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TO: CIAB

FROM: Scott Sinder
Kate Jensen
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RE: Proposed Rule on 2019 ACA Benefit and Payment Parameters

On October 27, 2017, the Department of Health and Human Services ("HHS") issued its proposed rule on 2019 benefit and payment parameters under the Affordable Care Act ("ACA"). The issues likely of greatest import for Council members are discussed in greater detail below; namely, the provisions which:

- Overhaul the Small Business Health Options Program ("SHOP"), shifting many functions and responsibilities from the exchanges to employers and issuers;
- Propose to let states select new essential health benefit ("EHB") benchmark plans, and contemplate formulating a federal EHB benchmark plan in the future;
- Do not specify standardized options for 2019;
- Modify the data and narratives a state must submit with a request for an adjustment to the medical loss ratio ("MLR"); and
- Ease the qualifying requirements for participating in the navigator program.

The proposal also covers several other ACA- and exchange-related topics, which may be of more general interest to Council members, including:

- Expanding the role of states in the qualified health plan ("QHP") certification process for federally-facilitated exchanges ("FFE");
- Establishing the parameters of the risk adjustment program for 2019; and

- Requiring agents and brokers to conduct an annual operational readiness review prior to participating in direct enrollment (and allowing them to select the third parties that conduct such reviews).

Comments on the proposed rule are due to HHS by November 27. We would appreciate receiving feedback from interested Council members by Thursday, November 16.

DISCUSSION OF RELEVANT PROVISIONS IN THE PROPOSED RULE

I. Small Business Health Options Program ("SHOP")

Since the ACA's enactment, development of the SHOP exchanges has lagged and significant rules have been implemented to scale back their operation. With this proposed rule, HHS plans to allow SHOPs to operate in an even "leaner fashion." State-based SHOPs can continue to operate as they see fit, provided they meet minimum federal and state law requirements.

Under the proposed approach, FF-SHOPs and the state-based exchanges on the federal platform ("SBE-FP") for SHOPs would no longer be required to provide employee eligibility, premium aggregation,[1] and online enrollment functionality.

Under the proposal, HHS would still perform these "leaner" SHOP functions:

- Assist qualified employers in facilitating the enrollment of their employees in a QHP offered in the small group market;
- Certify QHPs for sale through the SHOP;
- Provide small employers with an eligibility determination from the SHOP website that displays and provides QHP information;
- Determine employer eligibility (though, under the proposed rule, such a determination need not always happen before the issuer permits the purchase of coverage in a QHP through a SHOP, as noted below);
- Handle appeals as they relate to employer eligibility (and employee eligibility if tied to wrongful denial of a special enrollment period);
- Offer a premium calculator that generates estimated QHP prices and facilitates the comparison of available QHPs;
- Be involved in special enrollment periods (though their role would change because issuers will be primarily responsible for completing enrollments);
- Authorize a minimum participation rate (though they no longer would calculate it);
- Provide a call center to answer questions about the SHOP; and
- Provide eligibility data to the Internal Revenue Service (but only upon request).

The proposed rule would also implement some significant changes to the operation of the SHOPs, particularly as it relates to the role played by employers and issuers, including:

[1] HHS notes that SHOP-registered agents and brokers would be able to assist in the performance of these tasks.

- Eliminating the requirement that SHOPs enroll small groups in SHOP QHPs, instead requiring small employers to enroll by working with a SHOP-registered agent or broker, or directly through an issuer, which would be preliminarily responsible for enrollment;[2]
- Permitting an employer to obtain an eligibility determination after purchasing coverage, leaving issuers to establish processes to distinguish SHOP enrollments from non-SHOP enrollments;
- Charging issuers with calculating minimum participation rates (calculated at the employer group level); and
- Expecting issuers to comply with state and federal requirements for terminating coverage.

Employers would continue to offer their employees a choice of QHPs and stand-alone dental plans (either by metal level or by participating issuer) across issuers. Under the proposed rule, however, employers who choose to offer a choice of plans could be subject to several new obligations. Specifically, without the benefit of a SHOP's premium aggregation services, employers could have to:

- Collect the enrollment and payment information needed from each issuer whose plans the employer intends to offer;
- Distribute employee enrollments to each QHP issuer or SHOP-registered agent or broker; and
- Collect monthly premium payments from employees and send them to each issuer.

Additionally, because SHOPs will no longer accept employee applications, determine eligibility to enroll, notify employees about their eligibility (or if their employers withdraw from SHOP coverage), or otherwise interact with employees, the employer or issuer could be forced to be the intermediary should any employee-side issues arise.

