PUBLICATION

New 2019 ACA Payment Policies for Individual and Small Group Markets

Authors: Sheila P. Burke
April 19, 2018

On April 9, the Department of Health and Human Services (HHS) released the long-anticipated final Notice of Benefits and Payment Parameters (NBPP) for plan year 2019, providing standards for health insurers and the health insurance exchanges. The 2019 NBPP is the first annual Affordable Care Act (ACA) payment notice to be proposed and finalized by the Trump Administration. As part of the same announcement, HHS also issued the final Annual Issuer Letter providing technical guidance to insurers, new guidance on hardship exemptions, and a bulletin regarding transitional health plans.

HHS states that these payment policies, collectively, are intended to advance the Administration's goals for increasing flexibility, improving affordability, strengthening program integrity, empowering consumers, promoting stability, and reducing unnecessary regulatory burdens in the individual and small group markets.

In the bulletin released with the rule, HHS indicated that it would continue to extend transitional health plans that do not meet the ACA's coverage requirements through 2019. These non-ACA compliant plans were supposed to be phased out in 2014, but the Obama Administration allowed states to extend them following public outcry over insurance cancellations. The Trump Administration has continued this policy. Some health insurance experts argue that the extension of transitional plans has contributed to instability in the ACA insurance exchanges, since many individuals who may have purchased comprehensive ACA coverage have instead remained enrolled in these old plans.

The Major Provisions of the Final Payment Policies Include:

- **State Flexibility on EHBs:** Allows states more options in selecting an essential health benefit (EHB) benchmark plan and mixing-and-matching benefit standards across state EHB-benchmark plans.
- **Individual Mandate Exemptions:** Broadens exemptions to the ACA's individual mandate penalty, effective immediately. Individuals who live in counties with only one insurer selling coverage, and/or individuals who object to abortion and could only choose among plans that cover the procedure, will now be able to seek an exemption from the penalty.
- **Standardized Plan Options:** Eliminates the specification and differential display of standardized plan options on HealthCare.gov.
- **Navigators:** Scales back certain requirements for in-person navigator entities in the insurance exchange service areas.
- **Risk Adjustment:** Modifies the risk adjustment methodology to improve the accuracy of enrollee risk assessment and permits states to request a reduction in risk adjustment transfers to reflect unique state-specific features.
- **Rate Review:** Adjusts the rate review default threshold from premium increases of 10 percent to increases of 15 percent in states where the federal government reviews rates.
- **SHOP Exchanges:** Eliminates online enrollment requirements for the Small Business Health Options Program (SHOP) exchanges.

Of note, the final rule did not address the practice of "silver loading," referring to insurer decisions last year to concentrate premium increases on subsidized silver plans to compensate for the loss of Cost-Sharing

Reduction (CSR) payments. Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma stated that the agency continues to review the silver loading practice.

The final ACA payment policies may provide further clarity for states as they consider creative strategies to increase marketplace stability. Although CMS recently halted Idaho's efforts to allow non-ACA compliant plans in the individual market, CMS indicated that it would support other approaches deemed legally permissible. Iowa is attempting a similar strategy around the ACA, having recently enacted legislation to allow the Iowa Farm Bureau to sell non-ACA compliant insurance plans that will not be deemed "insurance" and therefore will not be subject to oversight by state and federal regulators. Other states, such as Colorado, New Jersey, and Maryland, are considering setting up reinsurance programs via section 1332 state innovation waivers.

Some of the major provisions of the final ACA payment policies are outlined in more detail below.

Essential Health Benefits

Although the ten core EHBs are not changing, CMS provides states with three additional options to select EHB-benchmark plans or mix-and-match EHB benefit standards from different states, starting in plan year 2020. The 2019 NBPP will allow states to:

1. Choose another state's entire EHB-benchmark plan used for the 2017 plan year;
2. Mix-and-match one or more of its ten EHB categories using categories from another state's EHB-benchmark plan for the 2017 plan year (for example, a state may select the prescription drug coverage EHB category from one state's EHB-benchmark plan and the hospitalization EHB category from another state's EHB benchmark plan); or
3. Select an entirely new set of benefits to serve as its EHB-benchmark plan.

States selecting option three are subject to two additional requirements. First, as in previous years, states can only select an EHB-benchmark plan that provides a scope of benefits equal to or greater than a typical employer plan. Second, states will now be prohibited from selecting an EHB-benchmark plan that exceeds the generosity of the most generous among a set of comparison plans, including the EHB-benchmark plan used by the state in 2017 and any of the state's base-benchmark plan options for the 2017 plan year. In other words, HHS is establishing a minimum and maximum EHB standard for states' benchmark plans. CMS states that it adopted the maximum EHB standard policy to prevent states from selecting a more generous benchmark plan that would make coverage unaffordable and increase federal costs.

