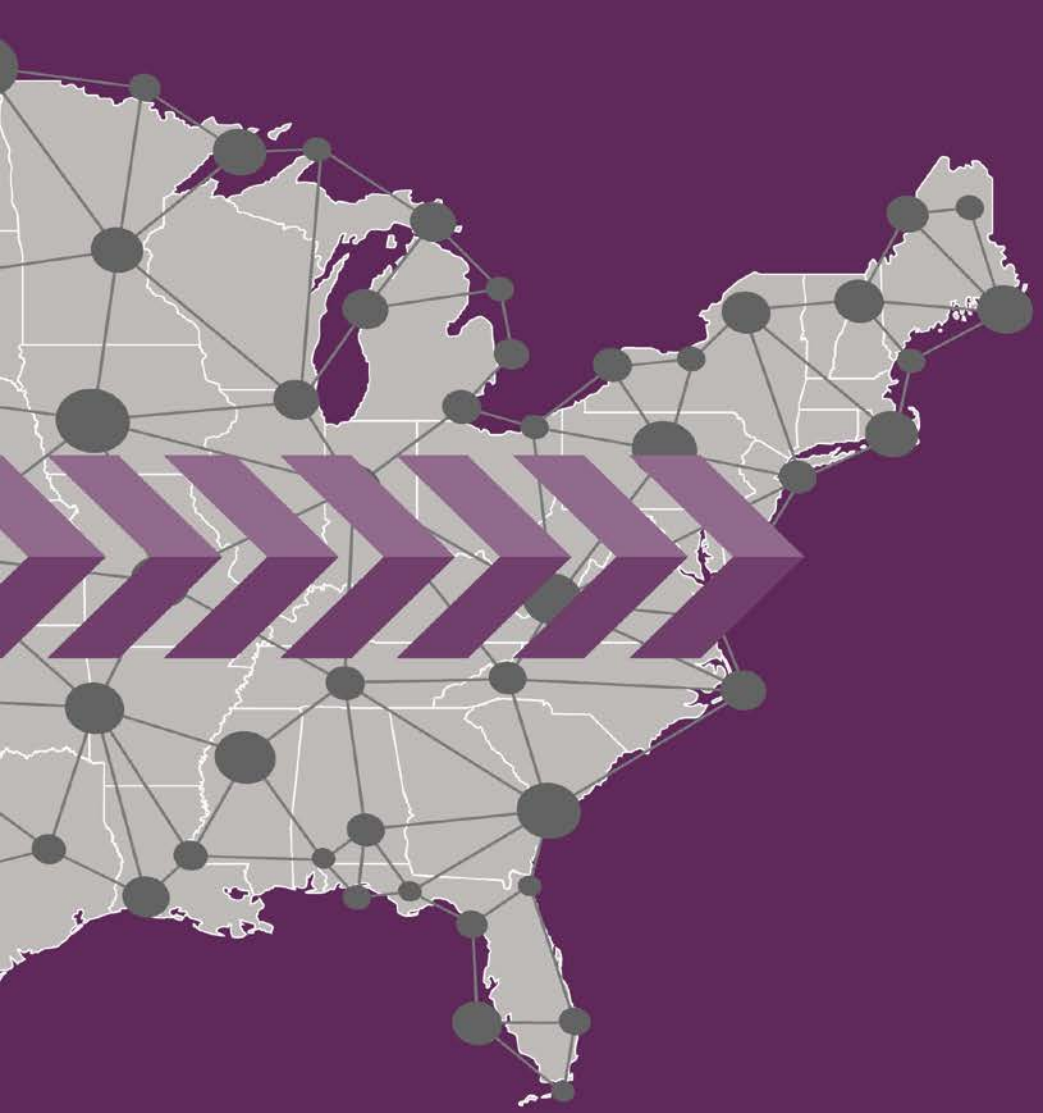

Final 2019 ACA Payment Notice

Implications for States

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April 20, 2018

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

About State Health Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

About Georgetown's Center on Health Insurance Reforms (CHIR)

- A team of experts on private health insurance and health reform
- Conduct research and policy analysis, provide technical assistance to federal and state policymakers, regulators, and consumer advocates
- Based at Georgetown University's McCourt School of Public Policy
- Learn more at https://chir.georgetown.edu/

About Manatt Health

Joel Ario with Manatt, Phelps & Phillips, LLP contributed to this presentation. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 90 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving health care policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

About Jason Levitis

Jason Levitis leads Levitis Strategies LLC, a health policy consultancy focusing on the ACA's tax provisions and state innovation waivers. He is also a nonresident fellow at the Brookings Institution and a senior fellow at Yale Law School's Solomon Center for Health Law and Policy. Until January 2017 he led ACA implementation at the U.S. Treasury Department.

