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CMS Proposes Changes to the Regulations Governing the ACA

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Health Care

Earlier this month, the Centers for Medicare & Medicaid Services (CMS) published the long-awaited 2019 Notice of Benefit and Payment Parameters, which includes significant changes to the implementation regulations of the Affordable Care Act (ACA). 82 Fed. Reg. 51,052 (Nov. 2, 2017). As described below, CMS proposes changes to the regulations and policies governing Essential Health Benefits, premium stabilization programs, eligibility and enrollment, and the medical loss ratio (MLR), among others. CMS also proposes changes to the regulations governing the Small Business Health Options Program (SHOP), which we will analyze in a future advisory.

In the preamble to the Notice, CMS noted that the proposed rules do not address every policy change the Trump Administration is considering or every proposal suggested in response to CMS's June 2017 Request for Information, and that additional ACA rulemaking will be forthcoming.

Comments to this proposed rulemaking are due **November 27, 2017.**

Essential Health Benefits

Background

The ACA requires that non-grandfathered health plans in the individual and small group markets cover "Essential Health Benefits," which includes items and services in 10 statutory benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

Under rules adopted by the Obama Administration, the Essential Health Benefits package is developed based on state "benchmarks," subject to complex procedures and requirements. *See* 45 C.F.R. Part 156, Subpart B. Under these rules, state insurance regulators must develop an "EHB-benchmark plan" based on the benefits in a "base-benchmark plan," which is either chosen by the State from a list in the CMS regulations or, if the State does not choose a base-benchmark, is "the largest plan by enrollment in the largest product by enrollment in the State's small group market." § 156.100. To the extent the base-benchmark does not cover all 10 EHB

categories, the base-benchmark plan must be supplemented with benefits from one of the other base-benchmark plan options to become the State's EHB-benchmark.

Health plans in the individual and small group markets are required to provide coverage that is "substantially equal" to the coverage in the State's EHB-benchmark. § 156.115(a)(1). Issuers can "substitute" for EHB-benchmark benefits, provided: the new benefit(s) are in the same Essential Health Benefits category as the benefit(s) being replaced; the new benefit(s) are actuarially equivalent to the benefit(s) being replace; and the benefit(s) being replaced are not prescription drug benefit(s). § 156.115(b).

Proposed Changes to the EHB-Benchmark

The proposed rules make significant changes to the process for defining Essential Health Benefits, effective January 1, 2019. First, instead of going through the complex, multi-step process described above for developing an EHB-benchmark, States would be able to choose an EHB-benchmark through one of several more straightforward processes:

1. Retaining the State's 2017 EHB-benchmark. (This is the default for a State that takes no action.)
2. Use an EHB-benchmark developed and approved for any other State for the 2017 plan year.
3. "Replacing one or more categories of EHBs" in its 2017 EHB-benchmark "with the same category or categories of EHB" used in any other State's 2017 EHB-benchmark.
4. "Otherwise selecting a set of benefits", provided that the benefit package does not "exceed the generosity of the most generous among" the following plans: (i) the State's EHB-benchmark plan for the 2017 plan year or (ii) any of the State's base-benchmark plan options for the 2017 plan supplemented as necessary under the Essential Health Benefits regulations.

Proposed 45 C.F.R. § 156.111(a).

All of these EHB-benchmarks would still be subject to the standards in 45 C.F.R. § 156.110. That is, they must cover all 10 Essential Health Benefits categories; supplement the plans to cover pediatric oral and vision services; comply with the non-discrimination provisions in 45 C.F.R. § 156.125; and cover the State's definition of habilitative services.

In addition, the proposed rules would require that, effective January 1, 2019, EHB-benchmark plans: "Be equal in scope of benefits to what is provided under a typical employer plan", which CMS proposes to define as: (a) an insurance plan product that covers in the aggregate at least 5,000 enrollees in the small group or large group markets in one or more States; or (b) a self-insured group health plan with at least 5,000 enrollees. Proposed § 156.111(b).

