Scott A. Sinder
202 429 6289
ssinder@steptoe.com

1330 Connecticut Avenue, NW
Washington, DC 20036-1795
202 429 3000 main
www.steptoe.com

Steptoe
STEPTOE & JOHNSON LLP

December 19, 2016

TO: CIAB

FROM: Scott Sinder
Kate Jensen

RE: Final Rule on 2018 ACA Benefit and Payment Parameters

The Department of Health and Human Services ("HHS") has issued final 2018 benefit and payment parameters under the Affordable Care Act ("ACA"). The issues likely of greatest interest to Council members are discussed in greater detail below; namely, the provisions on:

- New standardized options in the individual federally-facilitated exchanges ("FFE");
- Clarifications regarding non-English language tagline requirements for qualified health plan ("QHP") issuers and web brokers; and
- Additional requirements and consumer protection measures for agents and brokers assisting with QHP enrollment through direct enrollment pathways, including, among other things: differential display of standardized options, provision of more information regarding eligibility for subsidies, and demonstration of operational readiness and compliance with applicable privacy and security requirements.

The final rule covers several other ACA- and exchange-related topics which may be of more general interest to Council members, among them:

- The 2018 premium adjustment percentage and maximum annual limitation on cost sharing ($7,350 for self-only coverage and $14,700 for other than self-only coverage, a 2.8% increase from 2017);
- Updates to the child age rating structure (i.e., one age band for individuals 0 through 14 and single-year age bands for individuals age 15 through 20); and
- Adjustments to the medical loss ratio ("MLR") rules, including an option for issuers to defer reporting of policies newly issued with a full 12 months of experience (rather than

only policies newly issued and with less than 12 months of experience) in that MLR reporting year, as well as the option to limit the total rebate liability payable with respect to a given calendar year.

These benefit and payment parameters apply for plan years that begin on or after January 1, 2018.

HHS simultaneously issued an FAQ document regarding agent/broker compensation and discriminatory marketing practices. Specifically, in response to some issuers' attempts to discourage offering of insurance to higher risk/cost individuals by reducing or eliminating agent and broker compensation for sales to those individuals, HHS has clarified that such issuer practices constitute discriminatory marketing practices prohibited under federal law.[1]

DISCUSSION OF RELEVANT PROVISIONS IN THE FINAL RULE

I. Standardized Options

A. Background: the ACA Framework and the 2017 Benefit and Payment Parameter Rule

Under the ACA, HHS is required to establish a single, standard national benchmark plan which would become the standard basic plan in all of the state exchanges and in the "small group" market. The ACA dictates that if a state imposes benefit mandates that go beyond the benchmark plan requirements, the state is required to pay the subsidy associated with any premium for those extra benefits. The expectation was that the benchmark plan would be basic and affordable, and that the subsidization requirement would lead to massive mandate reform.

To date, however, HHS has punted by allowing each state to establish its own "benchmark" plan that includes every pre-ACA mandate required by the state. In fact, HHS regulations specifically relieve States from any subsidy obligations associated with state benefit mandates that pre-date the ACA.

The final 2017 benefit and payment parameter rule published in February 2016, called for "standardized options" to be offered on the individual FFEs. HHS's standardized option approach does not, however, establish a national benchmark in accordance with the ACA. Instead, HHS established a standardized option at each of the metal levels (bronze, silver, gold)—based on standardized cost-sharing structure, not benefits—which may be offered by QHP issuers on the FFEs. The goal of HHS's standardized option approach is to make it easier

[1] The FAQ document clarifies that such practices violate 45 CFR 147.104(e) and 156.225(b). HHS also states that it will not begin taking enforcement actions against issuers for failure to comply with the new guidance until after an issuer's next opportunity to update rates consistent with federal and state regulations. The FAQ may be found here: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Agent-Broker-Compensation-and-Discriminatory-Marketing-Practices.pdf.

for consumers to compare "apples to apples" on the exchanges, and not, apparently, to establish a single basic plan or drive mandate reform through state subsidy obligations on "extra" benefit mandates.

The 2017 final rule retained 45 CFR 155.170(a)(1) under which a state may require a QHP to offer benefits in addition to the essential health benefits ("EHBs"). The 2017 final rule amended 155.170(a)(2) to explicitly state:

> A benefit required by State action taking place on or before December 31, 2011 is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the [EHBs].

