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## HHS Releases Notice of Benefit and Payment Parameters for 2019 Proposed Rule

On October 27, 2017, the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services (“HHS”) released the Notice of Benefit and Payment Parameters (“NBPP”) for 2019 Proposed Rule (“Proposed Rule”). 82 Fed. Reg. 51052 (Nov. 2, 2017). The Proposed Rule addresses a range of issues and proposes greater state flexibility in a number of areas, including essential health benefits (“EHB”), medical loss ratio (“MLR”), rate review, and state certifications of qualified health plans (“QHPs”) in the Federally-facilitated Exchanges (“FEEs”) and State-based Exchanges using the federal platform (“SBE-FPs”). The Proposed Rule also proposes changes to risk adjustment and risk adjustment data validation (“RADV”) programs, special enrollment periods (“SEPs”), Exchange user fees, the annual limitation on cost sharing levels for 2019, and Exchange programs, including changes to the Small Business Health Options Program (“SHOP”).

Along with the Proposed Rule, HHS released: (1) the draft Actuarial Value [calculator](#) and [methodology](#) for 2019; (2) [draft guidance](#) proposing new options EHB benchmark selection; and (3) [draft guidance](#) for issuers to begin adopting the proposed changes for SHOP, which would start at the beginning of plan year 2018.

While legislation to repeal and replace the Patient Protection and Affordable Care Act (“PPACA”) has, to date, not passed, the Administration has been making administrative changes to give states more authority over their health insurance markets (as is their traditional role) and loosen requirements where possible. The results of these changes could depend on the specifics. For example, the changes to EHB requirements intend to increase state flexibility, but it is unclear how many states will elect new EHB benchmark plans and what effects those changes would have on that state’s health insurance markets. Similarly, increasing the rate review subject to review threshold could benefit certain stakeholders, but different states with different standards could cause operational difficulties, particularly for multi-state carriers. It is also unclear whether – or to what extent – changes to MLR, risk adjustment, or other Exchange processes would help contribute to a more stable health insurance market in certain states. Therefore, it is important for stakeholders to examine these proposals through the lens of specific state flexibility and markets to which they apply.

**Comments on the Proposed Rule are due November 27, 2017.** Below please find a summary of key issues.

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### ***Essential Health Benefits***

HHS proposes to give states flexibility in selecting EHB benchmark plans for plan years beginning on or after January 1, 2019. If the proposal is finalized, states would be able to change their benchmark plans annually, but if a state takes no action, it would maintain its current benchmark. As is the current requirement, state-mandated benefits enacted after December 31, 2011, will continue not to be considered to be EHBs and will require state defrayal of costs. States would be able to choose a benchmark plan using one of three options:

- Option 1: Using another state's 2017 plan year EHB-benchmark plan. Under this option, the selecting state would still be required to defray the cost of any benefit included in the selected state's EHB-benchmark plan that was mandated by that state after December 31, 2011, and subject to defrayal.
- Option 2: Replacing certain EHB categories from another state's 2017 plan year EHB-benchmark plan. The selecting state could choose one category from one state and another category from another state. The policy governing state-mandated benefits would remain unchanged, and the selecting state would still be required to defray the cost of any applicable benefits from that category.
- Option 3: Selecting a set of benefits for EHB-benchmark plan. A state could select a set of benefits for its benchmark using a different process, as long as the new benchmark plan does not exceed the generosity of the most generous of among a set of comparison plans (the state's 2017 plan year benchmark plan or any of the three largest small group plans) for the 2017 plan year. The generosity determination would be made via actuarial certification. HHS proposes that the state determine generosity in the same manner as HHS would use to measure whether the plan is equal in scope of benefits under a "typical employer plan," as discussed in more detail below. As is the case with the other options, the state would continue to defray the cost of any benefits mandated by state action after December 31, 2011.

