

MEMORANDUM

**To:** ACRM

**From:** Peter Thomas and Christina Krysiniski

**Date:** May 25, 2018

**Re:** Analysis of Final Rule: HHS Notice of Benefit and Payment Parameters for 2019

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On April 17, 2018, the Centers for Medicare & Medicaid Services (CMS) at the Department of Health and Human Services (HHS) published in the Federal Register its Notice of Benefit and Payment Parameters [final rule](#) for 2019 (the Final Rule).<sup>1</sup> **The Final Rule will be effective on June 18, 2018.**

The Rule finalizes changes that provide additional flexibility to States in establishing essential health benefits (EHB) benchmark plans, enhance the role of States in the certification of qualified health plans (QHPs), and provide States with additional flexibility in the operation and establishment of Exchanges, including the Small Business Health Options Program (SHOP) Exchanges. It also includes changes to payment parameters and provisions related to risk adjustment, the rate review program, the medical loss ratio program, and other related topics.

This memorandum provides an analysis of the Final Rule's implications for rehabilitative and rehabilitative services and devices, including the States' role in defining essential health benefits and qualified health plan certification, as well as the costs of coverage and network adequacy. The memo also summarizes CMS's response to comments submitted by interested stakeholders, including three coalitions: the Coalition to Preserve Rehabilitation (CPR), the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition, and the Consortium for Citizens with Disabilities (CCD) Health Task Force.

### **Essential Health Benefits**

**States' role in defining EHB benchmark plans.** In the Final Rule, CMS finalized its proposal to give states significantly more flexibility in defining their EHB benchmark plans starting in the 2020 plan year. States will now have three options when selecting an EHB benchmark plan:

1. Select an EHB benchmark plan used by another State;
2. Replace one or more EHB categories of benefits in the State's benchmark plan with the same category (or categories) of benefits from another State's benchmark plan; or
3. Otherwise select a set of benefits that would become the State's EHB benchmark plan (i.e., rewrite their own benchmark plan).

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<sup>1</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018).

In the Final Rule, CMS expanded its proposed “generosity test” to all EHB benchmark plan options. The generosity test prohibits an EHB benchmark plan from being more generous than the most generous comparison plan in the State.<sup>2</sup> In the Proposed Rule, this test only applied to the third EHB benchmark plan option where a State chooses to rewrite their plan. CMS believes that by extending the applicability of the generosity test, CMS is minimizing the opportunity for a State to select an EHB benchmark plan in a manner that would make coverage unaffordable for patients and increase federal costs.

In our comments, we expressed concern that the options available to States to redefine their benchmark plans may create a “race to the bottom” in the scope of coverage available to consumers in the various states. CMS was not persuaded that the new options will create a race for States to establish the least generous plan possible because all States’ EHB-benchmark plans will still be required to include coverage for all 10 EHB categories of benefits. In addition, CMS stated that because each State has different market conditions and demographic distributions, a plan that may be the least generous plan in one State may not be the least generous plan in another State, and therefore CMS is not concerned that this policy is going to create a race to establish the least generous plan.

Specifically with respect to the first and second proposed options (listed above), we expressed concern that States will exercise this option to select a more limited benefits package than they currently offer, particularly for the benefit category of rehabilitation and habilitation services and devices. CMS acknowledged in the Final Rule that consumers with specific health needs may be adversely impacted by this flexibility and may no longer have coverage for certain services. CMS believes, however, that it has appropriately restricted the scope of state flexibility within a limited range by requiring benefits to be equal or greater than the scope of benefits provided under a typical employer plan (a minimum EHB standard) but no more generous than a set of comparison plans (a maximum EHB standard).

With respect to the third option, we expressed concern that this will contribute to a significant decrease in coverage of EHBs and that, by granting States expansive power to alter their EHB benchmark plans annually, the Proposed Rule threatened any hope of predictability of coverage for consumers from year-to-year and State-to-State. CMS disagreed and stated that the requirement that States provide, at a minimum, a scope of benefits equal to the scope of benefits provided under a typical employer plan, but not to exceed the generosity of the most generous among a set of comparison plans, appropriately limits the range of benefits that can be considered EHB. CMS believes that, together, these requirements provide States with flexibility to adjust their States’ EHB-benchmark plan within a limited range.

Under the Final Rule, States must give reasonable notice and an opportunity for public comment on a State website any time they select a new EHB benchmark plan. CMS stated that the public notice and comment period is important for transparency to allow consumers to provide feedback on the States’ proposed changes to their EHB benchmark plans.

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<sup>2</sup> The comparison plans are the State’s 2017 EHB benchmark plan and the State’s largest small group health plans by enrollment.