Further, the final rule retained requirements under current regulations that:

- the states make payments to defray the cost of additional required benefits (i.e., those mandated after 2011) to enrollees or QHP issuers on behalf of enrollees (155.170(b)); and
- QHP issuers quantify cost attributable to each additional benefit required by the state, but rather than reporting those amounts to the exchanges, the final rule requires issuers to report directly to the states (155.170(c)).

Key features of HHS's standardized options established under the 2017 rule include:

- Application only in the individual market on the FFEs;
- QHP issuers may offer standardized options, but they are not required to do so;
- Each standardized option consists of a:
    - Fixed deductible;
    - Fixed annual limitation on cost-sharing; and
    - Fixed copayment or coinsurance for a key set of EHBs (i.e., EHBs in the AV calculator, plus urgent care);
- There is a standardized option for the bronze level, silver level (and the three associated silver cost-sharing reduction ("CSR") plan variations), and the gold level;
- Issuers may offer a standardized option at one more levels of coverage, but if they offer a silver option, they must also offer the three associated standardized silver CSR plan variations;
- An issuer may offer more than one plan for each standardized option within a service area, subject to meaningful difference requirements (e.g., the issuer could offer an HMO standardized option at the bronze level and a PPO standardized option at the same level);
- Issuers may continue to offer an unlimited number of non-standardized plans through an FFE (subject to meaningful difference and other QHP certification requirements);
- Standardized options have four drug tiers: generic, preferred brand, non-preferred brand, and specialty (with the option of providing additional lower-cost tiers);
- Standardized options have no more than one in-network provider tier;
- Standardized options exempt from the deductible certain routine services (e.g., primary care, generic drugs); and
- Standardized options do not vary by state or region, but rather, apply to all FFEs.

The 2017 rule amended 45 CFR 155.205(b)(1) to require exchange websites to provide "standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools." Notably, the states may still establish their own standardized plans specific to their state-wide markets. To the extent those state standardized plans differ from HHS's standardized options, however, they are not displayed in the same manner as the federal standardized options on the FFE website platform.

Additionally, HHS clarified that issuers may offer the standardized options as family plans by doubling the maximum annual limitation on cost-sharing and setting the family (or other than self-only) deductible at twice the deductible provided under the individual cost sharing structure.

B. The 2018 Rule

The 2018 rule retains the standardized option framework established in 2017, but builds upon the old standardized options to reflect changes in QHP enrollment-weighted data from 2015 and 2016 and to comply with various state cost-sharing standards. Accordingly, for the 2018 plan year, HHS has created three new sets of standardized options at each metal level.

As with the 2017 standardized options, those in 2018—with respect to in-network care—will have:

- A single provider tier;
- Fixed deductible;
- Fixed annual limitation on cost sharing; and
- Fixed copayment or coinsurance for key EHBs.

Unlike 2017, however, the 2018 options will:

- At the silver, silver CSR variations, and gold levels, have separate medical and drug deductibles;
- Require a $0 deductible for drug coverage at the highest silver CSR variation and gold levels; and
- Include a new standardized option at the bronze level that qualifies as a high deductible health plan ("HDHP"), eligible for use with a Health Savings Account ("HSA").

Overall, the 2018 rule includes three bronze-level standardized options (in addition to the HDHP option), and three standardized options at each of the silver, silver CSR variation, and gold levels. The additional sets are designed to comply with different state laws on cost sharing (e.g., requirements that drug tiers carry copayments rather than coinsurance, maximum deductible requirements, etc.).

HHS will select for each state operating a FFE *a* standardized option at each metal level that satisfies any existing cost-sharing requirements in that state (in addition to the HDHP option, if

permissible under state law). Tables 10, 11 and 12 in the final rule detail the sets of standardized options, as well as the states in which the different options will apply.

II. Rules for Agents and Brokers Assisting with QHP Enrollment

A. Expanded Direct Enrollment Pathways (still under Consideration by HHS)

The 2017 final rule indicated that HHS would establish a framework for expanded direct enrollment pathway options for web-brokers (i.e., agents and brokers authorized to assist qualified individuals and employers enroll in QHPs) and QHP issuers. Under the new enrollment framework, applicants would be able to complete exchange applications and enrollment through a broker's or issuer's website (rather than ultimately redirecting the applicant to an exchange website to apply for a QHP).