Concurrently with the Proposed Rule, HHS published [draft guidance](#) discussing actuarial certification methodology for comparing benefits of a state's EHB-benchmark plan to a typical employer plan.

A state's EHB-benchmark plan would be required to continue to meet certain provisions under the PPACA. Specifically, the benchmark plan would continue to provide EHB in each of the 10 categories specified in PPACA (with an "appropriate balance" among the 10 categories), and the benchmark would include a scope of benefits equal to what is provided under a "typical employer plan." HHS proposes to define a "typical employer plan" as an employer plan within a product with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more states, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more states.

A state would also have to provide reasonable (as determined by the state) notice and opportunity for public comment whenever a state changes its benchmark. In addition, a state would be required to notify HHS about the selection of a new benchmark each time a state changes its benchmark. The proposed deadlines for state submission of the required documents for the state's EHB-benchmark plan option would be March 16, 2018, for the 2019 plan year and July 1, 2018, for the 2020 plan year.

HHS also proposes to allow states to substitute benefits within the same EHB category and between EHB categories, as long as a substituted benefit is actuarially equivalent to the benefit being replaced and is not a prescription drug benefit.

For plan years further in the future, HHS is considering creating a federal default definition of EHB but is also considering allowing states continued flexibility to adopt their own EHB-benchmark plans, as long as they defray costs that exceed the federal default. HHS is specifically interested in comments regarding setting a national prescription drug benefit standard under a federal default EHB definition.

Changes to EHB benchmarks could cause significant variations in benefit offerings and requirements for health benefit in all markets. While the requirement to offer EHBs applies only to the individual and small group insured markets (inside and outside of the Exchanges), health insurance issuers and group health plans – including self-funded group health plans – in small *and* large group markets are prohibited from placing annual or lifetime dollar limits on EHBs and must count cost-sharing for EHB towards the annual limitation on cost-sharing. Therefore, if states loosen their EHB requirements, fewer benefits could be subject to the prohibition on annual and lifetime dollar limits and fewer benefits would count towards the annual limitation on cost sharing.

### **MLR**

HHS proposes a number of changes and seeks comment on certain provisions regarding MLR and rebate calculations. First, HHS seeks comment on whether to permit issuers to deduct federal and state employment taxes from premiums in their MLR and rebate calculations beginning in the 2017 MLR reporting year (reports filed by July 31, 2018). HHS also asks whether it should change current rules and collect employment tax data separately from other tax data as an informational item on the MLR Annual Reporting Form.

In addition, HHS proposes to include quality improvement activity (“QIA”) expenditures as a single, fixed percentage of premium (0.8 percent) instead of tracking an issuer’s actual QIA expenditures. An issuer that spends more than 0.8 percent of earned premium on QIA would still have the option to report its total QIA expenses instead of using the fixed percentage amount.

In an effort to address individual market stability, HHS proposes to allow for individual market MLR adjustments in a state. Under this proposal, a state would have to demonstrate – and the Secretary of HHS would have to determine that there is “reasonable likelihood – that an MLR lower than 80 percent (the current amount in the individual market) could help stabilize the individual market.

### **Rate Review**

HHS proposes to loosen the standards for rate review and to give effective rate review states more flexibility for reporting. HHS proposes to change the 10 percent “subject to review” threshold for review of unreasonable rate increases to 15 percent. While states are currently permitted to apply for state-specific thresholds, this proposal would require states to ask HHS to approve state-specific thresholds only if the proposed threshold is higher than the federal default threshold. These changes would be in effect for rate filings submitted on or after January 1, 2019, and HHS intends to issue future guidance on the process for submitting and reviewing these requests. HHS would continue to post on its website information about states with state-specific thresholds above the federal default threshold, but it would not post information about states using the federal threshold or a stricter standard (i.e., a threshold lower than the federal threshold).

