ITUP
Insure the Uninsured Project

# Summary of 2018 Federal Rulemaking

## 2018 Final Rules

| 2018 Final Rule | Brief Summary | Status |
|---|---|---|
| 29 Code of Federal Regulations (CFR) 2510<br><br>Definition of "Employer Under Section 3(5) of ERISA – Association Health Plans | ***This final rule removes federal restrictions on Association Health Plans (AHPs).***<br><br>***Background.*** Under the Employee Retirement Income Security Act (ERISA), an association of a "bona fide" group of small employers can form AHPs, so long as the association exists for a purpose other than offering health coverage and other restrictions are met. For example, the employers must have "commonality of interests" and the employer members are required to control the activities and operations of the AHP. These stricter requirements, which include underwriting specific member groups, for forming AHPs are retained under the final rule. Underwriting refers to the use of medical or health information in the evaluation of an applicant for coverage.<br><br>Under prior law, a self-employed working owner, also known as a sole proprietor, with no employees was unable to join an AHP.<br><br>***2018 Final Rule.*** The final rule provides an alternative path to form an AHP. The final rule modifies the definition of "employer" under ERISA allowing small employers and self-employed working owners to join together and create an AHP to offer coverage to their employees (and themselves) as long as they have a "commonality of interests". The final rule relaxes the commonality of interest test by allowing the association of small employers (and sole proprietors) to have as their primary purpose the creation of the AHP, so long as they also have one substantial business purpose unrelated to the provision of benefits for forming. The rule does not define "substantial business purpose," but requires that the activity be "substantial enough that the association would be a viable entity even in the absence of acting as a sponsor of an AHP." The employers must either be in the same trade, industry, line of business or profession, or in the same principal place of business within the same state or common metropolitan area to form an AHP.<br><br>Under the final rule, AHPs operate as large group employers and therefore, do not participate in the small group or individual markets and are not subject to the ACA requirements that apply to small employers, including the requirement to offer essential health benefits and meet specific minimum coverage standards. | Effective date: August 20, 2018 |
| 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 144, 146, and 148<br><br>Short-Term, Limited-Duration Insurance | ***This final rule amends the definition of short-term, limited duration insurance (STLDI) to expand the timeframe for coverage.***<br><br>***Background.*** STLDI is typically used to fill temporary gaps in coverage. Under 2016 rules, STLDI were limited to coverage for 3 months. STLDI products are not subject to ACA requirements or consumer protections. These insurance products do not meet the minimum essential coverage definition for compliance with the individual mandate. Health plans are required to provide a notice on STLDI contracts/applications informing consumers that STLDI does not meet minimum health coverage requirements. | Effective date: October 2, 2018 |

# Summary of 2018 Federal Rulemaking

| 2018 Final Rule | Brief Summary | Status |
|---|---|---|
| | ***2018 Final Rule.*** The final rule makes the following changes to STLDI:<br><br>▪ Extends the allowable term of coverage from 3 months up to 12 months and allows for renewals or extensions of coverage up to 36 months;<br>▪ Ensures the extended term of coverage to 12 months will remain operative even if the 36-month renewal period is invalidated; and<br>▪ Adds more explicit consumer warning notice requirements for STLDI products. | |
| 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147<br><br>Moral Exemptions and Accommodations for Coverage of Certain Preventive Services<br><br>26 CFR 54, 29 CFR Part 2590, 45 CFR Part 147<br><br>Religious Exemptions and Accommodations for Coverage of Certain Preventive Services | ***These final rules outline parameters for moral and religious exemptions for coverage of contraceptives services.***<br><br>***Background.*** Federal regulations require ACA-compliant plans to cover all U.S. Food and Drug Administration-approved contraceptive methods, sterilization procedures, and related education and counseling. Exemptions were allowed for organizations with financial support primarily from churches. Other entities that object to providing contraceptive services can use their insurer or a third-party administrator (TPA) to provide contraceptive services to the entity's plan participants.<br><br>***2018 Final Rule.*** The final rule provides the following on moral exemptions:<br><br>▪ Allows nonprofit organizations, small businesses, and individuals that have non-religious moral convictions opposing the availability of contraceptive services to exempt these services from the entity's plan coverage.<br>▪ The entity has the option to use their insurer or a TPA to provide contraceptive services but is not required to do so.<br><br>***2018 Final Rule.*** The final rule provides the following on religious exemptions:<br><br>▪ Authorizes entities and individuals that object to contraceptive services because of sincerely held religious beliefs to exempt these services from the entity's plan coverage.<br>▪ The entity has the option to use their insurer or a TPA to provide contraceptive services but is not required to do so. | Effective Date: January 14, 2019 |

