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

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TO: CIAB

FROM: Scott Sinder
Kate Jensen
Chelsea Gold

RE: HHS Final Rule on 2019 ACA Benefit and Payment Parameters

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On April 9, 2018, the Department of Health and Human Services ("HHS") released its final rule on 2019 benefit and payment parameters under the Affordable Care Act ("ACA").[1] 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;
- 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 final rule 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

[1] Final Rule, *HHS Notice of Benefit and Payment Parameters for 2019* (scheduled to be published in the Federal Register on Apr. 17, 2018) [hereinafter Final Rule].

- 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).

These regulations are effective on June 18, 2018. Generally, they apply for plan years that begin on or after January 1, 2019, though a few apply in 2018 (e.g., alleviating regulatory burdens on SHOP exchanges) and others will begin in the 2020 plan year (e.g., optional changes to state EHB-benchmark plans).

HHS simultaneously issued several guidance documents on topics including:

- MLR reporting and rebate requirements; and
- Requirements for state requests to adjust the MLR.

DISCUSSION OF RELEVANT PROVISIONS IN THE FINAL 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. The final rule allows SHOPs to operate in an even "leaner fashion" for plan years beginning on or after January 1, 2018. Specifically, the rule removes regulatory burdens on SHOPs, no longer requiring FF-SHOPs and the state-based exchanges on the federal platform for SHOPs ("SBE-FP") to provide employee eligibility, premium aggregation, and online enrollment functionality.[2] State-based SHOPs, on the other hand, can continue to operate as they choose, provided they meet minimum federal and state law requirements.

Under the final rule, these "leaner" SHOPs would still:

- Assist qualified employers in facilitating the enrollment of their employees in a QHP offered in the small group market;[3]
- Certify QHPs for sale through the SHOP;[4]
- Determine employer (but not employee) eligibility (though, under the final 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);[5]
- Notify employers of approval or denial of eligibility (and now termination of eligibility);[6]
- Handle appeals as they relate to employer eligibility (but not as they relate to employee eligibility);[7]

[2] *Id.* at 236.

[3] *Id.* at 238 (to be codified at 45 CFR 155.700(a)(2)).

[4] *Id.* (to be codified at 45 CFR 155.706(b)(5)).

[5] *Id.* at 238-39 (to be codified at 45 CFR 155.716(a); 45 CFR 155.716(b)).

[6] *Id.* at 256 (to be codified at 45 CFR 155.706(e)).

[7] *Id.* at 239 (to be codified at 45 CFR 155.741) (limiting application to the employer context).

- Offer several features (e.g., a premium calculator that generates premium estimates and facilitates a comparison of available QHPs);[8]
- Be involved in special enrollment periods (though their role would change because issuers will be primarily responsible for administering special enrollment periods);[9]
- Authorize a minimum participation rate (though they no longer would calculate it);[10] and
- Provide eligibility data to the Internal Revenue Service (but only upon request).[11]

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

- Minimizing the SHOPs' role in enrollment of small groups in QHPs (i.e., small employers can obtain an eligibility determination from a SHOP website but will enroll in a SHOP QHP by working with a SHOP-registered agent or broker, or with a QHP issuer participating in a SHOP, to complete the enrollment process);[12]
- Shifting some SHOP obligations to employers and issuers (e.g., SHOPs will no longer have to: (1) establish a process for QHP issuers and employers to follow regarding purchasing coverage and processing of enrollment (along with enrollment timelines, deadlines, and coverage effective dates); (2) transmit/reconcile enrollment information to QHP issuers; (3) process payments; (4) ensure a QHP issuer notifies qualified employees of the effective date of coverage; or (5) notify an employer in the event an employee terminates SHOP coverage);[13]
- Permitting an employer to purchase a QHP before obtaining a determination of SHOP eligibility and confirming with the issuer the status of the enrollment as being through a SHOP (leaving issuers to establish processes to distinguish SHOP enrollments from non-SHOP enrollments);[14]
- Charging issuers with calculating minimum participation rates (calculated at the employer group level);[15] and
- Expecting issuers to comply with state and federal requirements for terminating coverage, timelines and effective dates for termination, and any notice requirements.[16]

[8] *Id.* at 238.

[9] *Id.* at 239-40 (to be codified at 45 CFR 155.726(c)).

[10] *Id.* at 240-41 (to be codified at 45 CFR 155.706(b)(10)).

[11] *Id.* at 260 (to be codified at 45 CFR 155.721(b)).

[12] *Id.* at 238-39 (to be codified at 45 CFR 155.726). 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. If an enrollment meets this definition, the issuer must conduct enrollment with all applicable SHOP rules and policies. *Id.* at 239.

[13] *Id.* at 259-60 (to be codified at 45 CFR 155.721).