If the proposed rule is finalized, these changes would take effect on the effective date of the final rule. The guidance HHS released with the rule, however, indicates that HHS will allow state and federal SHOP exchanges, issuers, agents and brokers, and employers to begin operating in accordance with the proposed rule beginning with group enrollments for plan years that take effect in 2018.[3]

II. Essential Health Benefits ("EHB")

A. EHB-Benchmark Plan Options

[2] Enrollment by one of these entities would still qualify an employer for the small employer tax credits, provided the employer (1) obtains a favorable eligibility determination to participate in the SHOP; (2) enrolls in a SHOP QHP offered by an issuer, and (3) chooses to have the enrollment identified as being through the SHOP.

[3] CMS, *CMS to Allow Small Businesses and Issuers New Flexibilities in the Small Business Health Options Program (SHOP) for Plan Year 2018* (Oct. 27, 2017), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/New-Flexibilities-SHOP-2018.pdf. The guidance states that, if finalized, these changes would be applicable to all 2018 plans, regardless of whether they began after or before the effective date of the rule. In particular, while HHS considers comments to the proposed rules, it will permit FF-SHOPs and SBE-FPs for SHOPs, QHP issuers, SHOP-registered agents and brokers, and employers to begin operating in accordance with this approach for SHOP enrollment.

By way of background, under the ACA, HHS is required to establish a single, standard national benchmark plan that would incorporate all of the requisite EHBs and become the nationwide basic plan option in the individual and small group markets. The ACA dictates that if a state imposes benefit mandates that go beyond that benchmark plan's requirements, the state is required to pay the subsidy associated with any premium increase 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 "EHB-benchmark" plan that includes every pre-ACA mandate required by the state.

The proposed rule acknowledges the ACA's benchmark plan directive and notes that HHS is considering establishing a federal default definition of EHB in the future. HHS is soliciting comments on this approach, with a particular focus on establishing a national benchmark plan standard for prescription drugs under a federal EHB definition.

In the more immediate future, the proposed rule would provide states with additional flexibility to define their EHB-benchmark plans annually, beginning in plan year 2019 (though it seeks comment on if it should begin in 2020 to give states time to prepare). Specifically, HHS outlines three new options for states to select an EHB-benchmark plan:

- Selecting another state's 2017 EHB-benchmark plan;
- Replacing one or more of the required EHB categories in its 2017 EHB-benchmark plan with the same categories from another state's 2017 EHB-benchmark plan (e.g., State A could select the prescription drug coverage from State B's EHB-benchmark plan and State C's EHB-benchmark hospitalization category); or
- Selecting a new set of benefits that would become the state's EHB-benchmark plan, provided the EHB-benchmark plan is equal in scope and affordability to a typical employer plan (discussed further below).[4]

A state may also maintain its current 2017 EHB-benchmark plan without taking any action.

For each of these options, HHS would continue to apply its benefit mandate defrayal policy. Under 45 CFR 155.170, as amended by the 2017 final rule, "[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]." Under current law, states must make payments to defray the cost of these additional required benefits (i.e., those mandated after

[4] If a state opts to select a new EHB-benchmark plan, the state would have to undertake a comparison of benefits with other plans to ensure that states select EHBs in a manner that is equal to the scope of benefits provided under a typical employer plan. The comparison plans would be the state's 2017 EHB-benchmark plan and the state's three largest small group health plans by enrollment. The state then, based on an actuarial certification, would determine whether an EHB-benchmark meets the generosity standard and is equal in scope to the benefits provided under a typical employer plan. CMS has released guidance document containing an example one approach actuaries could follow for comparing benefits and completing the associated actuarial report. HHS seeks comment on this proposed methodology and guidance. CMS, *Draft Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-Benchmark Plan Selection to Benefits of a Typical Employer Plan as Proposed Under the HHS Notice of Benefit and Payment Parameters for 2019* (Oct. 27, 2017), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Example-Acceptable-Methodology-States-EHB.pdf. States that opt to adopt such plans would also be subject to a series of new data collection requirements.

2011) to enrollees or QHP issuers on behalf of enrollees. The proposed rule would apply this policy to each of the new proposed EHB-benchmark plans (i.e., even if the state selected another state's benchmark plan, replaced its categories with those of another state, or adopted a new EHB-benchmark plan altogether, it would still have to defray the costs of any benefits included in that state's EHB-benchmark plan that are mandated by the state after 2011 and not included in the ACA EHBs).

The proposal also includes requirements regarding the scope of benefits that must be provided by a state's EHB-benchmark plan (e.g., it must not have benefits unduly weighted toward any of the categories of benefits; provide benefits for diverse segments of the population, including women, children, persons with disabilities, etc.). In addition, HHS would codify the ACA requirement that EHB-benchmark plans be equal in scope to what is provided by a "typical employer plan." The proposed rule defines a "typical employer plan" as "[a]n employer plan . . . with substantial enrollment . . . of at least 5,000 enrollees sold in the small group or large group market, in one or more states; or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more states . . . . " It seeks comment on the definition of "typicality" (i.e., whether the definition should reflect a plan that would be typical in the state; whether an appropriate way to measure typicality would be to provide that the typical employer plan be defined to also have at least 100 enrollees enrolled in the plan or product in the applicable state; whether it should be defined in other ways; and whether additional guidance is needed).

