

WHAT YOU NEED TO KNOW



## 2019 Benefit and Payment Parameters Final Rule

The Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) published its [2019 Benefit and Payment Parameters final rule](#).

The final rule primarily affects the individual health insurance market inside and outside of the Exchange, the small group health insurance market, issuers, and the states.

Through this final rule, CMS intends to enhance the states' role in regulating insurance, promote state flexibility, reduce state administrative burdens, reduce issuer regulatory burdens, simplify the eligibility and enrollment process for consumers, strengthen program integrity, promote market stability, and make individual health insurance coverage more affordable.

Below are the regulations that most directly affect employers and their group health plans.

The regulations are effective on June 18, 2018, and generally apply for plan years beginning on or after January 1, 2019.

### **Maximum annual out-of-pocket limit on cost sharing for 2019**

- \$7,900 for self-only coverage
- \$15,800 for other than self-only coverage

### **Essential health benefits (EHBs)**

The final rule's changes to EHBs generally apply for plan years beginning on or after January 1, 2020.

- States have three new methods for changing their state EHB-benchmark plans. States may:
  1. Select the EHB-benchmark plan that another state used for the 2017 plan year.
  2. Replace one or more categories of EHBs in the state's EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another state used for the 2017 plan year.

3. Select a set of benefits that will become the state's benchmark plan using a different process, provided that the EHB-benchmark plan does not exceed the generosity of the most generous plan among a set of comparison plans and that the EHB-benchmark plan meets other specific requirements.
- A state's new EHB-benchmark selection can impact the way issuers set their annual limitation on cost sharing and how issuers determine which benefits may not be subject to annual and lifetime dollar limits.
- Although large group market and self-insured group health plans are not required to provide coverage of EHBs, they must use a definition of EHBs to determine which benefits apply to the prohibition of annual and lifetime dollar limits and the annual limitation on cost sharing. Because large group market and self-insured group health plans can use any state's definition of EHBs, a state's change under the new methods could impact plans nationwide.

## **Small Business Health Options Program (SHOP) Marketplace**

These changes generally apply for plan years beginning on or after January 1, 2018.

- Employers participating in the SHOP must distribute information to qualified employees about the process to enroll in a qualified health plan (QHP) through the SHOP.
- Employers must provide information about the enrollment process to employees hired outside of the initial or annual open enrollment period.
- Employers will no longer notify the SHOP if the eligibility status of an employee or employee's dependent has changed.
- Employers no longer need to adhere to the SHOP annual employer election period. The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. However, SHOP issuers must continue to offer an annual open enrollment period from November 15 to December 15 during which employers do not need to meet minimum participation requirements.
- Employers are required to notify an issuer of loss of eligibility to participate in the SHOP, or a desire to terminate the SHOP enrollment or coverage.
- Employers must submit a new application to the SHOP if the employer makes a change that could end its eligibility or withdraw from participation in the SHOP.
- Issuers will accept payment not only from the SHOP, but from a qualified employer or enrollee in a SHOP.
- SHOPs will no longer be required to provide employee enrollment, premium aggregation functions, and online enrollment functionality through a SHOP website. The federally-facilitated Exchange (FFE) and state-based Exchange using the federal platform (SBE-FP) for SHOP will no longer provide these services.
- Without a SHOP's premium aggregation functions, employers will have to collect the enrollment and payment information needed from each of the issuers whose plans the employer intends to offer to its employees. Employers will have to send employee enrollments to each issuer (or through a SHOP-registered agent or broker). Employers will have to collect premiums from their employees and send them to the issuer.

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- Employers will enroll in a SHOP plan through a SHOP-registered agent or broker, or through a qualified health plan issuer participating in the SHOP.
- The Small Business Health Care Tax Credit will continue to be available to employers who enroll their small group in a SHOP plan.

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