A leaner federal exchange and greater state and insurer flexibility

The 2019 ACA Marketplace proposed rule
On November 2, the U.S. Department of Health and Human Services (HHS) published the proposed Notice of Benefit and Payment Parameters for 2019. The proposed rule for the 2019 Marketplaces updates various annual individual and small group market insurance product parameters and begins to shape the program both in style and substance in line with the goals articulated by the Trump Administration and HHS this past spring in its Request for Information (RFI) entitled “Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients.”

In terms of style, this Administration favors the “Patient Protection and Affordable Care Act or PPACA” as the new “collective term” for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), as amended as opposed to the “Affordable Care Act,” the “collective term” used by the last Administration. In terms of substance, this proposed rule makes substantive policy changes clearly aimed at achieving the goals outlined in the RFI.

The RFI sought public recommendations for changes that would further the HHS priorities of empowering patients and promoting consumer choice; stabilizing the individual and small group health insurance markets; enhancing affordability; and returning regulatory authority to the States. The 2019 proposed rule is written to align policy changes with these goals and in the preamble HHS notes when proposed policies are supported by comments to the RFI. The comment period for the proposed rule closed on November 27.
The majority of changes support returning regulatory authority to the states and stabilizing markets, either by transferring authority for Exchange functions from the federal government to the states, or by providing greater flexibility for states to make adjustments to benefits and program operations in their individual markets. These deregulatory changes include policies such as:

**Essential Health Benefits (EHB)**

HHS proposes to provide additional options to states for selecting and modifying benchmark EHB plans. In addition to the current 10 options, these would now include any plan selected as a benchmark by any other State for the 2017 year; replacing one or more EHB categories in its plan with categories from another state’s 2017 benchmark plan, or selecting another set of benefits as long as the plan does not exceed the generosity of a set of 2017 plans. Despite these additional options, benchmark plans would still have to include all 10 statutorily-required EHB categories, meet requirements for balance, non-discrimination and minimum actuarial value, and be comparable in scope of benefits to a “typical employer plan”. HHS solicits comments on a federal definition of this typical plan standard, such as any small or large group or self-insured plan with at least 5,000 enrollees from any state. HHS also solicits comments on establishing a potential Federal default definition of EHB that “would better align medical risk in insurance products by balancing costs to the scope of benefits,” and provides the example of a national benchmark plan standard for prescription drugs.

Given that state benchmark plans will still have to cover all categories of EHB benefits and meet other current requirements, it is not clear whether these additional choices will lead to significantly lessened coverage or greater variation than currently exists on average, particularly in the short term. However, enrollees may begin to see different plan design and coverage options than in previous years depending on how individual states proceed. While HHS makes benchmark plan summary of benefits publicly available, there is little available publicly to help understand the extent of variation in scope of coverage between current benchmark plans and those additional plans meeting the proposed definition of “typical employer plans.”

Some health policy analysts believe this change could allow states to sharply limit benefits that current plans must cover, but it is not clear to what extent that could happen under the new choices, nor is it certain that states would have a clear interest in seeking more than marginal changes. In the associated Paperwork Reduction Act (PRA) filing, HHS estimates that 10 states per year would choose to use these new flexibilities in some manner. However, in the impact analysis accompanying the proposed rule, HHS indicates it is unable to predict the effects of this policy and is uncertain as to how States may elect to use this flexibility—only that it assumes any that did would be expected to do so to reduce benefits and premiums. HHS suggests this could increase affordability of health insurance for consumers in the individual and small group markets who do not receive subsidies.
Exchanges

A major change in the proposed rule is the option for Small Business Health Options Program (SHOP) to eliminate certain key functions. Employee eligibility determinations and appeals, premium aggregation, and online enrollment functions become optional for SHOPs. The federally-facilitated SHOP (FF-SHOP) will no longer conduct these functions, and will transfer these responsibilities to employers, issuers, and agents/brokers. The FF-SHOP will maintain certain functions, such as a website that displays qualified health plans (QHPs) and prices, a premium calculator, and potentially of greatest import, continue to conduct small employer eligibility determinations to qualify small businesses for the Small Business Health Care Tax Credit (SBHCTC) and certify QHPs sold through SHOP. These proposals would become effective on the date of the final rule, but HHS aims to help minimize plan year disruption by giving employers, issuers, and agents/brokers the option to treat the SHOP proposals as final starting on the first date that an employer makes plans available for the 2018 plan year. HHS also solicits comments on eliminating the requirement for SHOP issuers to offer average premiums.