**Definition of typical employer plan.** CMS finalized a new definition of a “typical employer plan.” In the Proposed Rule, CMS defined a typical employer plan as an employer plan or a self-insured group health plan sold in one or more states with enrollment of at least 5,000 employees. Under the Final Rule, CMS altered the definition so that a typical employer plan can be either:

1. One of the state’s ten base-benchmark plan options from the 2017 plan year; or
2. One of the five largest group health insurance products by enrollment in the state, as long as the product has at least 10% of the total enrollment among those products, the plan provides minimum value defined under the ACA, the benefits are not excepted benefits, and the benefits are from a plan year beginning after December 31, 2013.

We recommended that a typical employer plan should have to be from a recent year, as well as be required to meet minimum value standards or not be an indemnity plan or a health reimbursement arrangement. We also expressed concern that the lack of constraint placed on what constitutes a “typical employer plan” means that these plans would hardly be “typical” and may allow States to disregard the differences in health care needs between the populations of different states in establishing their benchmark plans.

CMS incorporated these comments into the definition in the Final Rule and adopted the 10% requirement to ensure that a state cannot select an outlier plan. CMS’s new definition ensures that the typical employer plan is a major medical plan, not an excepted benefit. In addition, in response to comments expressing concern about unique benefit designs and the ability to obtain plan information about self-insured plans, CMS removed self-insured plans from its definition of a typical employer plan. Under the Final Rule, CMS also requires that if one of the typical employer plans does not provide coverage of all 10 EHB categories, the plan must be supplemented to cover all categories.

**Nondiscrimination provisions of the ACA.** In the Final Rule, CMS codified many of the Affordable Care Act’s (ACA) statutory EHB requirements, such as the requirement that benchmark plans provide an appropriate balance of coverage of the ten EHB categories, provide benefits for diverse segments of the population, and not have benefits unduly weighted towards any of the categories.

We urged CMS to employ a broad, multi-prong approach to nondiscrimination compliance, monitoring, and enforcement and expressed concern that reliance on state monitoring and enforcement leads to disparate health care access and quality. In response to comments urging CMS to reiterate the ACA’s nondiscrimination requirements in the Final Rule, CMS opted to incorporate an existing requirement that a state’s EHB-benchmark plan cannot include discriminatory benefit designs that contravene the nondiscrimination standards in 45 C.F.R. § 156.125, which reflects the non-discrimination provisions of section 1302(b)(4) of the ACA.

**Impact on health care costs and access to care.** In light of concerns regarding States using their flexibility to limit EHBs, we recommended that states be required to track downstream costs when limiting coverage of rehabilitation and habilitation services and devices. In addition, we urged CMS to require States to assess and continually monitor the impact on access to care

for children and adults in the event that they limit coverage of rehabilitation services and devices. CMS declined to incorporate these requirements into the Final Rule, but encouraged States to consider the impact of changes to their EHB benchmark plans on health care costs and access to care.

### **Qualified Health Plan Certification**

**State determinations of network adequacy.** Under the Final Rule, CMS will defer to State review of network adequacy in States with the authority and capacity to enforce standards that are at least equal to the “reasonable access standard” in federal regulations. The Final Rule eliminates the requirement for State-based Exchanges on the federal platform (SBE-FPs) to enforce Federally-facilitated Exchange (FFE) standards for network adequacy—instead, SBE-FPs can determine how to implement network adequacy standards for the 2019 plan year and beyond.

We recommended that CMS strengthen federal network adequacy standards and expressed concern that a reduced federal role in reviewing network adequacy would only exacerbate network adequacy issues. We urged CMS to ensure that State review processes are sufficient to ensure that network adequacy standards safeguard access to a range of physically accessible, qualified providers across primary care, specialties, and subspecialties, without the burdens of significant travel distances and long wait times. We also stated that CMS must ensure that these standards are enforceable. However, CMS believes SBE-FPs are best positioned to determine these standards for the QHP certification process in their States, and elimination of the requirement that SBE-FPs enforce FFE standards for network adequacy would streamline certain aspects of the QHP certification process by reducing oversight burden on SBE-FPs.

**Removal of meaningful difference standard.** The Final Rule eliminates the requirement that QHPs offered through the FFEs or SBE-FPs be “meaningfully different” from other QHPs offered by the same insurer within a service area and metal level tier. This standard was previously adopted to facilitate consumer comparison and choice. CMS states that they are removing this requirement due to there being fewer QHPs and issuers to choose from in the Exchanges. CMS does not believe that removing the meaningful difference requirement will substantially increase the number of materially similar plans offered by the same issuer.

### **Navigator Program Standards**

CMS finalized its elimination of the requirement that each Exchange have at least two navigator entities and that one of these entities must be a community and consumer-focused nonprofit group. CMS also eliminated the requirement that navigators have a physical presence in an Exchange service area to provide in-person outreach and enrollment support.

