same standards and process for **Essential Community Providers (ECPs)**. However, CMS strongly suggested that all issuers consider the inclusion of telehealth services as part of their networks to ensure consumer access to all covered services.

CMS will modify the network breadth analysis for 2019, and perform the calculation for the specific county rather than the county type. Starting in 2020 or later, CMS may collect data directly from the issuers that is machine-readable, instead of using the Federal network template.

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.

However, CMS did not finalize the proposal to expand its reliance on state reviews in 2019 to include reviews of:

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

CMS will continue to perform these functions in 2019.

Specific to the accreditation standard, carriers that have previously had one or more QHPs certified through the FFE, but not for plan year 2018, and are returning to the Exchange will be treated as a second year QHP.

CMS will also 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.

*Meaningful Difference*

CMS eliminated the meaningful difference QHP certification requirement.

*State-Based Exchanges on the Federal Platform*

CMS eliminated the requirement that SBE-FPs enforce FFE standards for network adequacy and ECPs. SBE-FPs will decide how to implement those standards.

## Essential Health Benefits

*State Benchmark Plans*

The NBPP makes significant changes to the process and options for states to select Essential Health Benefits (EHBs) that will apply in the state as of 2020 (a year later than initially proposed). The state-led benchmark approach will be maintained. However, starting in 2020, states will have the *option* of changing their benchmark plan on an annual basis.

States also have new benchmark options to select from. In addition to the option of maintaining their 2017 benchmark plan, states can 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

Applicable to each of these options, the selection must not be more generous than the state's 2017 benchmark or the other options for the state's benchmark plan in 2017 (subject to supplementation requirements and based on an actuarial certification). This is an expansion of the "generosity" limitation that was proposed, which only applied the standard if the state designs its own benefits.

The requirement that the EHB be equal in scope to a typical employer plan still applies and, unlike as proposed, the comparison must be to employer plans with enrollment and being sold in the state. Specifically, the "typical

employer plan" may be one of the 10 benchmark options for the 2017 plan year or the largest health plan by enrollment in any of the five largest large group health insurance products by enrollment in the state, as long as:

- The product has at least 10 percent of total enrollment of the five largest large group health insurance products;
- The plan provides minimum value;
- The benefits are not excepted benefits; and
- The benefits are from a plan year beginning after December 31, 2013.

This analysis must be supported by an actuarial certification and report.

At the same time as releasing the Exchange guidance, CMS released a sample methodology for comparing EHB benchmark plans to aid in the "generosity" and "typicality" analyses outlined above.

The following requirements also will continue to apply:

- The benchmark plan must cover items and services in all 10 EHB categories and that there be an appropriate balance of coverage for the 10 EHB categories;
- The benchmark plan must include coverage of at least one drug in every USP category and class; and
- The benchmark plan must not include discriminatory benefit designs.

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). The state will not have to defray the cost of mandated benefits from another state from which it selects an EHB-benchmark plan as long as the selecting state does not have the same mandate that was newly put in place after December 31, 2011.

CMS will continue to consider establishing a uniform national default definition of EHB; if it does so and the cost of the state benchmark exceeded the cost for the national default, the state would have to defray that cost as well. CMS stated in the preamble that – in order to avoid market instability and inefficiencies for states that avail themselves of new options for EHB benchmarks outlined above – no state would be required to make changes to its newly-selected EHB-benchmark plan for the first three years following selection. CMS will publish more guidance on this requirement in the future. CMS is also considering instituting a national benchmark plan standard for prescription drug coverage.

*Selection Process*

CMS did not dictate which state entity must select the benchmark plan and may provide the state with technical assistance to aid in its selection. The state will be required to host a "reasonable" public notice and comment period prior to selecting a new benchmark, but reasonableness will be determined by the state. The final NBPP added the requirement that the state post a public notice on its website regarding the opportunity for public comment with associated information.

