WHITE PAPER

Summary of Provisions of HHS' Proposed 2019 Notice of Benefit and Payment Parameters

Michael Cohen, PhD
202.568.0633 •michael.cohen@wakely.com

Julie Andrews, FSA, MAAA
720.501.2323 • julie.andrews@wakely.com

Chia Yi Chin, ASA, MAAA
720.226.9819 • chiac@wakely.com

Summary

On November 2, 2017, HHS published the proposed Notice of Benefit and Payment Parameters for 2019[1]. The notice includes important proposed rules and parameters for the operation of the individual and small group health insurance markets in both 2018 and 2019. This paper summarizes key provisions of the proposed notice, and other related information recently released by HHS.

Overview

The key provisions proposed in the notice and other related guidance are as follows:

1. **Risk Adjustment:** HHS is proposing several updates to the risk adjustment model for the 2018 and 2019 benefit years. Keyupdates include: 1) re-calibration of the model, 2) providing states flexibility to modify small group transfer payments, and 3) details on the risk adjustment data validation.
2. **2019 Risk Adjustment User Fee:** The user fee will remain unchanged at $1.68 per "billable" enrollee per year for 2019.
3. **MLR Reporting:** The proposed rule will ease the application process for states seeking to modify their MLR limits in order to stabilize their marketplace. Additionally, simplification of the quality improvement expenses to a global allowable amount 0.8% is proposed.
4. **Standardized Plan Options:** The plans developed in prior years will no longer be specified in 2019.
5. **Maximum Out of Pocket (MOOP):** The proposed maximum out of pocket for 2019 will be $7,900 for self only coverage and $15,800 for family coverage.
6. **Rate Review:** The rate review threshold is increased from 10% to 15% and states will have greater flexibility in setting filing deadlines for non-QHP plans.

[1] Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019", November 2, 2017. https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf

The 2019 NBPP proposes greater flexibility and responsibility for states to manage their exchange markets.

7. **EHB:** States will be given greater flexibility in selecting EHB benchmarks and issuers greater flexibility in substituting benefits.
8. **Navigators:** The rule proposes to eliminate the physical presence restriction and requirement for two types of Navigators in order to provide Exchanges greater flexibility in managing enrollment support.
9. **Exchange User Fees:** User fees will remain unchanged at 3.5% for FFEs and 3.0% for partnership Exchanges.

The proposed notice covers many different topic areas. Further details are summarized below.

SHOP

CMS proposes to drastically reduce SHOP requirements. The federally-facilitated SHOP would cease major functions (eligibility, premium aggregate, online enrollment, etc.) although state-based SHOPs can continue these functions. Issuers are required to maintain records on which enrolled employers are SHOP and which are not.

Eligibility

Direct enrollment is being encouraged and requirements around direct enrollment relaxed. For example, issuers or agents/brokers who conduct direct enrollment are allowed to select the third-party entity for handling audits.

There were also tweaks to eligibility standards. New category of data matching inconstancies around income were created when an enrollee's attested income differs from IRS records. Enrollees whose IRS income data shows that their income is below 100% FPL or their income is greater than IRS data will now trigger data matching issues. Future guidance on the reasonable thresholds for triggering data matching issues will be forth coming.

CMS also proposed ending the requirement for direct notification to enrollees receiving APTC prior to discontinuing coverage for failure to file taxes.

Finally, there were a few changes to special enrollment periods (SEP) requirements including allowing women who lose access to CHIP (related to pregnancy related services) to qualify for a SEP. Also, SEPs applicable to on-exchange issuers are being expanded to non-QHP issuers. For example, the prior coverage requirement will be waived prior to an enrollee's qualifying event if they lived in a service area where no QHPs were offered on the Exchange.

In SHOP, for plan years starting on or after January 1, 2018; QHPs may restrict the availability of coverage of a group plan that does not comply with group participation rules to an annual enrollment period of November 15 to December 15 of each calendar year.

Maximum Out of Pocket Updates

The maximum out of pocket standards for standard plans and cost sharing variations for 2019 are proposed.

- Standard Plans: $7,900/$15,800 (single/family)
- 100-150% FPL: $2,600/$5,200 (single/family)
- 150%-200% FPL: $2,600/$5,200 (single/family)
- 200%-250% FPL: $6,300/$12,600 (single/family)

Risk Adjustment

Several updates to the risk adjustment program are included in the payment notice. The updates include:

Sequestration

Reinsurance and risk adjustment program will both be sequestered at a rate of 6.6 percent for payments made from fiscal 2018 resources.

Recalibration using EDGE Data

CMS is proposing to blend 3 years of data to recalibrate the coefficients used in risk adjustment model. For the 2019 benefit year, CMS intends to blend separately solved coefficients from the 2016 benefit year EDGE enrollee-level data and the 2014 and 2015 MarketScan data. The methodology to blend the coefficients will be finalized in the final 2019 payment notice.