This proposed rule nearly eliminates the FF-SHOP as it stands today, but does not come as a surprise to the industry or policy community. This proposed rule builds on guidance released by HHS earlier this year, as well as the final 2018 Payment Notice that removed the SHOP participation requirement for issuers for plan years beginning on or after January 1, 2018. While participation in these Exchanges has never been robust, some small employers would be expected to experience an increase of administrative burden with the removal of these functions. However, HHS believes that affordability would be improved because issuers would see a net cost savings, as their business processes for SHOP enrollments could be more closely aligned with their current business practices for enrollments outside the SHOP, and they would no longer be remitting user fees to support FF–SHOP and State-based Exchanges using the Federal platform (SBE–FP) SHOP enrollments.

Rate review

HHS proposes to exclude student health insurance coverage from the Federal rate review requirements. This would reduce burden related to duplicative rate review submissions and review for issuers and States. HHS also seeks to reduce the number of premium justification rate flings that must be submitted to the federal government through proposing to increase from 10% to 15% the default threshold for rate filing reasonableness reviews, and provides for greater state flexibility in setting submission deadlines and posting of public notices.

Network adequacy standards

The proposed rule would extend the policy established in the Market Stabilization rule policy for 2018 to 2019 and beyond to defer to state network adequacy assessments in states with authority and means to enforce reasonable access standards. In states without this capability, HHS proposes to defer to National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), and Accreditation Association for Ambulatory Health Care (AAAHC) accreditation, or to demonstration that the issuer’s network meets standards consistent with the National Association of Insurance Commissioners’ Health Benefit Plan Network Access and Adequacy Model Act. Similarly, HHS will also extend the policy to allow issuers to use the essential community provider (ECP) write-in process to identify ECPs that are not on the HHS list of available ECPs and will maintain the 20 percent ECP standard. In addition, all state-based exchanges would have the flexibility to determine how to implement the network adequacy and essential community provider standards with which issuers offering QHPs must comply.
The proposed rule builds on guidance released by HHS earlier this year, as well as the final 2018 Payment Notice that removed the SHOP participation requirement for issuers for plan years beginning on or after January 1, 2018.
State authority and flexibility (continued)

Other Qualified Health Plan (QHP) certification standards

HHS proposes to continue to enhance the State flexibilities in QHP certification that began for plan year 2018 by identifying areas where States are already performing reviews that are duplicative of the Federal QHP certification process and incorporating these reviews into the QHP certification process. For federally-facilitated exchanges (FFEs) in States performing plan management functions, HHS will continue to rely on State plan data review for QHP certification standards, including for rate outliers, service area and prescription drug formulary outliers, and non-discrimination in cost sharing. HHS proposes to also defer to States for additional review areas, including accreditation requirements, compliance reviews, minimum geographic area of the plan’s service area, and quality improvement strategy reporting.

Risk adjustment

For the 2019 benefit year, HHS proposes to recalibrate the risk adjustment models using the methodology finalized for the 2018 benefit year, with small modifications to the drug classes included in the 2019 benefit year adult models (removal of 2 of 12 RXC-HCC pairs), and incorporation of the 2016 benefit year EDGE data in the 2019 benefit year risk adjustment model recalibration. These changes are aimed at improving the precision in the risk adjustment model, which would tend to improve market stability. HHS also proposes to permit States to request a percentage adjustment in the calculation of the risk adjustment transfer amounts in their small group market (to proportionally reduce the magnitude of risk adjustment transfers for stabilization). This is a substantially less burdensome alternative to operating their own risk adjustment programs. HHS also solicits comment on permitting similar adjustments for states’ individual markets.