The final rule indicates that HHS is still exploring more robust direct enrollment channels, but will not implement any new measures until HHS can "ensure technical readiness and sufficient oversight of the eligibility application processes."

B. Non-English Language Taglines on Websites and Critical Documents

In general, exchanges, QHP issuers, and web brokers are required to provide non-English language taglines on website content and "critical" coverage documents (i.e., those critical to obtaining coverage or accessing services) indicating the availability of language services in at least the top 15 languages spoken by the limited English proficient ("LEP") population of the relevant state (the list of required languages is published in HHS guidance).

For exchanges using the federal platform (i.e., FFEs and state-based exchanges using healthcare.gov), certain issuers with controlled groups operating across multiple states, and for web brokers licensed in and serving multiple states, the final rule will allow those entities to aggregate the LEP populations across those states to determine the top 15 languages in which they must provide taglines. This aggregation rule will not, however, override the specific requirements for non-English language taglines required for summaries of benefits and coverage ("SBC") and internal claims and appeals documents. The final rule also will allow these entities to satisfy tagline requirements with respect to web content by posting a link prominently on their home page that directs individuals to the full text of the taglines and by including taglines in any standalone critical documents linked to or embedded in the website (e.g., PDFs of formulary drug lists accessible on the website).

In its proposed rule, HHS sought comments on whether these exchange/issuer/web broker tagline requirements are needed at all in light of the recent issuance of regulations under Section 1557 of the ACA (prohibiting discrimination on the basis of age, sex, disability, etc.), which include similar LEP tagline requirements. To avoid overlapping requirements and facilitate implementation efforts, the final rule clarifies that entities subject to (and in compliance with) the

analogous tagline requirements under the ACA nondiscrimination rules[2] will be deemed to be in compliance with the exchange tagline requirements in this final rule.[3]

C. New Requirements for Agents and Brokers and QHP Issuers Assisting with QHP Enrollment through Direct Enrollment Pathways

In addition to existing requirements for agents and brokers who assist with QHP enrollment laid out in 45 CFR 155.220, HHS has finalized the following new requirements:

- Differential display of standardized options when using a direct enrollment pathway (i.e., not healthcare.gov) to facilitate enrollment in a FFE or a state-based exchange using the federal platform ("SBE-FP") that has elected to implement differential display;
- Display, in a prominent manner, of information provided by HHS pertaining to eligibility for advance premium tax credits ("APTC") and cost-sharing reductions;
- Provide enrollees with an opportunity to input their desired amount of APTC and provide required APTC-related attestations;
- Demonstrate operational readiness, including compliance with applicable privacy and security requirements, prior to accessing any direct enrollment pathway, which would be subject to ongoing monitoring and audits by HHS (this requirement, per HHS, generally formalizes the current onboarding process);
- When an agent/broker provides access to her direct pathway to another agent/broker to assist with the enrollment process and the second agent/broker uses a third-party website to connect with the direct pathway, the original agent/broker will be responsible for ensuring compliance of those third-party websites with applicable HHS requirements; and
- Refrain from having a website that, in HHS's determination, could mislead consumers into believing they are visiting healthcare.gov.

Further, the final rule allows HHS to immediately suspend an agent or broker's ability to transact information with the exchange through the direct enrollment pathway if HHS determines that circumstances pose "unacceptable risk" to the exchange operations or IT systems. The suspension may continue until HHS is satisfied that the situation is solved or sufficiently mitigated.

Notably, HHS decided to *not* finalize a requirement that agents/brokers of record support post-enrollment activities (e.g., resolve discrepancies related to eligibility). HHS acknowledged that such a requirement would put a "significant burden" on agents and brokers, but also encourages agents and brokers to assist consumers with post-enrollment activities.

---

[2] *See* 48 C.F.R. § 92.8.

[3] Because web brokers generally are not "covered entities" for purposes of Section 1557 nondiscrimination rules (i.e., entities that receive federal financial assistance from programs operated by HHS), this provision is helpful primarily for the exchanges and QHP issuers.