



# Overview of Final 2019 Payment Notice



*Center for Consumer Information  
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***April, 27, 2018***

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# Background

- The final *HHS Notice of Benefit and Payment Parameters* went on display April 9, 2018.
  - Federal Register publication date : April 17, 2018.
  - Effective date: June 18, 2018.

# Essential Health Benefits

- Finalized new flexibility for States, beginning with the 2020 plan year
- Finalized new flexibility for issuers regarding substitution, if permitted by the State

# Essential Health Benefits: State Flexibility

Starting with the 2020 plan year, States will have more flexibility to select an EHB-benchmark plan using the following new options:

**Option 1 (45 CFR §156.111(a)(1)):** Selecting the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110.

**Option 2 (§156.111(a)(2)):** Replacing one or more categories of EHB under §156.110(a) under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110.

**Option 3 (§156.111(a)(3)):** Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan, provided certain conditions, including scope of benefits requirements, are met.

Alternatively, States have the flexibility to forgo these options, and may instead retain their current EHB-benchmark plans.

# Essential Health Benefits: Requirements and Benefits

A State's EHB-benchmark plan is required to:

- Provide coverage of items and services for at least the 10 EHB categories of benefits.
- Provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan.
- Not exceed the generosity of the most generous among a set of comparison plans.
- Not have benefits unduly weighted towards any of the categories of benefits.
- Provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups.
- Not include discriminatory benefit designs.

# Essential Health Benefits: Requirements and Benefits

Typical employer plan at §156.111(b)(2) is defined as:

- One of the selecting State's 10 base-benchmark plan options established at §156.100, and available for the selecting State's selection for the 2017 plan year; or
- The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at §144.103 provided that:
  1. The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State;
  2. The plan provides minimum value;
  3. The benefits are not excepted benefits, as established under §146.145(b), and §148.220; and
  4. The benefits in the plan are from a plan year beginning after December 31, 2013

# Essential Health Benefits: Requirements and Benefits

- The State's EHB-benchmark plan must not exceed the generosity of the most generous among a set of comparison plans, which are:
  - **§156.111(b)(2)(ii)(A)** The State's EHB-benchmark plan used for the 2017 plan year, and
  - **§156.111(b)(2)(ii)(B)** Any of the State's base-benchmark plan options for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110.
- This requirement limits the range of benefits that can be considered EHB under these new EHB-benchmark plan selection options.

# Essential Health Benefits: State Requirements

To select an EHB-benchmark plan, the State is required to:

1. Provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan (that includes posting a notice on its opportunity for public comment with associated information on a relevant State Web site).
2. Notify HHS of the selection of a new EHB-benchmark plan by a date to be determined by HHS for each applicable plan year.
  - If the State does not make a selection by the annual selection date, or its benchmark plan selection does not meet the regulatory requirements and section 1302 of the PPACA, the State's EHB-benchmark plan for the applicable plan year would be that State's EHB-benchmark plan applicable for the prior year.
3. Submit documents in a format and manner specified by HHS by a date determined by HHS.

# Essential Health Benefits: State Documentation Requirements (Continued)

- Deadline for State submission of its 2020 EHB-benchmark plan: **July 2, 2018**
- HHS will not be able to allow States to submit additional documentation or changes to submitted documents after the deadline.
- Any questions or issues that a State has about the EHB-benchmark plan documents would need to be asked and resolved prior to the State's submission deadline.

# Essential Health Benefits: Benefit Substitutions

- Substitution: An issuer of a plan offering EHB may substitute benefits for those provided in the EHB-benchmark plan under the following conditions—
  - The issuer substitutes a benefit that:
    - Is actuarially equivalent to the benefit that is being replaced; and
    - Is not a prescription drug benefit.
  - And, submits evidence of actuarial equivalence that is:
    - Certified by a member of the American Academy of Actuaries;
    - Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
    - Based on a standardized plan population; and
    - Determined without taking cost-sharing into account.