Medical Loss Ratio (MLR) standards

HHS invites comments on whether to allow all issuers to deduct Federal and State employment taxes from premiums in their MLR and rebate calculations, starting with the 2017 MLR reporting year. HHS also proposes to make amendments throughout the MLR requirements to allow for a streamlined process for States to request adjustments to the individual market MLR standard in any State that demonstrates that a lower MLR standard could help stabilize its individual market.

HHS proposes to recalibrate the risk adjustment models using the methodology finalized for the 2018 benefit year, with small modifications to the drug classes included in the 2019 benefit year adult models
Other policy changes in the proposed rule more indirectly support the HHS enhancing-affordability goal and the promoting-consumer-choice goal (in the sense of increasing the variety of plans in the market). These changes would generally lessen either restrictions on plan designs or operational burden on issuers, such as:

**Standardized plan options & meaningful differences**

HHS proposes not to specify any standardized plan options for the 2019 benefit year, proposes to not provide any differential display for standardized options on HealthCare.gov, and to eliminate the meaningful differences standards. HHS also solicits comments on ways to foster innovation, encourage value-based insurance design, promote offering of high deductible health plans paired with health savings accounts (HSAs), and encourage benefit designs that incentivize use of higher value care and preventive care and wellness services.

**Risk adjustment data validation**

HHS proposes to adjust issuers’ risk scores only when data validation error rates materially deviate from the national central tendency of error rates. This change is intended to reduce uncertainty and improve market stability, and HHS expects most issuers required to participate in risk adjustment data validation would not have their risk scores adjusted. HHS also proposes that, beginning with 2017 benefit year risk adjustment data validation, issuers with 500 billable member months or fewer that elect to establish and submit data to an EDGE server would not be subject to the requirement to hire an initial validation auditor or submit initial validation audit results. In addition, if a provider is prohibited from furnishing a full mental or behavioral health record by State or Federal privacy laws, the provider instead may furnish an abbreviated mental or behavioral health assessment that providers routinely prepare, for validation of a mental or behavioral health diagnosis. HHS also proposes to clarify and amend the bases upon which HHS may impose CMPs for violations of risk adjustment data validation requirements.
Greater flexibility (continued)

In-Person consumer assistance programs

HHS proposes to remove the requirement that each Exchange must have at least two Navigator entities, and that one of these entities must be a community and consumer-focused nonprofit group. Additionally, HHS proposes that each entity does not need to have a physical presence in the service area. HHS states that these changes will give more flexibility to each Exchange to structure its Navigator program to best serve its Exchange service area, but notes that entities with a physical presence and strong relationships in their communities tend to deliver the most effective outreach and enrollment results. Federal grants support Navigators in FFE states, and this policy shift will result in substantial funding cuts for in-person assistance in these states. HHS believes removing these requirements would provide Exchanges with cost reductions and/or improved flexibility to award funding to the strongest applicants, regardless of organization type.

Third-Party audit requirements

Current rules require an HHS-approved third party to conduct onboarding operational readiness reviews and audits specific to use of the direct enrollment pathway by agents and brokers registered with the FFEs. HHS proposes to expand the applicability of this requirement to issuers, but also proposes to eliminate federal certification requirements to increase availability and competition for these services in lieu of modified standards that third-party entities must satisfy to perform the reviews to demonstrate operational readiness.

Exceptions for certain plan types

HHS proposes to eliminate actuarial value requirements for stand-alone dental plans and exempt student health insurance coverage from federal rate review requirements.
Additional modifications to current regulation

Other changes are designed to improve the rules through simplification or modifications. These include a mix of consumer-focused and program integrity-enhancing policy changes such as:

**Special Enrollment Period (SEP)**
HHS proposes to amend the prior coverage requirements in service areas where no QHPs were offered; provide for SEP rule consistency for dependent enrollment options; and expand the loss of coverage SEP for loss of temporary pregnancy-related coverage. HHS expects that simplifying these rules would reduce the need for costly casework support and the burden on consumers and have a positive effect on the risk pool.

**Hardship exemptions**
HHS proposes to permit Exchanges to use the lowest cost plan available to an individual when no bronze level plan is available for hardship exemptions from the individual shared responsibility provision.

**Minimum essential coverage**
HHS proposes to expand the definition of minimum essential coverage to include coverage under a CHIP buy-in program.