CMS also proposes to codify in regulation the statutory requirements that the EHB-benchmark provide: "an appropriate balance of coverage" among the 10 Essential Health Benefits categories; "[n]ot have benefits unduly weighted" toward any of the 10 categories; and provide "benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups." *Id.*

In the preamble to the proposed regulations, CMS states that, for plan years after 2019, it is "considering establishing a Federal default definition of EHB," and solicits comments on that

possibility. 82 Fed. Reg. at 51,102. CMS explains the competing considerations in developing a default plan: "The benefits of a Federal default could outweigh the potential impact on flexibility afforded to States, but we are also considering allowing States continued flexibility to adopt their own EHB-benchmark plans, provided they defray costs that exceed the Federal default." *Id.* One option under consideration is establishing a "national benchmark plan standard for prescription drugs" only. *Id.*

Proposed Changes to Plan Substitution Rules

The proposed rules would give insurers more flexibility in substituting benefits. Specifically, insurers would be able to substitute benefits across Essential Health Benefits categories, "as long as the plan with substitutions still provides benefits that are substantially equal to the EHB-benchmark plan, provides an appropriate balance among the EHB categories such that benefits are not unduly weighted towards any category, and provides benefits for diverse segments of the population." Proposed 45 C.F.R. § 156.115(b)(1)(ii).

Risk Adjustment

For 2019, CMS proposes to retain the 2018 risk adjustment methodology and payment transfer formula, subject to a number of changes, several of which we describe below.

State Flexibility Regarding Transfers in the Small Group Market

CMS acknowledges "some State regulators' desire to reduce the magnitude of risk adjustment charge amounts for some issuers." 82 Fed. Reg. at 51,072. In response, CMS notes that "the States have the statutory authority to operate their own State risk adjustment program under a Federally-certified alternate risk adjustment methodology as they deem fit." *Id.* at 51,073.

CMS now proposes to also allow State insurance regulators "to request a percentage adjustment in the calculation of the risk adjustment transfer amounts in the small group market in their State, beginning for the 2019 benefit year," up to 50 percent of the premium used in the applicable benefit year. *Id.* That is, in addition to the option of developing its own risk adjustment program, a State will have the option to use the CMS risk adjustment methodology with a state-requested percentage adjustment to the transfer amount in the small group market.

States seeking to implement such an adjustment would be required to submit an application with 30 calendar days of the proposed notice of benefit parameters for the applicable year. For example, States seeking an adjustment for plan 2019 would need to submit an application to CMS within 30 days of the November 2 publication of 2019 Notice of Benefit and Payment Parameters. *Id.*

CMS also seeks comment on whether it should extend this state adjustment option to the individual market, in addition to the small group market. *Id.* CMS believes state adjustments may be more important in the small group market than in the individual market because "risk selection can be significantly less in a State's small group market compared to its individual market." *Id.* However, CMS acknowledges that States may believe that its risk adjustment methodology, "which is calibrated on a national dataset, disproportionately accounts for relative actuarial risk differences in its individual market risk pool." *Id.*

Prescription Drugs

In a previous Notice of Benefit and Payment Parameters, CMS announced that it would incorporate prescription drug data in the risk adjustment formula beginning in the 2018 benefit year. However, CMS only included 12 drug categories in the 2018 data.

For the 2019 benefit year, CMS proposes to remove two of the 12 drug categories: Ammonia Detoxicants and Diuretics, and Loop and Select Potassium-Sparing. These two categories will be used in 2018 for "severity-only"; that is, "the presence of the drug alone would not lead to the imputation of additional plan liability costs attributed to the plan," but the presence of the drug would increase predictive costs for individuals with an associated diagnosis. 82 Fed. Reg. at 51,016. CMS asserted the these two drug categories "have extremely small coefficients that no longer predict meaningful incremental plan risk associated with a severe health condition." *Id.*

CMS proposes continuing to incorporate the remaining 10 drug categories in the risk adjustment methodology in 2019. These 10 categories are: anti-HIV agents; anti-Hepatitis C agents; antiarrythmics; phosphate binders; inflammatory bowel disease agents; insulin; anti-diabetic agents; multiple sclerosis agents; immune suppressants and immunomodulators; and cystic fibrosis agents.