Prescription Drugs

CMS is proposing to remove the two severity-only RXCs (RXC 11: Ammonia Detoxicants, and RXC 12: Diuretics, Loop and Select Potassium-Sparing) as both RXCs have extremely small coefficients due to low average cost per enrollee per year and are constrained to the average cost of the drugs to avoid overcompensation.

High Cost Risk Pool Adjustment

CMS is proposing to maintain a $1 million threshold and 60 percent coinsurance rate for the high-cost risk pool for 2019 benefit year risk adjustment program.

Cost-sharing reductions adjustments

Risk scores adjustment for CSR plans will continue for the 2019 benefit year as finalized in 2018 payment notice (similar factors as used in 2016 and 2017 benefit year). The CSR adjustments will be multiplied against the sum of the demographic, diagnosis and interaction factors, and enrollment and prescription drug utilization factors for the adult model. CMS anticipates adjusting these factors for the 2020 benefit year when enrollee-level data for the individual market will be available (through the model recalibration effort for the 2019 benefit year).

Risk Adjustment Payment Transfer Formula

There is no change to the risk adjustment payment transfer formula than as finalized in the 2018 payment notice. However, CMS is proposing to permit States' insurance regulators to request a percentage adjustment in the calculation of the risk adjustment transfer amounts in the small group market beginning in the 2019 benefit year. The adjustment will be made by reducing the statewide average premium used in the HHS risk adjustment transfer formula by up to 50 percent. States will need to submit their proposal for an adjustment within 30 calendar days after publication of the proposed HHS notice of benefit and payment parameters for the applicable benefit year. HHS will then make final determinations of approval of State requests by March 1 of the benefit year prior to the applicable benefit year, in time for issuers' initial rate setting deadline.

Note that the statewide average premium used in the HHS risk adjustment transfer formula beginning in 2018 will be 86% of unadjusted statewide average premium to account for admin cost loaded in premiums. Therefore, the maximum adjustment for 2019 allowed will be 43% of the unadjusted statewide average premium (or 50% of the statewide average premium after administrative cost adjustment). The above adjustment also only applies to the small group market; CMS is seeking comments if this adjustment should also apply to the individual market.

Despite considered changes to the CSR adjustment in the risk adjustment formula in August, CMS has proposed no changes for 2018 or 2019.

Risk Adjustment Data Validation (RADV)

CMS is proposing evaluating material statistical deviation in error rates in applying error rates to risk scores beginning with the 2017 benefit year risk adjustment data validation. CMS is considering adjusting an issuer's risk score only when the issuer's error rate materially deviates from the central tendency of nationally observed error rates. CMS also proposes to apply the difference between the mean error rate or the confidence interval around the central tendency and the mean error rate, instead of the full error rate. If issuers do not have error rates that materially deviate from the national central tendency, CMS is proposing to not apply any adjustments. CMS did not specify what would deem these error rates as "materially deviate".

CMS propose to retroactively adjust payment transfer for issuers who are exiting the market using the error rate derived from the RADV process of their final benefit year in the market. For all other issuers who will remain in the market, CMS intends to use the error rate derived from the applicable benefit year to adjust for plan average risk scores in subsequent benefit year.

For issuers with 500 billable member months or lower and who elect to establish and submit data to an EDGE server, CMS is proposing that they do not have to go through the initial validation audit (IVA) process. These issuers will receive an error rate that is the lower of national average negative error rate, or the average negative error rate within a State. However, CMS notes that if the proposal to implement a central tendency approach to payment adjustments is finalized (as stated in earlier paragraph), it is possible that no adjustment would occur for these issuers.

Since the 2016 benefit year is another pilot year for RADV, CMS propose to postpone application of the materiality threshold[2] until the 2018 benefit year. All issuers of risk adjustment covered plans other than issuers with 500 billable member months or fewer will be required to conduct IVA for the 2017 benefit year RADV. In addition, CMS is also proposing to treat 2016 benefit year as an initial year of risk adjustment data validation such that initial validation auditors may meet the lower inter-rater reliability standard of 85 percent.

In addition, CMS also clarified in the Payment Notice that sample size in the IVA will be 200 enrollees per issuer per risk pool, not 200 enrollees per plan. CMS also proposes that starting benefit year 2017, IVA will only apply to in states where there are more than one issuer and where HHS conducted risk adjustment on behalf of the State.

For providers that are subjected to state or federal privacy laws that prohibit providers from providing a complete mental or behavioral health record to HHS, CMS is proposing that providers attest the laws that prohibit submission as well as furnish mental or behavioral health assessments instead. The assessments will contain: (i) enrollee's name; (ii) gender; (iii) date of birth; (iv) current status of all mental or behavioral health diagnoses; and (v) dates of services.