States will be required to notify CMS of new benchmark plan selections and submit required documentation by deadlines to be set forth in the NBPP. The deadline for submission of a benchmark plan for 2020 is July 2, 2018. Deadlines for submission for future years will be announced in the annual NBPP. 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;
- An actuarial certification that the benchmark does not exceed generosity of comparable plans;
- A description of the benchmark's benefits and limitations; and
- Information necessary for CMS to operationalize the benchmark plan (including a summary chart).

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), its existing selection would remain.

*Insurer Substitutions*

CMS also provided more flexibility for insurers seeking to make substitutions relative to the EHB benchmark plan. Also delayed to a 2020 start, in addition to being able to make substitutions of benefits within the same EHB category, the NBPP allows insurers to substitute benefits across categories as long as the substituted benefit is actuarially equivalent to the benefit being replaced. Prescription drug benefits may not be 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.

These substitutions will only be allowed if the state in which the plan will be offered permits such substitutions and notifies CMS that it will allow substitutions between categories in the same manner (which should be done in the same manner that it will notify CMS of a change to its EHB benchmark plan). CMS specified in the final NBPP that this does not alleviate plans of other regulatory requirements, including the requirement to cover preventive health services.

## Standardized Options

The NBPP and the Letter eliminate the standardized plans that were introduced for the 2017 plan year. CMS did not specify standard plan designs for 2019 and it will not provide differential display for standardized plans.

## Rate Review

CMS released the following rate review related guidance in conjunction with the Letter and NBPP:

- Bulletin: State-Specific Threshold Proposals Submission and Review Process
- 2019 Unified Rate Review Instruction- Rate Filing Justification: Parts I, II, and III as of March 2018
- Key Certification Dates; including Rate Review
- Rate Review Justifications for Transitional Policies

As a reminder, CMS did not make major changes to the actuarial value calculator for 2019.

*Student Health Plans*

The NBPP exempts student health plans from rate review beginning in 2019, though states can still choose to review rates. This provision applies to all coverage that begins on or after July 1, 2018.

*Reasonable Review Threshold*

CMS increased the threshold for rate increases that will be subject to a reasonableness review from 10 percent to 15 percent. States can select a different threshold; only higher state thresholds will require CMS approval. In conjunction with the NBPP, CMS released a bulletin with additional guidance for states on how to submit state specific thresholds. States have until August 1, 2018 to submit state specific thresholds. CMS will only provide notice of states that apply higher thresholds.

*Timeline*

CMS finalized the rate filing deadlines for 2019 as had been proposed:

| 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 that includes a QHP to be in a final status in the URR system. | 8/22/18 |
| Deadline for all rate filing justifications for single risk pool coverage that includes only non-QHPs to be in a final status in the URR system. | 10/15/18 |
| Target date on which CMS will post all final rate changes. | 11/1/18 |

CMS will allow Effective Rate Review Program (ERRP) states to set different deadlines for rate filings from insurers *only* filing non-QHPs.

The NBPP reduces 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). CMS did not finalize the proposal to allow ERRP to post rates on a rolling basis; states and CMS will continue to post rates on a uniform basis.

## Small Business Health Options Program (SHOP)

The NBPP codifies CMS's announcement from last spring that it will allow for "leaner" SHOPs. As of plan years beginning on or after January 1, 2018, SHOPs are no longer required to directly facilitate enrollment and the FF-SHOP will eliminate its enrollment functionality.

SHOPs are still 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 (and handle related appeals).

SHOPs may eliminate (and the FF-SHOP has) the following functions:

- Employee eligibility and termination (and related notices and appeals);
- Enrollment; and
- Premium payment and aggregation.

Instead, enrollment can 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), receives a favorable eligibility determination, and enrolls in a SHOP QHP. For enrollments that are identified as SHOP enrollments, SHOP enrollment rules and policies will still apply, including related to Special Enrollment Periods. In leaner SHOPs, payments will be made directly to insurers and insurers will have the option of whether to offer average ("composite") premiums to the extent state law does not dictate that decision.