CMS noted that these categories "do not engender significant gaming concerns due to the cost and side-effects of the drugs if prescribed without cause," and "there is a high rate of presence of a diagnosis code in the associated [hierarchical condition category]." 82 Fed. Reg. at 51,016.

Civil Money Penalties

Current regulations give CMS the authority to impose a civil money penalty for any plan that (1) fails to engage an initial data validation auditor; or (2) fails to submit the data validation audit results to CMS. 45 C.F.R. § 153.630(b)(9).

CMS is proposing to amend these rules to also give it the authority to impose a civil money penalty for any plan that "[e]ngages in misconduct or substantial non-compliance with the risk adjustment data validation standards and requirements applicable to issuers of risk adjustment covered plans"; or "intentionally or recklessly" misrepresents or falsifies data to CMS. Proposed 45 C.F.R. § 153.630(b)(9). The purpose of this proposed change is to clarify that CMS has the authority to impose civil money penalties for these two categories of conduct for *all* risk adjustment-covered plans, not just plans sold on the federally-facilitated Exchange.

Medical Loss Ratio (MLR)

CMS proposes a number of changes to make it easier for insurers to comply with the MLR.

Counting 0.8 Percent of Premium Revenue as Expenditures on Health Care Quality Activities

Under the MLR statutory provision and implementing regulations, expenditures for activities that improve health care quality are counted in the numerator of the MLR, and thus do not count against an insurer when determining whether the insurer must pay an MLR rebate to enrollees. For example, if an insurer subject to the 80 percent MLR in the individual market received $10 million in premium revenue, paid out $7.8 million in claims, and spent $200,000 on activities that improve health care quality, it would not be required to pay an MLR.

CMS proposes to give issuers "the option of reporting an amount equal to 0.8 percent of earned premiums" in lieu of reporting its actual expenditures on health care quality activities. Proposed 45 C.F.R. § 158.221(b)(8). CMS chose .8 percent because issuers reported that, on average, they spent .8 percent on health care quality activities from 2012 through 2015. 82 Fed. Reg. at 51,114.

This proposed change would give insurers that spend less than .8 percent on health care quality activities more breathing room on the MLR, and it would allow them to avoid the administrative cost of tracking and reporting health care quality expenditures. It may even benefit insurers that spend slightly more than .8 percent on health care quality activities, as it may be cost-effective for those insurers to stop tracking health care quality expenditures and just report the .8 percent of premium revenue amount.

State Adjustments to the MLR

CMS proposes to provide more flexibility for States seeking approval from CMS for an adjustment to the MLR percentage. Specifically, the proposed rule would:

1. Remove the requirement that States applying for an adjustment must estimate rebates that would be paid with and without an adjustment. Proposed 45 C.F.R. §§ 158.301, 158.322.
2. Change the standard the Secretary applies to state adjustment requests. Under current rules, a State must show that there is a "reasonable likelihood" that the MLR will "destabilize the individual market in that State." The proposed rule would change this standard to a "reasonable likelihood that an adjustment . . .will help stabilize the individual market in that State." Proposed § 158.301; *see also* Proposed § 158.322.
3. Broaden the criteria the Secretary may consider in evaluating state adjustment requests to include: the "financial performance" of issuers (not just whether they will exit the market); "the likelihood that an adjustment to the 80 percent MLR standard could help increase competition in the individual market in the State, including in underserved areas"; and "whether an adjustment to the 80 percent MLR standard for the individual market may improve consumers' access to agents and brokers." Proposed 45 C.F.R. § 158.330.
4. Eliminate the requirement that the Secretary consider, in evaluating state adjustment requests, "[t]he mechanisms, such as guaranteed issue products, an issuer of last resort, or a State high risk pool, available to the State to provide coverage to consumers in the event of an issuer withdrawing from the market, and the affordability of these options compared to the coverage provided by exiting or potentially exiting issuers." *Id.*