These additional options will provide states with some increased flexibility to require different benefits in ACA plans, but only to the extent of existing variation among 2017 state standards on EHBs. The effects of this policy change for plan designs available to consumers will likely vary depending on how each state chooses to structure its EHB benefits.

Individual Mandate Exemptions

As part of the announcement of 2019 ACA payment policies, CMS included new guidance on hardship exemptions to the ACA's individual mandate penalty, effective immediately. CMS outlines four hardship exemptions for individuals who:

4. Live in a rating area in which no insurers are offering health plans through the insurance exchange;
5. Live in a rating area in which only one insurer is offering health plans through the insurance exchange and can show that the resulting lack of choice has precluded them from obtaining coverage;
6. Live in a rating area in which all affordable plans available through the insurance exchange provide coverage of abortion, if contrary to one's beliefs; or

7. Experience personal circumstances that create a hardship in obtaining coverage through the insurance exchanges, such as the need for specialty care by a specialist physician not covered under the plans available.

Although the individual mandate penalty is repealed starting in 2019, the new CMS guidance allows consumers to obtain these hardship exemptions in 2018 and to seek retroactive relief for 2017. It remains uncertain how many consumers will take up the new hardship exemptions. Given that nearly half of ACA rating areas have only one participating insurer and many states require ACA plans to cover abortions, there are large numbers of consumers that are potentially eligible.

Standardized Plan Options

Unlike under the Obama Administration in plan years 2017 and 2018, CMS will not specify standardized plan options or provide a differential display of standardized plan options on HealthCare.gov for the 2019 plan year. CMS will also discontinue requiring agents, brokers, and insurers that assist consumers with plan selection and enrollment to provide a differential display of standardized plan options.

CMS cited concerns that providing differential display for standardized plan options may limit enrollment in non-standard plan options, reducing incentives for insurers to offer coverage with innovative plan designs. CMS also highlighted the risk that consumers with special coverage needs may be steered to standardized plans that do not meet their particular needs.

Navigator Program

Under the final rule, CMS will scale back requirements on insurance exchanges for the navigator program. First, CMS will remove the requirements for each insurance exchange to have at least two navigator entities and at least one navigator entity that is a community and consumer-focused non-profit group. Second, CMS will eliminate the requirement that navigators maintain a physical presence in the insurance exchange service area to provide in-person outreach and enrollment support. These policy changes are intended to allow insurance exchanges greater flexibility in awarding navigator grants. However, eliminating these requirements may result in some consumers having fewer or no in-person navigator options available for enrollment assistance.

Risk Adjustment

The ACA's risk adjustment program requires insurance plans in the individual and small group markets with healthier risk populations to transfer funds to plans with costlier risk populations. CMS will amend the risk adjustment program methodology in three ways intended to reduce burden, increase flexibility, and improve the accuracy of risk assessment.

8. CMS will recalibrate the risk adjustment model for the 2019 benefit year using blended coefficients from the 2016 enrollee-level External Data Gathering Environment (EDGE) data and 2014 and 2015 MarketScan data. CMS states that enrollee-level EDGE data includes the actual experience of individual and small group market enrollees, and will therefore more closely reflect the relative risk differences in these markets.
9. CMS will remove two severity-only drug classes from the 2019 benefit year risk adjustment models that no longer meaningfully predict incremental risk.
10. CMS will provide states with the flexibility to request a reduction to the otherwise applicable risk adjustment transfers in the individual or small group market by up to 50 percent beginning with the 2020 plan year. States requesting such a reduction must provide supporting evidence and analysis that show the state-specific rules or market dynamics warrant an adjustment to more precisely account for the relative risk differences in the state's market, and justify the reduction amount requested.

The 2019 ACA payment policies are another part of the Trump Administration's efforts to continue shaping the law significantly through the regulatory process. Focus will now turn to the states and to insurers for implementation of these payment policy changes. HHS issued the 2019 NBPP later than in previous years (typically issued in January), which will reduce the time available for insurers and states to adjust and approve insurance plans for next year in response to the final rule's changes. Insurers must submit their 2019 insurance exchange plans to CMS by June 20, 2018 for approval. Expect the Administration to continue to advance modifications to the ACA through regulations that may impact the health insurance exchanges, EHBs, Section 1332 waivers, and other state flexibilities.