Final 2019 Notice of Benefit and Payment Parameters: Setting Rules for the ACA's Marketplaces, Insurance Reforms, and Premium Stabilization Programs

Overview: Key Provisions Affecting State Insurance Regulation & Marketplaces

- Transitional Policy
- Medical Loss Ratio
- Risk Adjustment
- Essential Health Benefits
- Special Enrollment Periods
- Rate Review
- QHP Certification
- Marketplace Flexibility
- SHOP
- Navigator Program
- Eligibility for APTCs/CSRs
- Data Matching Issues

Transitional Policy & Medical Loss Ratio (MLR)

- Extends transitional plans up to Dec. 31, 2019
  - If permitted by the state
  - 14 states + D.C. currently prohibit transitional policies
- Eases ability of states to request a reduction in MLR standard for the individual market
  - HHS assumes 22 states will request an adjustment
  - Decrease rebate payments by ~$52-$64M

Risk Adjustment: New Option for States to Reduce Transfer Payments

- Gives states authority to reduce R.A. transfers in individual, small-group, and merged markets
- Up to 50% reduction permitted
- States must provide evidence to justify reduction
- Reduced transfers must result in <1% premium increase
- State requests must be submitted 2 calendar years in advance

EHB: New Benchmark Options

- Effective in 2020, EHB benchmark options:
  - (1) State's own 2017 benchmark
    - May replace 1 or more categories with the same category/categories from another state's 2017 benchmark
  - (2) Another state's 2017 benchmark
  - (3) A newly developed set of benefits, subject to certain limitations
    - Typical employer plan
    - Generosity test
    - Benefits can't be unduly weighted towards particular category
    - Must provide benefits for diverse segments of population
    - No discriminatory benefit designs

EHB: New Benchmark Options

- State Benefit Mandates
  - Existing policy is retained
  - For a state (State A) selecting another state's (State B) benchmark or EHB category:
    - No requirement to defray costs of State B's mandated benefits, unless such benefits were mandated in State A after Dec. 31, 2011
  - Flexibility to incorporate other states' mandates limited by generosity test

- States may change benchmark plan each year.
  - For 2020:
    - Benchmark selection must be submitted by July 2, 2018

EHB: New Policy on Benefit Substitution

- Effective in 2020, states may allow plans to substitute benefits across EHB categories
  - State must opt in to this approach by notifying CMS
  - Substituted benefits must be actuarially equivalent
  - No substitution for prescription drug benefit
  - Plans still subject to all other EHB requirements

Special Enrollment Periods

- Rules for dependents
  - Aligns enrollment options across trigger events
    - State-based marketplaces may take “additional time” to implement
  - Aligns coverage effective dates
- Exception to prior coverage requirement
  - Protects individuals in the case of a bare county
- New SEP for women who lose access to services provided through CHIP coverage for unborn children

Rate Review: Higher Review Threshold

- Changes definition of an unreasonable premium increase from 10 to 15% for 2019
  - States can retain lower threshold without HHS approval
  - Must get HHS approval to have threshold higher than 15%
- States may set rate filing deadlines later than the federal deadline (June 21 this year)
  - Can have different dates for insurers that offer QHPs and those that only offer non-QHPs
- Requirement to give HHS advance notice of posting rate information reduced from 30 days to five days
  - Proposal to allow rolling postings not finalized

QHP Certification: More State Deference

- FFM states given increased flexibility over QHP network adequacy and ECP standards
  - State must have authority & capacity to do review
  - Federal default to accreditation or NAIC model
  - ECP threshold reduced from 30% to 20%
- Did not finalize proposal to defer to FFM states on:
  - Accreditation requirements
  - Compliance reviews
  - Minimum geographic area
  - Quality improvement strategy reporting
- Overall approach of avoiding duplicative reviews

Marketplaces and Technology

- HHS working with web-brokers and insurers on “enhanced direct enrollment” (EDE) to give states new options on technology platform
- Still unable to customize healthcare.gov for states, barrier to some 1332 waivers
- Seeking input to make SBM-FP model more attractive to states
  - EDE and other technology options
  - Access to data and state branding opportunities

SHOP: Back to Pre-ACA Enrollment Model

- FFM will no longer provide online functionality for SHOP beginning this year (including SBM-FP states)
  - Eliminated services include employee eligibility, premium aggregation, and online enrollment
  - Remaining services include plan certification, informational web site, premium calculator and call center
  - Leaves small group market to direct enrollment through agents and brokers
- SBMs operating SHOP can eliminate same online services

Navigator Program: Fewer Marketplace Requirements

- No longer required to fund 2 entities
- No longer required to have one be a consumer-focused non-profit
- No longer required to maintain physical presence in service area

Losing Eligibility for APTC/CSRs: New Marketplace Obligations

- Enrollees are generally ineligible for ongoing APTC/CSRs if they fail to file tax return reconciling past year's APTC
- Old regs required clear notice to enrollees before APTC cut-off
- FFM provides this notice, but many SBMs can't
- Final reg eliminates notice requirement, so SBMs must cut off subsidies even if can't provide clear notice

Trigger for a Data Matching Issue: New Marketplace Obligations

- Marketplaces required to generate data matching issue for consumers if
  - Consumer attests to income between 100-400% FPL
  - Marketplace has data indicating income is *below* 100% FPL
  - Marketplace has not assessed consumer as eligible for Medicaid/CHIP and
  - Income projected exceeds the income reflected in available data by a reasonable threshold (which must be least 10%, and may also include a threshold dollar amount)
- Marketplace must discontinue subsidies if consumer cannot document income
- HHS rejected requests from SBMs to be exempted from this policy

Thank you

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