**Income verifications & eligibility redeterminations**
HHS proposes to tighten processes around income verification and eligibility redeterminations to ensure subsidies are paid only for eligible individuals. HHS signals that it intends to issue additional rulemaking and guidance on a number of program integrity issues, including further examination of processes for denying eligibility for subsidies for individuals who have failed to reconcile an advance premium tax credit (APTC) on their Federal income tax return, Exchange processes for matching enrollment data with Medicare and Medicaid in order to remove duplicate enrollments, and rules around recalculation of eligibility for APTC following a midyear change in eligibility.
What does the rule mean for states, insurers, and consumers?

The 2019 Marketplace proposed rule by and large transfers responsibility for certain Exchange functions from the federal government to the states where states have sufficient review and enforcement capabilities, provides greater flexibility for states to perform and fund Exchange functions, eliminates potentially burdensome requirements on issuers, and simplifies or modifies certain rules that have been identified by HHS as problematic.

Some states and insurers will likely commend HHS for proposing policies that allow for greater state flexibility and the removal of potentially redundant oversight mechanisms, such as processes surrounding QHP certification and plan design requirements. Supporters may state that these policies will create innovation at the local level and reduce industry costs, which may ultimately be passed through to consumers in the form of increased health care choices and lower monthly premiums. On the other hand, issuers and employers may have mixed feelings about the costs shifted to them from the federal platform.

Opponents may argue that decentralization and defunding of Exchange functions will lead to considerable variation in access to health care across states, such as the proposals surrounding EHBs and in-person assistance. Individuals living in states that either cannot afford to adopt new-found responsibilities, or states that have historically been opposed to the ACA, may face fewer consumer protections and health insurance options than individuals in states that have traditionally embraced the ACA or ACA “like” policies. Additionally, some policy experts will likely argue that the market stabilization proposals, specifically those surrounding MLR, aren’t strong enough.

References


7 Supra note 1, at 82 FR 51131


Conclusion

It is not clear that the flexibility afforded by the proposed policy changes will necessarily have the effects either desired or feared by various stakeholders, most of whom still have vested interests in the stability of the PPACA markets. If the changes proposed in this rule are finalized, how the additional flexibility is utilized will ultimately depend primarily upon how individual States decide what best serves their insurance markets and residents.

Additionally, on November 27, 2017 CMS released several other draft implementing guidance documents, which are released annually by CMS to give stakeholders, primarily issuers and states, the opportunity to provide feedback to CMS on various operational issues. The documents include (1) 2019 Draft Letter to Issuers in the FFEs; (2) proposed timeline for the QHP certification process for 2019, which will take place starting in May 2018 (the same as last year); (3) rate review for single risk pool coverage, and risk adjustment for benefit year 2017; and (4) the proposed timing of rate filing justification submissions for single risk pool coverage effective on or after January 1, 2019. The documents, specifically the letter to issuers, largely mirror 2018 guidance, while incorporating new policies contained within the 2019 proposed rule. Comments on these documents were due December 11, 2017.
Contact us:

S. Lawrence Kocot  
Principal and National Leader  
Center for Healthcare Regulatory Insight  
lkocot@kpmg.com  
202-533-3674

Ross White  
Manager  
Center for Healthcare Regulatory Insight  
rosswhite@kpmg.com  
202-533-3691

Tracey McCutcheon  
Director  
Center for Healthcare Regulatory Insight  
traceymccutcheon@kpmg.com  
202-533-5380

The Center would like to acknowledge and thank Sophie Stern for her significant contributions to this paper.

To learn more about the KPMG Center for Healthcare Regulatory Insight please visit: www.kpmg.com/us/hcls-hcinsight

About KPMG

KPMG is a global network of professional firms providing audit, tax, and advisory services. We operate in 152 countries and have 189,000 people working in member firms around the world. The independent member firms of the KPMG network are affiliated with KPMG International Cooperative (“KPMG International”), a Swiss entity. Each KPMG firm is a legally distinct and separate entity and describes itself as such.

Some or all of the services described herein may not be permissible for KPMG audit clients and their affiliates.

kpmg.com/socialmedia