ITUP
Insure the Uninsured Project

# Summary of 2018 Federal Rulemaking

## 2018 Pending Proposed Rules

| 2018 Proposed Rule | Brief Summary | Status |
|---|---|---|
| 8 CFR Parts 103, 212, 213, 214, 245, and 248<br><br>Inadmissibility on Public Charge Grounds | ***This proposed rule outlines new health care programs proposed to be included in a public charge determination.***<br><br>***Background.*** Under federal law, an individual seeking admission to the U.S., or seeking to become a permanent resident (obtain a green card), is "inadmissible" if the individual at the time of application for admission or adjustment of status, is found to be likely at any time to become a "public charge" which includes, among other factors, whether they are likely to rely on public benefits for subsistence in the U.S.<br><br>Current federal guidance lists only two public benefits that can be considered as evidence of an immigrant's likelihood of becoming a public charge:<br><br>1. Receipt of public cash assistance for income maintenance; or<br>2. Institutionalization for long-term care at government expense.<br><br>***2018 Proposed Rule.*** The proposed rule adds to the list of public health care programs and benefits that must be considered in a public charge determination including the addition of the following programs:<br><br>▪ Supplemental Nutrition Assistance Program;<br>▪ Section 8 Project-Based Rental Assistance;<br>▪ Non-emergency Medicaid; and<br>▪ Medicare Part D Premium and Cost Sharing Subsidies.<br><br>For more information on public charge, see ITUP fact sheet and comments on the proposed rule. | Comments due: December 10, 2018 |
| 42 CFR Parts 438 and 457<br><br>Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care | ***This proposed rule rolls-back provisions in the 2016 comprehensive Medicaid managed care final rule.***<br><br>***Background.*** In 2016, the Centers for Medicare and Medicaid Services (CMS) issued a comprehensive Medicaid managed care rule (MMCR), the first comprehensive MMCR in over a decade. Goals of the MMCR would advance delivery system reform, improve quality of care, improve accountability and transparency, and strengthen key beneficiary protections.<br><br>The 2016 MMCR added various beneficiary protections to improve quality of care and beneficiary experience including:<br><br>▪ Requirements that states implement beneficiary support systems with enrollment information and up-to-date provider directories;<br>▪ Network adequacy requirements for 11 specified types of providers, an annual state certification of compliance, and allowable exceptions to the standards in recognition of special situations; and<br>▪ Requirements for states to develop quality of care standards, including performance measures, a state plan to reduce health disparities, and the | Comments due: January 14, 2019 |

## Summary of 2018 Federal Rulemaking

| 2018 Proposed Rule | Brief Summary | Status |
|---|---|---|
| | establishment of a quality rating system (QRS) based on federal standards.<br><br>The 2016 MMCR also changed how Medicaid managed care rates must be developed and approved by CMS. The 2016 MMCR invalidated the use of rate ranges, instead requiring greater specificity and justification in the rate development process.<br><br>***2018 Proposed Revision***. The 2018 proposed revisions to the 2016 MMCR diminish some of the consumer protections. For example, the 2018 proposed rule allows states to establish their own network adequacy standards, instead of complying with the standards articulated in the 2016 rule. Requirements to ensure limited-English-proficient beneficiaries can access plan written information are proposed to be relaxed, as are some of the requirements intended to ensure up-to-date provider directories. Under the 2018 proposed revisions, states can implement their own QRS. The QRS must allow for meaningful comparisons with other states and include federally identified mandatory measures.<br><br>The 2018 proposed revisions reinstate the use of rate ranges within specified parameters. | |