# Essential Health Benefits: Benefit Substitutions

To apply substitution:

- An issuer may substitute a benefit within the same essential health benefit category, unless prohibited by applicable State requirements; and
- For plan years beginning on or after Jan. 1, 2020, between essential health benefit categories *only* when the State in which the plan will be offered notifies HHS that substitution between EHB categories is permitted in the State. The plan that includes substituted benefits must:
  - Provide benefits that are substantially equal to the EHB-benchmark plan;
  - Provide an appropriate balance among the EHB categories such that benefits are not unduly weighted toward any category; and
  - Provide benefits for diverse segments of the population.

# Overview of Key Final Policies

## **Key Exchange and Qualified Health Plan Provisions:**

- Qualified Health Plan Certification Standards
- SADP Actuarial Value
- Small Business Health Options Program
- Navigator Program
- Additional Policies

# Qualified Health Plan Certification Standards

- **Key Exchange and Qualified Health Plan Provisions:** Qualified Health Plan Certification Standards
- We did not finalize the proposal to defer to States for additional certification review areas such as accreditation requirements, compliance reviews, quality improvement strategy reporting, and service area
- We have finalized the policy to maintain the expanded role of States in the QHP certification process for FFEs and SBE-FPs. Specifically, we will rely on States for network adequacy reviews, where the State has a sufficient network adequacy review process.
- We finalized a 20 percent essential community provider (ECP) standard.
- We have also eliminated the meaningful difference requirement for QHPs.

# SADP Actuarial Value

We finalized our proposal to remove the requirement for stand-alone dental plan (SADP) issuers to meet the low (70 percent +/- 2 percentage points) or high (85 percent +/- 2 percentage points) AV levels specified in §156.150(b). SADP issuers must:

- Continue to certify their plans' level of coverage of EHB.
- Continue to limit annual cost sharing for the pediatric EHB, as required in §156.150(a) and provide the pediatric dental EHB as required by §155.1065, in order to be certified as QHPs.

# Small Business Health Options Program (SHOP)

- The 2019 Payment Notice final rule allows SHOPs to operate in a leaner fashion.
- The Federally-facilitated (FF) SHOPs and State-based Exchanges on the Federal Platform (SBE-FP) for SHOP will operate per the new policy, and State-based Exchanges would have the flexibility to operate a SHOP in the way they choose in accordance with Federal and State law.

# Navigator Policies

- We are providing more flexibility for Exchanges in the operation of Navigator programs.
  - Removal of the requirement that each Exchange must have at least two Navigator entities.
  - Removal of the requirement that one of these entities must be a community and consumer-focused nonprofit group.
  - Removal of the requirement that each Navigator entity maintain a physical presence in the Exchange service area.

# Additional Policies

- We finalized the policy that there will be no standardized options for the 2019 benefit year, and a differential display for standardized options will not be provided on HealthCare.gov.
- We have finalized an approach for direct enrollment partners wherein agents, brokers, and issuers can select their own third-party auditors—consistent with HHS-defined requirements, but without HHS pre-approval—for conducting annual operational readiness reviews of HHS-defined requirements.

# Premium Stabilization & Payment Parameters

## Key Premium Stabilization Programs & Payment Parameters Provisions:

- Risk Adjustment
- Risk Adjustment Data Validation (RADV) Audits
- 2019 FFE and SBE-FP User Fees
- Premium Adjustment Percentage
- Maximum Annual Limit on Cost Sharing

# Several Updates to Risk Adjustment

## Recalibration Using Enrollee-level EDGE Data

- Blends coefficients using 3 years of data including 2014 and 2015 MarketScan® data, and 2016 enrollee-level EDGE data.
- Provides stability within the risk adjustment program and minimizes volatility in changes to risk scores from the 2018 to 2019 benefit years due to differences in the datasets' underlying populations.