States would also have more flexibility over submission processes and deadlines. Beginning with plan year 2019, states with effective rate review programs could set different submission deadlines for rate filings from issuers that offer only non-QHPs (issuers with both QHPs and non-QHPs would continue to submit filings on the QHP timeline). In

addition, a state would be required to notify HHS about posting rate increases 5 days – instead of 30 days – before the posting, and states could post these rate increases on a rolling basis.

In addition, student health insurance would be exempt from rate review for policy years beginning on or after January 1, 2019. However, states would continue to have the flexibility to review these rate increases if they choose to do so. In states without effective rate review programs, HHS would conduct targeted market conduct examinations to monitor compliance of student health insurance coverage with market rating reforms.

### ***Annual Limitation on Cost Sharing***

As HHS generally does in each NBPP, HHS proposes the annual limitation on cost sharing, which is also known as the maximum out-of-pocket limit (or “MOOP”) and applies to both health insurance issuers and group health plans (including those that are self-funded). For 2019, HHS proposes that the MOOP be \$7,900 for self-only coverage and \$15,800 for other than self-only coverage (an approximately 7 percent increase above the 2018 parameters of \$7,350 for self-only coverage and \$14,700 for other than self-only coverage).

### ***Risk Adjustment***

HHS proposes to recalibrate the risk adjustment models using the methodology finalized for the 2018 benefit year. HHS would also incorporate 2016 benefit year EDGE data in the 2019 benefit year risk adjustment model recalibration, and would blend three years of data to recalibrate the coefficients used in the risk adjustment model. Similar to previous years, HHS proposes to finalize 2019 benefit year blended coefficients with 2014 and 2015 MarketScan data. Specifically, the risk adjustment model would include the following adjustments:

- **Prescription drugs**: HHS would remove the two severity-only RXCs.
- **High-cost risk pool adjustment**: HHS would maintain a \$1 million threshold and 60 percent coinsurance rate for the high-cost risk pool.
- **Cost-sharing reduction (“CSR”) adjustments**: HHS would continue an adjustment for the receipt of CSRs in the model to account for induced demand with the adjustment factors from 2018.

In the risk adjustment payment transfer formula, HHS proposes to maintain the high-risk enrollee adjustment to the transfers with the threshold of \$1 million and a coinsurance rate of 60 percent. HHS would continue to reduce the statewide average premium 14 percent to account for the administrative costs that do not vary with claims. In addition, state insurance regulators would be able to request a percentage adjustment when calculating the risk adjustment formula in the small group market. HHS seeks comment regarding whether states should be able to request adjustments in the individual market as well.

The Proposed Rule also proposes to modify the RADV process by adjusting an issuer’s risk score only when the issuer’s error rate materially deviates from a statistically meaningful value nationally, and using the error rate to adjust the payment transfer for issuers exiting the market. Beginning with 2017 benefit year RADV, issuers with 500 billable member months or fewer that elect to establish and submit data to an EDGE server would not be required to hire an initial validation auditor or submit initial validation audit results. Instead, these issuers would have their risk score adjusted by a default error rate equal to the lower of either the national average negative error rate, or the average negative error rate within a state, as set forth in the 2018 NBPP. HHS also proposes to postpone applying the

materiality threshold (total annual premiums at or below \$15 million) to the 2018 benefit year, when issuers below the materiality threshold would not be required to conduct an initial validation audit every year. These issuers would still be subject to an initial validation audit approximately every three years. Issuers below the materiality threshold that are not subject to random and targeted sampling would have their risk adjustment transfers adjusted by a default error rate equal to the lower of the average negative error rate nationally, or the average negative error rate within a state.

The Proposed rule also includes other proposed changes to risk adjustment, including those regarding sampling, sharing mental and behavioral health records, civil money penalties, and transfer adjustments due to incorrect data. The risk adjustment user fee for the 2019 benefit year would be \$1.68 per billable member per year (\$0.14 PMPM), which would be the same as for the 2018 benefit year.