We urged CMS to retract its proposal to reduce the number of required navigator entities in a state from two to one, as well as the requirement that one entity be a community and consumer-focused non-profit organization. CMS asserts that requiring at least one navigator to be a community and consumer-focused nonprofit group unnecessarily limits an exchange’s ability to award grants to the strongest applicants.

We stated that we did not support the proposal to remove the requirement that a navigator entity maintain a physical presence in the Exchange service area. CMS agreed that entities with a physical presence and strong relationships in their FFE service areas tend to deliver the most effective outreach and enrollment results. CMS stated that nothing in the Final Rule prevents an Exchange from selecting grantees that are physically present and available to provide a spectrum of in-person, local outreach, education, and assistance, including directing these services towards vulnerable and hard-to-reach populations. However, while in-person assistance may be more helpful than remote services in some situations, CMS believes that determining which entities are well-situated to serve consumers within a particular Exchange is best left up to each Exchange. By allowing Exchanges greater flexibility, each Exchange will be better able to ensure that its service area can be assisted by the entity or entities that best fits the needs of its population.

### **Review of Issuer Rate Increases**

The Final Rule finalizes CMS's proposal to raise the default threshold for review of "unreasonable" premium increases from 10% to 15%. These changes will apply to single risk pool rate filings submitted by issuers for the 2019 plan year. States can impose higher or lower filing thresholds than the federal default but will have to obtain CMS permission for higher thresholds. CMS stated that by increasing the threshold trigger to 15 percent, they are providing an opportunity for States to reduce their review burden. After an analysis of all rates subject to review that were determined to be "unreasonable" since the inception of the review threshold, CMS found only one filing that fell within the 10 to 15 percent range. As a result, CMS does not believe this change will normalize excessive increases.

CMS also exempted student health insurance from federal rate review requirements. Some commenters expressed concern that exempting student health insurance coverage would result in minimal oversight and decreased affordability. CMS noted that States maintain the flexibility to review rate increases of any size and any other aspects of student health insurance coverage. In States that do not have an effective rate review program, CMS will continue to monitor the compliance of student health insurance coverage with applicable market rating reforms based on complaints and as part of targeted market conduct examinations.

### **State Adjustments to the Medical Loss Ratio**

Under the Final Rule, States can now petition for a reduction in the medical loss ratio (MLR) in the individual market. The MLR is the percentage of premiums a health plan receives that must be spent on health care services to enrollees. States can also more easily request a MLR rebate adjustment. In order to do so, States must show that a lower MLR standard can help stabilize the market. Additionally, CMS made other changes to the MLR program to reduce the burden on issuers.

### **Risk Adjustment Transfers**

The Final Rule gives States more flexibility regarding risk adjustment transfers in their markets. The HHS risk adjustment payment transfer formula generally transfers amounts from issuers with lower-than-average actuarial risk to those with higher-than-average actuarial risk. It is a mechanism to spread risk among the issuers participating in each marketplace and limit the impact of adverse selection. HHS will consider requests to reduce transfers beginning with the 2020 plan year. This change means that less money would be transferred between lower-risk plans and higher-risk plans in the small group market in some States. CMS stated that allowing certain State-specific adjustments to the otherwise applicable transfers can tailor the HHS-operated risk adjustment program to the particularities of a State's individual, small group or merged market without requiring the State to undertake operation of its own risk adjustment program or pursue a section 1332 waiver to implement a reinsurance program.

### **SHOP Exchanges**

Under the Final Rule, SHOPS will no longer be required to provide employee eligibility, premium aggregation, or online enrollment functionality for plan years beginning on or after January 1, 2018. CMS stated that these changes would allow for a more efficient SHOP, such that employers and employees could enroll in SHOP coverage by working with a QHP issuer or SHOP-registered agent or broker. Small employers will still get an eligibility determination from the SHOP exchange to qualify them for small employer tax credits. CMS stated that the primary purpose of these regulatory changes was not to increase the attractiveness of SHOPS to small employers, but to remove the regulatory burden on SHOPS to give Exchanges the flexibility to operate their SHOPS in a cost-effective way that best meets the needs of their State's small group market.

### **Conclusion**

Absent passage of more comprehensive ACA repeal and replace legislation, the Trump Administration is using the regulatory process to place its stamp on the individual and small group markets. This regulation is one of several (including the short-term duration health plans proposed rule and the Association Health Plan proposed rule) where the decision-making authority is being sent to the states with greater flexibility for states to pursue their own path. This trend is being pursued in the name of expansion of more affordable plan options for consumers, but many fear it will trim critical benefits and limit choices for those with greater-than-average health care needs, such as people with disabilities and chronic conditions.