## Prescription Drugs

- Removes two severity-only drug classes that do not predict meaningful incremental plan risk associated with a severe health condition from the 2019 benefit year adult models.

## High-cost Risk Pool

- Maintains the parameters established for the 2018 benefit year of \$1 million threshold and 60 percent coinsurance rate for the 2019 benefit year.

## State Flexibility

- Beginning with the 2020 benefit year, permits States to request a reduction to the calculated risk adjustment transfers in their individual, small group, or merged market to more precisely account for differences in actuarial risk in the State market. Requests must include evidence and analysis to justify the reduction.

## Risk Adjustment User Fees

- We are finalizing a risk adjustment user fee of \$1.80 per billable member per year, or \$0.15 PMPM.

# User Fees

## ***FFM User Fee***

- Assess a user fee rate of 3.5% on FFM issuers for 2019.
  - No change from 2014-2018 rate

## ***SBE-FP User Fee***

- Assess a user fee rate of 3% on SBE-FP issuers for 2019.

## ***FF-SHOPs and SBE-FP SHOPs User Fee***

- For plan years beginning on and after January 1, 2018, HHS will not assess a user fee on issuers offering QHPs through FF-SHOPs or SBE-FP SHOPs as HHS will no longer provide to issuers the special eligibility and enrollment benefits previously available through FF-SHOPs and SBE-FP SHOPs.

# Update to Premium Adjustment Percentage

- Measures the premium increase since 2013, based on the most recent National Health Expenditures Accounts projection of per enrollee employer-sponsored insurance (ESI) premiums.
- Used to set the rate of increase for:
  - The maximum annual limitation on cost sharing
  - The required contribution percentage for eligibility for a hardship exemption
  - The affordability percentage for calculation of the individual responsibility payment
- For 2019, we are finalizing a premium adjustment percentage of approximately 25% (reflecting an increase of 7.7% from 2018).

# Update to Maximum and Reduced Annual Limitations on Cost Sharing

- Is the product of the dollar limit for calendar year 2014 (\$6,350 for self-only coverage) and the premium adjustment percentage for 2019.
- For 2019, maximum annual limitation on cost sharing will be \$7,900 for individual coverage and \$15,800 cumulative for family coverage.
- For 2019, the reduced maximum annual limitation on cost sharing will be:
  - \$2,600 for self-only coverage and \$5,200 for other than self-only coverage for enrollees with incomes between 100-200% of FPL.
  - \$6,300 for self-only coverage and \$12,600 for other than self-only for enrollees with incomes between 200-250% of FPL.

# Eligibility and Enrollment

## **Key Eligibility and Enrollment Provisions:**

- Special Enrollment Periods
- Verification of Eligibility for Insurance Affordability Programs
- Exemptions

# Special Enrollment Periods (SEPs)

- Metal level restrictions for new dependents: Aligns enrollment options for all dependents who are newly enrolling in Exchange coverage through an SEP and being added to an application with current enrollees. Extends the same rules to dependents who qualify for all SEPs as was established in the 2017 Market Stabilization Rule for just new dependents, which allows those dependents to either be added to an enrollee's current plan or enroll in a separate plan.
- Prior coverage requirement: Exempts consumers in service areas without QHPs offered through the Exchange from the prior coverage requirement that applies to certain SEPs.
- CHIP unborn child coverage: Establishes loss of CHIP unborn child coverage as a loss of coverage SEP-qualifying event for pregnant women who are receiving health care services through CHIP coverage for their unborn child.
- New Dependents: Amends and aligns coverage start date options for those who gain or become new dependents due to birth, adoption, placement for adoption, placement in foster care, or through a child support or other court order.

# Verification of Eligibility for Insurance Affordability Programs

- We have finalized a policy to create annual income data matching issues in a limited number of circumstances when a household's attested income is above income from trusted data sources.
- This policy will target households that are not eligible for APTC and may be inflating their income to appear eligible for APTC.