The Letter specifies that guidance from the 2018 Letter will no longer apply to SHOP QHPs for the 2019 plan year.

Employee choice remains (employers can view plan options on the SHOP and enroll in plans and pay premiums directly with insurers) and states will continue to have the option of opting out of vertical employee choice (where an employer can offer all plans from a single issuer). Insurers will be required to spread minimum participation rates across all plan selections.

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

These changes went into effect as plans newly start or are renewed after January 1, 2018. The old regulations will remain in effect for plans to were purchased in 2017 until the end of the plan year.

States will not be able to request approval of SBE-FP SHOPs going forward, though existing SBE-FP SHOPs in Kentucky and Nevada can continue to rely on the remaining functionality of the FF-SHOP.

## Medical Loss Ratio

At the same time as finalizing changes to the medical loss ratio (MLR) standard in the NBPP, CMS released the CCIIO Technical Guidance: Process for a State to Submit a Request for Adjustment to the Individual Market Medical Loss Ratio Standard of PHS Act Section 2718 and CCIIO Technical Guidance: Question and Answer Regarding the Medical Loss Ratio (MLR) Reporting and Rebate Requirements to further explain the MLR process for 2019 and beyond.

The final NBPP allows issuers the option to elect an automatic 0.8 claim in earned premium for quality improvement reporting requirements or to continue tracking and reporting the actual QIA expenses (for select states and markets).

CMS eased the burden on states requesting an adjustment to the MLR in the individual market. States can request an adjustment for up to three years while submitting less data. CMS will permit the adjustment for any state that demonstrates that a lower MLR standard could help stabilize its individual market. Any state requesting an adjustment to the MLR must submit the request and the information required in 45 CFR 158.320 through 158.323 to the Secretary via the following email address: MLRAdjustments@cms.hhs.gov. State requests for MLR adjustments will be treated as public documents, and will require a public comment period. CMS also clarified the specific criteria that will be used in evaluating MLR adjustment requests, to include, for example, whether the adjustment will increase access to agents and brokers and / or competition. CMS will consult with states to determine effective dates of any approved adjustments.

The technical guidance released in conjunction with the NBPP provides additional details and procedures states must follow for both MLR adjustment and QIA reporting.

CMS did not finalize the proposal to exclude Federal and state employment taxes from premiums in calculating the MLR but will collect data on this issue and continue to consider it.

## Risk Adjustment

CMS finalized the following changes in the NBPP pertaining to risk adjustment:

- Modifying the drug classes used for the 2019 model: The NBPP confirmed the removal of two of the twelve drug diagnosis pairs that were used only to predict severity of a diagnosis
- Recalibrating the risk adjustment model for the 2019: The 2019 model will use blended coefficients from the 2016 EDGE data and 2014 and 2015 MarketScan data. The use of the 2016 EDGE data will ensure the data more closely reflect the Exchange population.
- CMS is allowing state regulators to request a percentage adjustment of the individual and / or small group risk adjustment transfer amount (CMS had only proposed adjustments of the small group market transfer amount) if the state can show that the actual risk differences due to adverse selection are mitigated.

CMS, in conjunction with the NBPP, released additional guidance and details regarding the changes to the risk adjustment model including; Exemption from HHS-Operated Risk Adjustment Data Validation (HHS-RADV) for Issuers in Liquidation or Entering Liquidation,

## Minimum Essential Coverage

CMS decided not to finalize its proposal 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) because Congress statutorily designated CHIP buy-in plans with benefits that are at least identical to the CHIP plan as MEC. States will have the option to verify with CMS that its CHIP buy-in program meets the statutory requirements by submitting documentation that includes a detailed summary of the coverage provided by the buy-in program and the CHIP coverage via the HIOS. CMS is not finalizing the proposed "substantially resemble" standard for other CHIP buy-in programs, however, the plan sponsor may also apply for "MEC-recognition" through CMS by demonstrating that the coverage meets substantially all of the requirements of Title I of the Affordable Care Act pertaining to individual health insurance coverage.

**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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