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CMS Finalizes Changes to the Regulations Governing the ACA

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Health Care

Last month, the Centers for Medicare & Medicaid Services (CMS) finalized the 2019 Notice of Benefit and Payment Parameters, which includes changes to the Affordable Care Act's (ACA) implementing regulations. 83 Fed. Reg. 16,930 (April 17, 2018). In this advisory, we analyze the most significant of these regulatory changes, focusing on the key differences between the final regulations and proposed regulations. For a more detailed summary of the proposed regulations, please see the advisory we circulated last November.

Essential Health Benefits

In the proposed rules, CMS advanced a number of significant changes to the process for defining Essential Health Benefits (EHB) for the 2019 plan year. For example, CMS proposed to allow States to choose an EHB-benchmark through one of several new options:

1. Retaining the State's 2017 EHB-benchmark. (This is the default for a State that takes no action.)
2. Using 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).

In addition, CMS proposed to require that EHB-benchmark plans be equal in scope of benefits to those provided under a "typical employer plan", defined 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. *Id.* § 156.111(b).

CMS also proposed to allow insurers to substitute benefits across EHB 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).

In the final rule, CMS changed the effective date of these changes to the EHB rules from January 1, 2019 to January 1, 2020. 83 Fed. Reg. at 17,009. That is, the changes to the EHB regulations will not apply until plan year 2020. Plan years beginning before January 1, 2020 will be subject to the existing selection process outlined in § 156.100.

Otherwise, CMS generally finalized these changes to the EHB regulations as proposed, with a few modifications, including the following:

1. Typical employer plans: In response to commenters' concerns with the proposed definition of "typical employer plan" described above, CMS changed the definition. Under the final rule, States have two choices in defining a "typical employer plan," for purposes of ensuring a minimum scope of benefits for the State's EHB-benchmark plan: (1) One of the State's 2017 base-benchmark plan options listed in 45 C.F.R. § 156.100; or (2) the largest health insurance plan by enrollment in any of the five largest large group health insurance products by enrollment in the State, provided that the plan meets a number of additional requirements. § 156.111(b)(2).
2. Notice requirement: CMS finalized a requirement that the State must post a notice of its decision about an EHB-benchmark plan on a relevant State website, with information about the opportunity for public comment on the decision. § 156.111(c).
3. EHB-benchmark plan options: CMS will require States to ensure that any EHB-benchmark plan chosen does not exceed the generosity of the most generous of the State's 2017 EHB-benchmark plan or any of the State's 2017 base-benchmark plan options. § 156.111(b)(2)(ii).
4. Substituting benefits: CMS finalized the proposed change to allow issuers to substitute benefits between EHB categories, with several clarifications and limitations. Specifically, CMS will only permit cross-category substitution if the relevant State permits such substitution and notifies CMS of its decision, and CMS will continue to require the plan to comply with the requirements for EHB coverage in Section 156.115(a), § 156.115(b)(3)(i).

Risk Adjstment

The changes to the risk adjustment methodology in the proposed rules were generally finalized as proposed. CMS finalized its proposal to 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. 82 Fed. Reg. at 51,073. That is, in addition to the option of developing its own risk adjustment program, a State would 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. However, this change will not become effective until the 2020 benefit year.

In addition, for the 2019 plan year, CMS finalized its proposals to remove two of the categories of prescription drug data – Ammonia Detoxicants and Diuretics, and Loop and Select Potassium-Sparing – used in in the risk adjustment formula, and CMS finalized its proposal to amend the regulations to give the agency the authority to impose a civil money penalty for "misconduct or substantial non-compliance with the risk adjustment data validation standards and requirements" and for "intentionally or recklessly" misrepresenting or falsifying data, 45 C.F.R. § 153.630(b)(9).