[14] *Id.* at 253-54. HHS opted to finalize this policy as proposed, without establishing a timeline under which employers must obtain an eligibility determination from a SHOP for their SHOP enrollments. *Id.* at 254.

[15] *Id.*at 241, 248.

Employers could continue to offer their employees a choice of stand-alone dental plans or QHPs (either by metal level or by participating issuer) across issuers. But under the final rule, employers who choose to offer a choice of plans could be subject to several new obligations. Specifically, employers could have to:

- Collect the enrollment and payment information needed from each issuer whose plans the employer intends to offer and disseminate it to its employees;
- Collect the information from its employees and distribute it to each QHP issuer or SHOP-registered agent or broker; and
- Collect monthly premium payments from employees and send them to each issuer.[17]

Additionally, because SHOPs will no longer accept employee applications, determine or notify employees of 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.

In accordance with the guidance issued alongside the proposed rule,[18] these changes are applicable to all 2018 plans, regardless of whether they began before or after the effective date of the rule.

II. Essential Health Benefits ("EHB")

A. EHB-Benchmark Plan Options

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 final rule provides states with additional flexibility to define their EHB-benchmark plans annually, beginning in plan year 2020 (as opposed to 2019, as originally proposed).[19] A state may also maintain its current 2017 EHB-benchmark plan without taking any action.

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[16] *Id.* at 256-57, 269-70 (to be codified at 15 CFR 155.736 (sunsetting the requirement that SHOPs must determine the timing, form, and manner in which coverage or enrollment in a SHOP QHP may be terminated)).

[17] The final rule notes that SHOP-registered agents and brokers can assist employers in performing these tasks, if the employer chooses to work with a SHOP-registered agent or broker. *Id.* at 240.

[18] 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).

[19] Final Rule, *supra* note 1, at 283.

If a state opts to redefine its EHB-benchmark plan, HHS outlines three new options from which the state may choose:

- 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.[20]

The final rule establishes a "generosity ceiling," which restricts states' ability to increase the overall scope of benefits in its EHB-benchmark plan beyond that of the most generous among a set of comparison plans. These comparison plans include a state's 2017 EHB-benchmark plan and any of the state's three largest small group health plans by enrollment that were available as benchmark plan options in 2017.[21]

The final rule also establishes a floor, recognizing the ACA requirement that EHB-benchmark plans be equal (or greater) in scope to what is provided by a "typical employer plan."[22] The rule finalizes two sets of typical employer plans for a state to choose from when establishing the minimum scope of its EHB-benchmark plan. A "typical employer plan" can be:

- One of the state's base-benchmark plan options (i.e., small group plan, state employee plan, state non-Medicaid HMO, or Federal Employees Health Benefits Program plan, as provided under 45 CFR 155.100) from the 2017 plan year; or
- One of the five largest group health insurance plans by enrollment in the state so long as certain requirements are met (i.e., the plan has at least 10% of the total enrollment among those plan; the plan provides minimum value (as defined under the ACA); the benefits are not excepted benefits; and the benefits are from a plan year beginning after December 31, 2013).[23]

The final rule also includes additional 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; must provide benefits for diverse segments of the population, including women, children, persons with disabilities; must include discriminatory benefit designs that counter existing non-discrimination standards, etc.).[24]

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[20] *Id.* at 283-85, 90 (to be codified at 45 CFR 156.111(a)). It warrants noting that for states that opt to select a new set of benefits, additional data collection obligations attach.

[21] *Id.*at 286-88 (codified at 45 CFR 156.111(b)(2)(ii)). "In practice, this requirement limits states' ability to select a new EHB-benchmark plan that transfers benefits that were previously only applied to the state's large group market, or that were mandated by another states' actions prior to 2012, into its new EHB-benchmark plan." *Id.* at 166.

[22] *Id.* at 299-314.

[23] *Id.* at 307-08 (to be codified at 45 CFR 156.111(b)(2)(i)).

[24] *Id.* at 302 (to be codified at 45 CFR 156.111(b)(2)(iii)-(v)).