# Verification of Employer-Sponsored Coverage (cont'd)

- Extends the option for Exchanges to conduct verification of applicant enrollment in or eligibility for a qualifying employer-sponsored plan for purposes of determining eligibility for Exchange affordability programs using an HHS-approved alternative process to sampling as an alternate verification procedure through plan year 2019.
- Gives Exchanges flexibility to choose method of verification while data sources continue to be compiled and approaches to sampling are refined.

# Exemptions

- Exchanges will use the cost of the lowest cost bronze plan to determine eligibility for the affordability exemption.
- Due to limited offerings of plans on the Exchanges in many regions, there may be individuals who live in a rating area without a bronze plan.
- If there is no bronze level plan sold through an Exchange in a rating area, that Exchange can make the affordability exemption determination using the annual premium for the lowest cost Exchange metal level plan available in the individual market through the Exchange in the State in the rating area in which the individual resides.

# Failure to File and Reconcile (FTR)

- We have removed the “direct notification” rule that became effective in January 2018 regarding the requirement to file a tax return for a year in which APTC was paid on a tax filer’s behalf and to reconcile the associated APTC (155.305(f)(4)(ii)).
- As in prior years, the Exchanges may deny APTC for enrollees flagged as having failed to file and reconcile (known as FTR), regardless of whether the Exchange can “directly” communicate with the tax filer why they are at risk for losing—or are losing—APTC.
- These revisions will increase program integrity and we believe that processes employed in past years to notify consumers that they may lose APTC due to FTR are sufficient.

# Termination Effective Dates

- We have made the 14-day “reasonable notice” (155.430(d)(2)(ii)) and “newly eligible for Medicaid/CHIP/BHP” (155.430(d)(2)(ii)) provisions at the option of the Exchange.
- This policy will reduce consumer confusion by enabling Exchanges to align all enrollee-initiated terminations to take effect on the date of enrollee request or a later date of their choosing.

# Market Reform

## Key Market Reform Provisions:

- Rate Review
- Medical Loss Ratio
- Minimum Essential Coverage Designation for CHIP Buy-in Programs

# Rate Review

We have finalized several rate review changes which will:

- Exempt student health plans from the federal rate review process, effective for coverage effective on or after July 1, 2018.
- Allow states with Effective Rate Review Programs to establish a different deadline for rate filing submissions from issuers that only offer non-QHPs.
- Reduce States' advanced notification of posting of rate increases from 30 days to 5 business days.
- Raise default threshold for rate increase subject to review (from 10% to 15%).

We did not finalize the proposal to eliminate the uniform posting requirement, which would have allowed states with Effective Rate Review Programs to post proposed and final rate filing information on a rolling basis.

# Medical Loss Ratio

- ***Reporting QIA expenses***
  - Allow issuers the option to continue tracking and reporting actual QIA expenses using the five allowable categories or to use a standardized amount equal to 0.8 percent of the issuer's earned premium for the year.
- ***State's request for adjustment to MLR standard***
  - Simplify the process for the State's request for adjustment to the 80% MLR standard in the individual market.

# Minimum Essential Coverage Designation for CHIP Buy-in Programs

- We are not finalizing the policy to categorically designate as MEC CHIP buy-in programs that provide identical or greater coverage to the title XXI CHIP program, due to legislation passed since the proposed rule was released.
- States will have the option to verify with HHS that their CHIP buy-in program meets the definition of a CHIP look-alike plan.
- We are also not finalizing a “substantially resemble” standard of review.

# Links

- HHS Notice of Benefit and Payment Parameters for 2019 (<https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf>).
- Example of an Acceptable Methodology for Comparing Benefits of a State's EHBbenchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii) (<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Example-Acceptable-Methodology-for-Comparing-Benefits.pdf>).
- SHOP Early Flexibility Guidance for issuers to begin adopting the proposed changes for SHOP starting at the beginning of PY 2018 (<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/New-Flexibilities-SHOP-2018.pdf>).

# Questions?

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