## 2018 Policy Guidance

| 2018 Policy Guidance | Brief Summary | Status |
|---|---|---|
| State Medicaid Director (SMD) Letter RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects | ***The SMD Letter released on budget neutrality policies for Section 1115 Medicaid Demonstration Waivers, restates 2016 policy changes that limit federal resources likely to be available through waivers.***<br><br>***Background.*** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (Secretary) authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program, known as §1115 Waivers. Under these §1115 Waiver authorities, the Secretary may waive certain provisions of Medicaid law providing states additional flexibility in program design.<br><br>CMS requires §1115 Waivers to be budget neutral to the federal government. A budget neutral demonstration project does not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration. The budget neutrality calculation is based on projections of the amount of federal financial participation (FFP) that the state would likely have received in the absence of the demonstration (baseline expenditures) compared to projections of FFP under the waiver. If projected FFP under the waiver is lower than baseline expenditures, states can capture a portion of these federal savings.<br><br>Previously, when seeking an extension of an existing waiver, the budget neutrality calculation relied on the original baseline expenditures for the | Effective when issued: August 22, 2018 |

# Summary of 2018 Federal Rulemaking

| 2018 Policy Guidance | Brief Summary | Status |
|---|---|---|
| | extension. The baseline expenditures for many states, including California, were, in part, based on Medicaid expenditures under a fee-for-service delivery system. States that included managed care transitions in §1115 Waivers have been allowed to capture savings from this transition every time a state secures an extension, accumulating "roll over" savings with each extension.<br><br>***2018 Policy Guidance.*** In 2016 and restated in the SMD Letter, CMS updated its approach to the budget neutrality calculation, basing expenditures on recent state spending trends. The updated approach allows:<br><br>▪ Only savings from the most recent five years to "roll over" into an extension from prior approval periods.<br>▪ Beginning with the next demonstration extension approval period starting on or after January 1, 2021, baseline expenditures must be rebased to more accurately reflect recent state spending trends.<br>▪ Beginning with the next extension of state demonstration projects, CMS will incorporate a transitional phase-down of the accrued savings from extensions that used the baseline expenditures of prior §1115 Waivers. | |
| 31 CFR Part 33 and 45 CFR Part 155<br><br>State Relief and Empowerment Waivers | ***CMS guidance easing restrictions on Section 1332 Waivers.***<br><br>***Background.*** Section 1332 of the ACA allows states to waive specific ACA requirements to adopt alternative coverage approaches in the individual and small group market. Alternative coverage approaches are required to meet or maintain certain protections or "guardrails" including the following the requirement that states securing waivers:<br><br>▪ Provide coverage that is at least as comprehensive as the coverage offered through health insurance exchanges under the ACA, coverage that meets all essential health benefit requirements;<br>▪ Provide coverage and cost sharing protections against excessive out-of-pocket costs that are at least as affordable as coverage under the ACA;<br>▪ Provide coverage to a comparable number of individuals as would have been covered under the ACA; and not increase the federal deficit.<br><br>***2018 Policy Guidance.*** The new guidance relaxes how states can meet the guardrails standards. The new guidance, among other things:<br><br>▪ Loosens how the federal government will define comprehensiveness and affordability;<br>▪ Allows the number of individuals in "comparable" coverage to include individuals choosing to enroll in less comprehensive coverage so long as comparable coverage is available;<br>▪ Relaxes how the federal government will evaluate whether essential health benefits and cost-sharing requirements are met; and<br>▪ Requires an evaluation of the aggregate impact of the waiver, instead of prohibiting waivers that disproportionately adversely impact vulnerable residents such as the elderly, those with high health care needs, and low-income individuals. | Effective beginning October 22, 2018<br><br>Comments due by December 24, 2018 |

# Summary of 2018 Federal Rulemaking