Finally, HHS would require states to implement reasonable public notice and comment requirements on the state's selection of an EHB-benchmark plan. No specific directions are provided in the proposed rule; rather, it leaves it to the states to develop such procedures. Upon selection of an EHB-benchmark approach and by an "annual selection date," the states would be required to notify HHS of their new EHB-plans. If a state does not notify HHS of its selection by the annual selection date, the state would retain the EHB-benchmark plan that was applicable for the prior plan year.

The proposed rule would retain other regulatory requirements and standards related to the provision of EHBs under 45 CFR 156.115 (i.e., a health plan must provide benefits that are substantially equal to the EHB benchmark plan, do not exclude an enrollee from coverage in an EHB category, include preventative health services, etc.), prescription drug benefits (45 CFR 156.122), and the prohibition on discrimination (45 CFR 156.125).

B. EHB Benefit Category Substitution

Under current law, EHB compliant plans are allowed to substitute benefits within categories, if allowed by the state, provided that the benefits (other than prescription drug benefits) are actuarially equivalent to the benefit that is being replaced. Plans cannot, however, substitute benefits between different benefit categories.

HHS would revise the rules regarding EHB benefit category substitution to allow for substitution to occur within the same EHB category and between EHB categories, as long as the substituted benefit is actuarially equivalent to the benefit being replaced and is not a prescription drug benefit. The plans would still be required to meet other EHB requirements (e.g., be substantially equal to the EHB-benchmark plan, not be unduly weighted, serve diverse segments of the population, and demonstrate actuarial equivalency).

III. Standardized Options

The final 2017 and 2018 benefit and payment parameter rules specified "standardized options" to be offered on the individual FFEs, encouraging issuers to offer such plans and provide differential display of these plans on HealthCare.gov.

Unlike the final rules for 2017 and 2018, HHS chose not to propose any standardized options for the 2019 plan year; HHS also will not provide differential displays of these plans on HealthCare.gov. If finalized, agents, brokers, and issuers that assist consumers with QHP selection and enrollment would similarly not be required to provide differential displays for standardized options on those third-party websites.

IV. Medical Loss Ratio ("MLR")

HHS proposes to make significant changes in the current MLR rules, including:

- Allowing issuers to report a single fixed percentage (0.8 percent) of earned premium in a relevant state and market as quality improvement activity expenses;
- Streamlining the process to request adjustments to the MLR standard by reducing the information a state must submit to HHS when requesting such an adjustment (e.g., a state would no longer have to describe its MLR standard and formula for assessing compliance; its market withdrawal requirements; the mechanisms available to the state to provide consumers with alternate coverage; the after-tax profit and profit margin for the individual market business in the state); and
- Simplifying the process for HHS to grant such adjustment requests (i.e., adjustments would be permitted whenever HHS determines that there is a "reasonable likelihood" that an adjustment will help stabilize the individual market in a given state).

States would still be required to submit information on total earned premium, total agent and broker commissions, and risk-based capital information for insurers with more than 1,000 enrollees in the state. The proposed rule also supplements three current requirements—that states report (1) "net underwriting gain" (in lieu of "net underwriting profit"); (2) both insurer market exits from and entrances into the individual market, including those to or from the exchanges or certain geographic areas; and (3) information on the total number of enrollees for each type of coverage sold or renewed in the state's individual market (in lieu of detailed enrollment and premium data for each issuer and each issuer's market share). States would only be required to present data on issuers "actively offering" individual market coverage in five categories: on-exchange, off-exchange, grandfathered, transitional, and non-grandfathered single-risk pool coverage.

Finally, the proposed rule seeks comments on whether it should allow issuers to deduct federal and state employment taxes (e.g., social security, railroad retirement, unemployment, and similar taxes) from premiums in their MLR and rebate calculations starting with the 2017 reporting year.

V. Navigator Program

Currently, 45 CFR 155.210 imposes a series of requirements with respect to navigators, among them:

- Each exchange to include among its navigator grantees both a community and consumer-focused nonprofit group and at least one other entity (e.g., professional associations, chambers of commerce, unions, licensed agents and brokers, tribal entities, etc.); and
- Each navigator to maintain a physical presence in the exchange service area.

HHS proposes to eliminate both of these requirements (and corresponding requirements to the extent they apply to non-navigator entities). This would permit an exchange to award a grant to a single navigator entity from any of the permitted types and give an exchange the flexibility to determine the importance of a navigator's physical presence when selecting grantees. HHS acknowledges, however, that this could result in consumers having fewer navigator options and potentially no in-person enrollment assistance from a navigator.

HHS also seeks comment on alternative types of entities that could qualify as navigators and possible new ways in which navigators could carry out their duties.

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We hope this is helpful. Again, we would appreciate hearing from interested Council members by Thursday, November 16.