ACA COMPLIANCE BULLETIN

HIGHLIGHTS

- The ACA's out-of-pocket maximum limit would increase to $7,900 (self-only coverage) and $15,800 (family coverage).
- The required contribution percentage for the individual mandate's affordability exemption would increase for 2019.
- Standardized plans in the Exchange would be eliminated in favor of value-based insurance design.

IMPORTANT DATES

October 27, 2017
The 2019 Proposed Notice of Benefit and Payment Parameters was issued.

2019 Benefit Year
If finalized, the changes included in the proposed rule would generally apply for the 2019 benefit year.

Provided By:
Touchstone Consulting Group

Proposed Notice of Benefit and Payment Parameters for 2019

OVERVIEW

On Oct. 27, 2017, the Department of Health and Human Services (HHS) released its **proposed Notice of Benefit and Payment Parameters for 2019**. This proposed rule describes benefit and payment parameters under the Affordable Care Act (ACA) that would be applicable for the 2019 benefit year. Proposed standards included in the rule relate to:

- ✓ Annual limitations on cost-sharing;
- ✓ The individual mandate's affordability exemption; and
- ✓ Special enrollment periods in the Exchange.

The proposed rule would also establish new options for states in selecting their essential health benefits (EHB) benchmark plans and make changes to certain standards for enrollment in the Small Business Health Options Program (SHOP) Exchange.

Finally, the rule would eliminate standardized plan options in the federally facilitated Exchanges (FFEs) and, instead, look for ways to encourage value-based insurance design. In particular, HHS would like to encourage the use of high-deductible health plans (HDHPs) that can be paired with a health savings account (HSA).

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Annual Limitations on Cost-sharing

Effective for plan years beginning on or after Jan. 1, 2014, the ACA requires non-grandfathered plans to comply with an overall annual limit—or an out-of-pocket maximum—on EHB. The ACA requires the out-of-pocket maximum to be updated annually based on the percent increase in average premiums per person for health insurance coverage.

- For 2016, the out-of-pocket maximum is **$6,850 for self-only coverage** and **$13,700 for family coverage**.
- For 2017, the out-of-pocket maximum is **$7,150 for self-only coverage** and **$14,300 for family coverage**.
- For 2018, the out-of-pocket maximum is **$7,350 for self-only coverage** and **$14,700 for family coverage**.
- Under the proposed rule, the out-of-pocket maximum would increase for 2019 to **$7,900 for self-only coverage** and **$15,800 for family coverage**.

Under the proposed rule, the required contribution percentage used to determine eligibility for an exemption from the individual mandate would increase to 8.3 percent in 2019.

Individual Mandate's Affordability Exemption

Under the ACA, individuals who lack access to affordable minimum essential coverage (MEC) are exempt from the individual mandate penalty. For purposes of this exemption, coverage is considered affordable for an employee if the required contribution for the lowest-cost, self-only coverage does not exceed **8 percent of household income**.

This required contribution percentage is adjusted annually after 2014, as follows:

- For 2015, the required contribution percentage is **8.05 percent of household income**.
- For 2016, the required contribution percentage is **8.13 percent of household income**.
- For 2017, the required contribution percentage is **8.16 percent of household income**.
- For 2018, the required contribution percentage **decreased** to **8.05 percent of household income**.

Under the proposed rule, the required contribution percentage would **increase in 2019**. The proposed rule provides that, for 2019, an individual would be exempt from the individual mandate penalty if he or she must pay more than **8.3 percent of his or her household income** for MEC.

Exchange Special Enrollment Periods

Under the Exchanges, certain special enrollment periods (SEPs) are available to ensure that people who lose health insurance during the year, or who experience other qualifying events, have the opportunity to enroll in coverage. The 2019 proposed rule would establish a new SEP, which would allow pregnant women who are

receiving health care services through Children's Health Insurance Program (CHIP) coverage for their unborn child to qualify for a loss of coverage SEP upon losing access to this coverage.

New EHB Benchmark Plan Options

Beginning in 2014, the ACA requires non-grandfathered plans in the individual and small group markets to offer a core package of items and services, known as EHBs. The EHB package includes items and services in 10 general benefit categories (such as hospitalization, maternity and newborn care, mental health and substance use disorder services and prescription drugs), and should be equal in scope to benefits offered by a typical employer health plan. To meet this requirement in every state, HHS further defines EHBs based on a state-specific benchmark plan. States could select a benchmark plan from among the following options:

- The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market;
- Any of the largest three state employee health benefit plans options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or
- The HMO plan with the largest insured commercial non-Medicaid enrollment in the state.

If a state did not select a benchmark, HHS selected the largest plan by enrollment in the largest product by enrollment in the state's small group market as the default benchmark plan.

The 2019 proposed rule would allow states to select a new EHB-benchmark plan on an annual basis, and would provide substantially more options in what they can select as an EHB-benchmark plan. Under the proposed rule, states would be allowed to:

- Choose from the 50 EHB benchmark plans that other states used for the 2017 plan year;
- Replace one or more EHB categories of benefits under its EHB benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB benchmark plan used for the 2017 plan year; or
- Otherwise select a set of benefits to become its EHB-benchmark plan, provided that the new EHB benchmark plan does not provide more benefits than a set of comparison plans and is equal to the scope of benefits provided under a typical employer plan, as required by the ACA.

Changes to the SHOP Exchange

Each state is required to have a small business component of their Exchange, called the SHOP, where small businesses can purchase health insurance coverage for their employees. The proposed rule would remove several existing SHOP requirements related to online enrollment through a SHOP Exchange, and instead would allow groups to enroll through a SHOP plan issuer or a SHOP-registered agent or broker (called "direct

enrollment"). The federally-facilitated SHOPs (FF-SHOPs) and state-based SHOPs using the federal platform would adopt this enrollment approach for plan years beginning on or after Jan. 1, 2018.

State-based SHOPs could maintain their current online enrollment operations, or take advantage of the proposed regulatory flexibilities to design a SHOP that best meets the needs of the small group market in their state. The Small Business Health Care Tax Credit would continue to be available to employers who enroll their small group in a SHOP plan.

Standardized Exchange Plan Options

Beginning in 2017, the FFE has offered a number of standardized benefit plan options—called "**simple choice plans**"—in the individual market FFE to simplify the plan selection process by allowing consumers to more easily compare plans across issuers in the FFE. The standardized options each had a single provider tier, fixed deductible, fixed annual cost-sharing limit, four drug tiers, and fixed copayment or coinsurance for a key set of EHB that comprise a large percentage of the total allowed costs for a typical population of enrollees. In addition, HHS provided differential display of these plans on www.HealthCare.gov.

However, the 2019 proposed rule **would eliminate the standardized plan options in the FFE for the 2019 plan year**. According to the proposed rule, there is concern that providing differential display for these plans may limit enrollment in coverage with non-standardized option plan designs, removing incentives for issuers to offer coverage with innovative plan designs.

Instead, the proposed rule requests input on how to encourage value-based insurance design within the individual and small group markets and ways to support issuers in using cost-sharing to incentivize more cost-effective enrollee behavior and higher quality health outcomes. The proposed rule notes that **HHS wants to encourage insurers to offer HDHPs that can be paired with an HSA** as a cost-effective option for enrollees. As a result, HHS is particularly interested in exploring how to use plan display options on www.HealthCare.gov to promote the availability of HDHPs to applicants, and requests input on how best to do that.

Source: Department of Health and Human Services