### ***Special Enrollment Periods***

The Proposed Rule would amend certain SEP rules. First, the proposed rule establishes a distinction between the treatment of (1) existing enrollees who qualify for an SEP themselves or when enrollees and their dependents qualify for an SEP; and (2) new dependents who qualify for an SEP. Regarding certain SEPs:

- Enrollees and their dependents who qualify for an SEP would continue to be able to use their SEP to change to another QHP within the same metal level (or one metal level higher or lower if no such QHP is available).
- When only a dependent not currently enrolled in Exchange coverage qualifies for an SEP, the Exchange must allow the enrollee to add the dependent to the enrollee's current coverage. If the plan's business rules do not allow this addition, the Exchange must allow the enrollee to change to another QHP within the same metal level (or one metal level higher or lower if no such QHP is available). Alternatively, the enrollee could enroll the dependent in a separate QHP at any metal level.
- If both the enrollee and the new dependent qualify for the applicable SEPs, the Exchange would allow both the enrollee and dependent to switch to a new QHP at the same metal level, if available.

The Proposed Rule would also exempt consumers from the prior coverage requirement (i.e., having minimum essential coverage, living in a foreign country or territory, or having Indian status 1 out of 60 days before a qualifying event) for a permanent move or gaining a dependent through marriage SEPs, if they lived in a service area without QHPs available through an Exchange. This change would apply to consumers seeking coverage on the individual market outside the Exchange as well.

The rule proposes other SEP changes as well, such as allowing an individual who encountered material plan or benefit display errors to switch to a different QHP at any metal level; aligning effective dates for an individual gaining or becoming a dependent through birth, adoption, foster care, or a court order; allowing an individual to elect a coverage effective date the first of the month following plan selection instead of following a qualifying event; and allowing a woman receiving pregnancy care through CHIP to qualify for an SEP after the birth of her child.

### ***Exemptions***

Individuals are exempt from paying the individual mandate penalty if the amount they would have to pay for minimum essential coverage would exceed a particular percentage of their household income. The Proposed Rule would set the required contribution percentage for 2019 at 8.3 percent, an increase of .25 percentage points from

the 2018 required contribution percentage of 8.05 percent. If no bronze coverage is available in a particular rating area, HHS proposes to allow Exchanges to use the annual premium for the lowest-cost Exchange plan in the rating area.

### ***Exchange Standards and State Flexibility***

The Proposed Rule would set the 2019 user fee for issuers on the FFE at 3.5 percent, and 3.0 percent for issuers on SBE-FPs.

The Proposed Rule would also give FFE and SBE-FP states more flexibility and would generally loosen standards in FFEs and SBE-FPs. Specifically:

- HHS would allow states with adequate review processes to review network adequacy in FFEs and SBE-FPs.
- HHS would continue to allow issuers to use the Essential Community Provider (“ECP”) write-in process to identify ECPs that are not on the HHS list of available ECPs. HHS would also maintain the 20 percent ECP standard.
- HHS would eliminate meaningful difference standards for QHPs offered through an FFE or SBE-FP.
- For Plan years 2019 and beyond, HHS would defer to states for additional review areas, including: accreditation requirements; compliance reviews; minimum geographic area of a plan’s service area; and quality improvement strategy reporting.

### ***SHOP***

HHS proposes to remove SHOP enrollment requirements and to allow groups to enroll through a QHP issuer directly or through a SHOP-registered agent or broker. Small employers would continue to obtain an eligibility determination from the SHOP, and applicable small employers would still have access to the Small Business Health Care Tax Credit (via a separate process). The FF-SHOP user fee would be eliminated for new enrollments. While the FF-SHOP would make these changes, the changes would be optional for State-based SHOPS.

Concurrently with the Proposed Rule, HHS issued separate [guidance](#) explaining that, while changes would not officially be effective until the rule is finalized, the FF-SHOP will generally begin following the proposed approach for coverage effective on or after January 1, 2018, effective on the effective date of the final rule.