Medical Loss Ratio (MLR)

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

CMS proposed 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 finalized this policy as proposed, except that CMS added provisions requiring that issuers that elect this reporting option must: apply it consistently across all of their States and markets that are subject to the MLR requirements; apply the reporting method for a minimum of three consecutive reporting years; and ensure that all affiliated issuers elect the same reporting method. 83 Fed. Reg. at 17,032, 033.

Under current rules, a State may apply to CMS for certain adjustments to the MLR in the State. To reduce the burden on States, CMS finalized its proposal to remove the requirements that a State must justify how its proposed adjustment was determined and estimate rebates that would be paid with and without an adjustment. § 158.322; *see also* 83 Fed. Reg. at 17,035.

In the preamble to the proposed rule, CMS invited 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. The final rule does not include this change, but CMS explains in the preamble that its intends to gather data and further analyze the potential impact of the proposal. 83 Fed. Reg. at 17,032. While issuers already report the employment tax amounts together with other taxes on the MLR reporting form, CMS intends to propose changes to the MLR Annual Reporting Form to include a separate line that will show these tax amounts for each issuer. *Id*. This will provide CMS with better data on employment taxes to more precisely estimate how potential modifications to the current policy may affect issuers and consumers and to determine whether such modifications would likely improve market stability. *Id*.

Eligibility Determinations

CMS proposed to require Exchanges to request additional documentation to verify the consumer's attested income, for purposes of determining eligibility for advance payments of the premium tax credit (APTC) and cost-sharing reductions. If the Exchange remained unable to verify the applicant's income upon requesting additional documentation, the Exchange would be required to 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).

CMS finalized this policy generally as proposed, except that CMS exempts from this additional income verification requirement non-citizen applicants who are lawfully present and ineligible for Medicaid by reason of immigration status. *Id*. CMS reasoned that these applicants do not have

the same incentive to inflate their reported household income to qualify for APTC, since they are also able to qualify for APTC with a household income under 100 percent FPL.

CMS also finalized the provision in the proposed rules allowing the Exchanges to continue to use CMS-approved alternative processes to verify eligibility for employer-sponsored insurance. § 155.320(d)(4). 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, CMS has permitted Exchanges to use a CMS-approved alternative process. The final rules will allow Exchanges to use CMS-approved alternative processes through benefit year 2019. § 155.320(d)(4).

In the proposed rules, CMS requested 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. at 51,088. The final rules did not make any changes to this policy. 83 Fed. Reg. at 16,989.

Enrollment and Termination

CMS proposed various changes to the regulations governing special enrollment periods; audits of agents, brokers, and issuers; coverage effective dates; and termination effective dates.

CMS generally finalized its changes to the special enrollment regulations, auditing provisions, and the coverage effective dates as proposed.

For termination of coverage, CMS did not adopt the change as proposed. The current rule specifies alternative termination dates depending on whether the enrollee provided the plan with reasonable notice, which is defined as at least 14 days before the requested effective date of termination. CMS proposed to change the last day of enrollment to be the date on which the termination is requested by the enrollee or on another prospective date selected by the enrollee. Proposed 45 C.F.R. § 155.430(d). CMS did not finalize this policy as proposed, and instead amended the regulation to allow Exchanges to choose whether to retain the current policy or operate under the proposed policy. 83 Fed. Reg. at 16,993.

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." In the proposed rules, CMS sought 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). This threshold is a default standard; States may implement a higher or a lower threshold for CMS review. CMS proposed to require a State to submit its thresholds for CMS review only if that threshold is greater than the 15 percent Federal default threshold. Proposed § 154.200(a)(2). CMS also proposed to amend the rules to exempt student health insurance rates from review, beginning in 2019. Proposed 45 C.F.R. § 154.103.

CMS finalized these provisions as proposed, with one modification. § 154.200. CMS added language to clarify that State proposals to use a threshold above 15 percent must be submitted in the form and manner specified by the Secretary. *Id*. CMS will post information from States that request a threshold higher than 15 percent and will issue further guidance on the process for submission and review of such requests. 83 Fed. Reg. at 16,973.

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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