Treatment of Employment Taxes

In the preamble, CMS announced that it is considering, and inviting comments on, whether it should allow all issuers to deduct Federal and State employment taxes from premiums in their MLR and rebate calculations. 82 Fed. Reg. at 51,114. CMS is "not reconsidering the treatment of the other taxes that cannot be excluded from premiums in MLR and rebate calculations . . . because [it] believes those taxes can be distinguished from employment taxes and the [National Association of Insurance Commissioners] had explicitly recommended to [the U.S. Department of Health and Human Services ("HHS")] that such taxes should not be excluded from premiums." *Id.*

Eligibility Determinations

CMS proposes a new set of rules for verifying individual eligibility for advance payments of the premium tax credit (APTC) and cost-sharing reductions.

Under current rules, a consumer can attest that their income is higher than income data from the Internal Revenue Service (IRS) and Social Security Administration (SSA). The proposed rules would require Exchanges to request additional documentation to verify the consumer's attested income if: (1) a consumer attested to a projected annual income between 100 and 400 percent of the Federal poverty level (FPL); (2) the Exchange has data from IRS and SSA showing that their income is below 100 percent of the FPL; (3) the Exchange has not assessed or determined the consumer to be income-eligible for Medicaid or the Children's Health Insurance Program (CHIP); and (4) the consumer's attestation of annual income exceeds the income data by a reasonable threshold (to be established by the Exchange and approved by CMS, but at least 10 percent). If the Exchange remains unable to verify the applicant's attestation upon requesting additional documentation, the Exchange must determine the tax filer ineligible for the APTC and cost-sharing reductions. Proposed 45 C.F.R. § 155.320(c)(3)(iii)(F), (c)(3)(vi)(F).

In addition, the proposed rule removes the direct notification requirement in the current rules, which prohibits the Exchange from denying eligibility for the APTC unless direct notification is first sent to the tax filer stating that his or her eligibility will be discontinued as a result of the tax filer's failure to comply with the requirements. Proposed 45 C.F.R. § 155.305(f).

HHS also requests comments regarding whether to shorten the time period that Exchanges are authorized to obtain updated tax return information. Under current rules, enrollees may authorize the Exchange to obtain tax return information for up to five years. 82 Fed. at Reg. 51,088.

Finally, the proposed rule would allow the Exchanges to continue to use HHS-approved alternative processes to verify eligibility for employer-sponsored insurance. Consumers eligible to enroll in employer-sponsored coverage are not eligible for the APTC unless the plan's coverage is unaffordable (i.e., exceeds 9.5 percent of the employee's household income) or does not provide minimum value. To determine APTC eligibility, Exchanges must determine whether an applicant is enrolled in or eligible for employer-sponsored coverage by obtaining electronic employment data. If an Exchange cannot access this data, HHS permitted Exchanges in 2016 and 2017 to use an HHS-approved alternative process. The proposed rules would allow Exchanges to use HHS-approved alternative processes through benefit year 2019. Proposed § 155.320(d)(4).

Rate Review

The ACA requires the Secretary, in conjunction with States, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage." CMS proposes to increase the threshold triggering this federal review from a 10 percent premium increase to a 15 percent premium increase. Proposed 45 C.F.R. § 154.200(a)(1). All insurers would still be subject to the parts of CMS's uniform rate review that apply to all rate changes. 82 Fed. Reg. at 51,079.

The threshold set by CMS constitutes a minimum standard, and some States employ stricter rate review standards. Current rules require States to submit a proposal to the Secretary for approval of any State-specific threshold. Under the proposed rules, CMS would require submission of a proposal only if the State-specific threshold is greater than the 15 percent Federal default threshold. Proposed § 154.200(a)(2).

Finally, CMS proposes to amend the rules to exempt student health insurance rates from review, beginning in 2019. Proposed 45 C.F.R. § 154.103.

Enrollment and Termination

The proposed rule makes various changes to special enrollment periods; coverage and termination effective dates; and audits of agents, brokers, and issuers participating in direct enrollment.