The Payment Notice also proposes that HHS may impose civil money penalties on issuers of a risk adjustment covered plan that:

1. Fails to engage an initial validation auditor
2. Fails to submit the results of an initial validation audit to HHS
3. Engages in misconduct or substantial non-compliance with the risk adjustment data validation standards and requirements

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[2] Issuers with total annual premiums at or below $15 million will not be subject to annual IVA, but will be subject to IVA approximately every 3 years.

applicable to issuers of risk adjustment covered plans

4. Intentionally or recklessly misrepresents or falsifies information that it furnishes to HHS

CMS proposes that demographic or enrollment errors found during RADV would be used to adjust the applicable benefit year transfer amount, rather than subsequent benefit year risk score. Additionally, in cases where there is a material impact on risk adjustment transfers due to incorrect EDGE server premium data, HHS would calculate the dollar differences in risk transfers, and where the difference is detrimental to one or more issuers in the market, CMS proposes to adjust the other issuers' risk adjustment transfer amount by that calculation and increase the risk adjustment charge (or decrease the risk adjustment payment) to the issuer that made the data error.

Risk Adjustment User Fee

The risk adjustment user fee is estimated to be $1.68 per billable member per year, or $0.14 PMPM for the 2019 benefit year. It is unchanged from the user fee in the 2018 benefit year.

Rate Review

The rule is proposing additional flexibility for states in reviewing rates. Starting in 2019, the rate review threshold will be increased from 10% to 15%. Parts I, II and III will continue to be required filing elements. States may retain stricter review thresholds. Additionally, states with effective rate review programs may set different fling deadlines for QHP vs. non-QHP filings to allow flexibility in the timing and management of the review.

The advance notice to CMS for the posting of rate increases is to be reduced from 30 days to just 5 days, providing states greater flexibility in managing their review timeline. CMS will no longer set a uniform deadline for the positing of all rates by states.

Student health insurance plans currently viewed as individual coverage will be exempted from Federal rate review requirements as their development and rating is more similar to a large group product.

Standardized options will not be established in 2019 and there will no longer be a differential display on the exchange for these options.

EHB Flexibility

The 2019 Payment proposes to provide far more flexibility to states and issuers. States, starting in 2019, would be allowed to update their EHB benchmark on an annual basis. They could update their benchmark either by 1) selecting another state's benchmark 2) substituting a category of benefits without another state's benefits or 3) selecting a new set benefits provided that the benefits are equal in scope to a typical employer plan and is less generous than the most generous comparison plan (comparison plans are plans identified in the 2017 EHB benchmark process). A typical employer is defined as a large or small employer or self-insured group health plan with at least 5,000 enrollees. The Payment Notice also hints at a potential Federal standard in the future (specifically mentioning standard around prescription drugs). The Payment Notice also would allow issuers to substitute benefits across categories provided that the benefits are of actuarial equivalence and that plans maintain some balance across EHB categories.

Navigator Changes

The exchanges are being allowed greater flexibility in the management of their Navigator programs. The requirement to provide two types of Navigators, community and consumer focused, will be eliminated. The restrictions to only Navigators who maintain a local physical presence is also to be lifted.

MLR Formula

The proposed rule is suggesting easing the application requirements for states that would

like to apply for an exception to the existing Federal MLR standards. The goal is to provide the States greater flexibility in managing their markets through the MLR requirements. Additionally, the rule is proposing changes to the formula. The proposal includes the expansion of the definition of taxes to include Federal and State employment taxes. The current formula allows for the allocation and reduction in premium for quality improvement expenses, the tracking and reporting of which can be burdensome for issuers. Historically, quality improvement expenses have averaged 0.8%, and therefore, the rule is proposing that issuers may use this percentage in their MLR reporting and pricing without explanation. If an issuer spends more than 0.8% they may continue to report the higher amount but must demonstrate and support the reporting.

Miscellaneous Items

There is also proposed less Federal oversight and more state oversight over QHP certification. These areas include network adequacy, ECPs, compliance reviews, accreditations, and other areas.

Simplified Choice plans (also known as standardized options) which were designed to provide consumers in Healthcare.gov states with plan choices that met standard cost-sharing requirements to facilitate comparison, would be discontinued.

The meaningful difference requirement, or the requirement that QHPs must be sufficiently different from other QHPs, is proposed to be eliminated for Healthcare.gov states.

Exchanges may use any lowest cost plan for determination of affordable coverage where no Bronze plan is available in a service area.

The designation of minimum essential coverage will now apply to CHIP buy-in programs where the coverage is identical to the Title XXI program.

The 2019 AV Calculator

The actuarial value calculator did not experience major changes. In order to maintain stability in 2019, the underlying data is not being changed for 2019. CMS trended the data from 2015 to 20108 at the rate of 3.25% for medical and 11.5% for pharmacy. For 2019, the medical trend increased to 5.4%. The MOOP limits are updated to $8,000 and the expanded deminimis ranges remain untouched. Despite the flexibility for states to redefine their EHBs, the standard population are unadjusted from that defined for 2018.

Please contact Michael Cohen at michael.cohen@wakely.com , Chia Yi Chin at chiac@wakely.com or Julie Andrews at julie.andrews@wakely.com with any questions or to follow up on any of the concepts presented here.