If a state chooses to change its EHB-benchmark plan, it must submit, among other things, an actuarial certification and associated report that affirms that the state's EHB-benchmark plan provides a scope of benefits that is equal to (or greater than) the scope of benefits under a typical employer plan, and that it does not exceed the generosity of the most generous among comparison plans. CMS released a guidance document containing an example of an acceptable methodology for actuaries.[25]

For each of these options, HHS would continue to apply its benefit mandate defrayal policy under 45 CFR 155.170.[26] Under this policy, a state would not have to defray the cost of a benefit mandated prior to 2012, but it must defray the costs of benefits mandated after that date. Therefore, if a state selects a new EHB-benchmark plan, the benefits mandated by the selecting state prior to 2012 will continue to be considered EHBs and the state will not have to defray the cost of those benefits. If, on the other hand, a state selects another state's benchmark plan (or EHB category), and the selected EHB-benchmark plan (or category) includes benefits mandated by the originating state that are EHBs, those benefits would also be incorporated into the selecting state's EHB-benchmark plan without requiring the selecting state to defray the costs related to the other state's mandated benefits (unless the selecting state has its own mandates regarding the same benefits that were adopted in 2012 or later and are therefore subject to defrayal).[27]

Finally, HHS will require states to implement reasonable public notice and comment requirements on a state's selection of an EHB-benchmark plan. HHS declined to adopt specific notice and comment standards, instead only requiring a state to post a notice regarding the opportunity for public comment on a relevant state website.[28] Upon selection of an EHB-benchmark plan and by an "annual selection date," the states would be required to notify HHS of their new EHB-benchmark 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 final rule retains 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).[29]

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[25] CMS, *Example of an Accepted Methodology for Comparing Benefits of a State's EHB-Benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii)* (Apr. 9, 2018).

[26] 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 2011) to enrollees or QHP issuers on behalf of enrollees.

[27] Final Rule, *supra* note 1, at 162, 284-88.

[28] *Id.* at 313-14 (to be codified at 45 CFR 156.111(c)).

[29] *Id.* at 302.

B. EHB Benefit Category Substitution

Under 45 CFR 156.115, 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.

The final rule revises the rules regarding EHB benefit category substitution—beginning with the 2020 plan year—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.[30] Prior to offering a plan with substituted benefits, however, the state must notify HHS that substitution between EHB categories is permitted in the state.[31] 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).[32]

III. Standardized Options

Unlike the final rules for 2017 and 2018, the 2019 rule does not specify any standardized options for the 2019 plan year; HHS also will not provide differential displays of these plans on HealthCare.gov. Therefore, agents, brokers, and issuers that assist consumers with QHP selection and enrollment are not required to provide differential displays for standardized options on those third-party websites.[33]

IV. Medical Loss Ratio ("MLR")

HHS finalized 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 ("QIA") expenses starting with the 2017 MLR reporting year;[34]
- 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, etc.);[35] and

[30] *Id.* at 324-25 (to be codified at 45 CFR 156.115(b)(2)(ii)).

[31] *Id.*

[32] *Id.* at 325 (to be codified at 45 CFR 156.115(b)(3)).

[33] *Id.* at 153.

[34] *Id.* at 371 (to be codified at 45 CFR 158.224(b)(8)). In the final rule, HHS clarified how the new QIA reporting option will operate. Specifically, HHS specified that issuers and their affiliates that elect the standardized QIA reporting option must:

- Apply it consistently across all of their states and markets that are subject to the MLR requirements under federal law;
- Apply it for a minimum of 3 consecutive reporting years; and
- Elect the same QIA reporting method. *Id.* at 373-74.

- 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).[36]

States would still be required to submit information on total earned premium, total agent and broker commissions, and risk-based capital information (at the issuer level).[37] The final rule also revises three current requirements—that states report (1) "net underwriting gain" (in lieu of "net underwriting profit");[38] (2) both insurer market exits from and entrances into the individual market, including those to or from the exchanges or certain geographic areas;[39] 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).[40] 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.[41]

Finally, based on comments received, HHS intends to collect data on the impact of excluding federal and state employment taxes (e.g., social security, railroad retirement, unemployment, and similar taxes) from earned premium in the MLR and rebate calculations.[42]

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.

The final rule eliminates both of these requirements (and corresponding requirements to the extent they apply to non-navigator entities).[43] 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.

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[35] *Id.* at 376-79, 406 (to be codified at 45 CFR 158.321).

[36] *Id.* at 376, 380-81 (to be codified at 45 CFR 158.301).

[37] *Id.* at 377 (to be codified at 45 CFR 158.321(a)(1), (3), (5)).

[38] *Id.* at 378-79 (to be codified at 45 CFR 158.321(a)(4)).

[39] *Id.* at 379 (to be codified at 45 CFR 158.321(a)(6)).

[40] *Id.* at 377 (to be codified at 45 CFR 158.321(a)(2)).

[41] *Id.* at 378 (to be codified at 45 CFR 158.321(b)).

[42] *Id.*at 369-70.

[43] *Id.* at 171-172 (to be codified at 45 CFR 155.210(c)(2), (e)(7)).

Some comments noted the potential use of other entities (e.g., local agents and brokers) to provide enrollment assistance or remote services to consumers. HHS agreed that local collaboration and leveraging community partnerships can help reach marginalized communities and noted that it will take those comments into consideration when drafting navigator selection criteria for navigator funding opportunity announcements in future years.

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