Special Enrollment Period

Under current law, qualified individuals with certain triggering events may be able to enroll in subsequent coverage during a special enrollment period, outside of open enrollment. CMS proposes several changes to the regulations governing special enrollment periods.

The proposed rules would make it easier for individuals who live or lived in an area without access to a QHP to qualify for a special enrollment period when coverage becomes available. Under current rules, certain individuals must demonstrate coverage in the 60 days prior to a qualifying event to be eligible for a special enrollment period, which an individual can satisfy by demonstrating that they had minimum essential coverage for one or more days during that 60-day period; lived in a foreign country or in a United States territory for one or more days during that 60-day period; or are an Indian. The proposed rule adds that qualified individuals can also access the special enrollment period by demonstrating that they lived in a service area without access to a QHP for one or more days during that 60-day period. Proposed 45 C.F.R. § 155.420(a)(5).

For dependents who qualify for a special enrollment period through birth, adoption, placement for adoption, or placement in foster care, the proposed rule would change the options available for coverage effective date. Specifically, the Exchange would be required to ensure that the coverage effective dates include either the date of the qualifying event, the first day of the month following plan selection, or standard coverage effective dates (described below). *Id.* § 155.420(a)(5)(b)(2)(i).

Finally, the proposed rule would expressly specify that women who lose access to pregnancy-related CHIP coverage qualify for a special enrollment period. *Id.* § 155.420(d)(1)(iii).

Coverage Effective Dates

In the current rules, coverage must become effective the first day of the month following plan selection. Under the proposed regulation, for coverage in the small group market, and in the large group market if such coverage is offered through a SHOP in a State, for a plan selection received on the first through the fifteenth day of any month, the coverage effective date would be the first day of the following month. For a plan selection received on the sixteenth through

last day of any month, the coverage effective date must be the first day of the second following month. Proposed 45 C.F.R. § 147.104(b)(1)(i).

Termination Effective Dates

In the case of coverage termination, the proposed rule would change the last day of enrollment through the Exchange to the date on which the termination is requested by the enrollee or on another prospective date selected by the enrollee. The current rule specifies alternative dates depending on whether the enrollee provided the plan with reasonable notice, which is defined as at least fourteen days before the requested effective date of termination. Proposed 45 C.F.R. § 155.430(d).

Third-Party Auditors

Currently, CMS imposes standards for HHS-approved vendors to audit agents, brokers, and issuers participating in direct enrollment. The proposed rule would create standards for third-parties performing audits of agents, brokers, and issuers participating in direct enrollment. Under the proposed rule, an agent, broker, or issuer participating in direct enrollment would be required to engage a third-party entity to conduct an annual review. Among other requirements, third party must have experience conducting audits; adhere to HHS specifications for content, format, privacy, and security; share with HHS all data related to the third-party entity's audit; and disclose to HHS any financial relationships between the entity and individuals who own or are employed by an agent, broker, or issuer. Proposed 45 C.F.R. § 155.221.

Hardship Exemption

Section 1311(d) of the ACA allows individuals to seek an exemption from the minimum essential coverage requirement due to a lack of affordable coverage based on an individual's projected income. The proposed rule adds a provisions governing hardship exemptions for individuals who cannot afford coverage. Specifically, if the Exchange does not offer a bronze level plan in an individual's rating area, then the Exchange would need to determine whether coverage exceeds the affordability threshold by using the annual premium for the lowest cost Exchange metal level plan available in the individual market in the rating area in which the individual resides, proposed 45 C.F.R. § 155.605(d)(2)(iv).

Comments and Next Steps

Comments to the Notice of Benefit and Payment Parameters are due **November 27, 2017**.

It appears that this proposed rulemaking is the first of several sets of ACA regulatory changes that the Trump Administration's CMS plans to propose. In the preamble to the Notice, CMS noted that the proposed rules do not address every policy change the Trump Administration is considering, and they do not address every proposed regulatory change suggested in response to CMS's June 2017 Request for Information. CMS states that additional rulemaking will be forthcoming.

If you have any questions concerning the material discussed in this client alert, please contact the following members of our Health Care practice:

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