SQUIRE PATTON BOGGS

HHS Final Rule Scales Back Affordable Care Act Regulations

This week, the US Department of Health and Human Services (HHS) published a Final Rule in the Federal Register that will scale back regulations applicable to health insurance subject to the Patient Protection and Affordable Care Act (ACA).[1] In issuing the Final *Notice of Benefit and Payment Parameters for 2019* Rule (Final Rule), HHS observed that premium rate increases and health insurance company market exits have threatened the stability of individual and small group Exchanges in many regions. According to HHS, the Final Rule enhances the role of the states in regulating health insurance, provides states with additional flexibilities, reduces unnecessary regulatory burdens and improves affordability.[2]

The Final Rule continues actions by the Administration to eliminate previously adopted requirements that implement the ACA. Last year, the Administration repealed the penalties associated with the individual mandate to purchase health insurance and began the process to repeal certain ACA regulations.[3] The Final Rule further reduces regulations associated with the ACA, with some reforms taking effect immediately and others taking effect in future years. Although the reforms are comprehensive and far-reaching, they generally fall into the following categories:

- Enhancing the Role of States
- Reducing Regulatory Requirements
- Making Exchanges More Efficient
- Increasing Regulatory Oversight

The following provides a summary of the significant changes contained in the Final Rule.

Enhancing the Role of States

States Will Review Network Adequacy

Beginning with plan year 2019, states will review network adequacy, not HHS as is currently the case, provided that the state has a sufficient network adequacy review process.[4] Additionally, State Exchanges are no longer required to enforce federal network adequacy standards, but may enforce State Standards.[5]

State Flexibility as to Essential Health Benefits (EHB)

Starting with plan year 2020, states will have greater flexibility to define EHB, and may choose from the following additional EHB options: (1) select an EHB benchmark plan used by another state, (2) replace benefits in EHB categories with benefits from a benchmark plan used by another state or (3) independently select a set of benefits for an EHB benchmark plan.[6] A state may also allow plans to substitute EHB benefits both within and between EHB categories, provided the substitution is actuarially equivalent.[7] However, if a state selects a benchmark plan with benefits greater than an allowed "generosity standard," then the state must defray the cost for the excessive benefits.[8] Finally, HHS may establish, through future regulatory action, a federal default definition of EHB, including a national prescription drug benefit.[9]

Medical Loss Ratio Flexibility

HHS may adjust the MLR standards in a state to stabilize markets, and the process for a state to request MLR adjustments will be less burdensome.[10] Additionally, a state may allow issuers to report quality improvement activities as a fixed percent of premium amount, equal to 0.8%, for purposes of the MLR calculation, in lieu of tracking such expenses.[11]

Risk Adjustment Flexibility

A state may request that HHS reduce risk adjustment program transfers in the individual and small group markets based on market dynamics beginning in 2020.[12]

State Flexibility as to Operating Exchanges

State Exchange requirements no longer need to be as strict as standards imposed by the federal Exchange.[13]

1 Final Rule, "Notice of Benefit and Payment Parameters for 2019," 83 Fed. Reg. 16930 (March 17, 2018).
2 83 Fed. Reg. 16930-16931 (Apr. 17, 2017).
3 Tax Cut and Jobs Act of 2017, Pub. L. 115-97, Section 11081.
4 83 Fed. Reg. 16978 (Apr. 17, 2017) (repealing 45 C.F.R. § 155.200(f)(2)(ii) effective for the 2019 plan year).
5 Id.
6 83 Fed. Reg. 17009 (Apr. 17, 2017), to be codified at 45 C.F.R. § 156.111(a) (effective for the 2020 plan year).
7 83 Fed. Reg. 17011 (Apr. 17, 2017), to be codified at 45 C.F.R. § 156.115(b) (effective for the 2020 plan year).
8 83 Fed. Reg. 17009 (Apr. 17, 2017), to be codified at 45 C.F.R. §156.111(b)(ii) (effective for the 2020 plan year).
9 83 Fed. Reg. 17008-17009 (Apr. 17, 2017).
10 83 Fed. Reg. 17037 (Apr. 17, 2017), to be codified at 45 C.F.R. §§ 158.301,158.321, 158.322, and 158.330 (effective for the 2019 plan year).
11 83 Fed. Reg. 17032 (Apr. 17, 2017), to be codified at 45 C.F.R. §158.221 (effective for the 2017 plan year, for reports filed in 2018).
12 83 Fed. Reg. 16954 (Apr. 17, 2017), to be codified at 45 C.F.R. § 153.320(d) (effective for the 2020 plan year).
13 83 Fed. Reg. at 16978 and 17054 (Apr. 17, 2017) (repealing 45 C.F.R. § 155.200(f)(2)(ii-iv), effective for the 2019 plan year).

Reducing Regulatory Requirements

Raise the Premium Rate Review Threshold

The threshold that triggers a premium rate increase justification review will rise from the current threshold of 10% to a higher threshold of 15%.[14] However, a state may request higher or lower thresholds with HHS approval.

Exempt Student Health Plans From Rate Review

Student health plans become exempt from federal rate review.[15]

No More Standardize Plan Options

CMS will no longer specify standardized plan options beginning with the 2019 plan year.[16]

No More Meaningful Difference Standards

Meaningful difference requirements for plans were repealed.[17]

Soften the Impact of the Risk Adjustment Program

HHS will recalibrate the coefficients used in the risk adjustment program by blending three years of data to minimize volatility of payments.[18]

Making Exchanges More Efficient

Reduce Requirements on Agents and Insurers Enrolling Consumers in Exchange Coverage

Regulatory requirements for insurers and agents that seek to enroll individuals and groups in Exchange coverage through their own websites have been reduced.[19] The Final Rule permits agents, brokers and issuers that participate in direct enrollment to select their own third-party entities for conducting audits, rather than requiring HHS to initially review and approve these entities.

Reduce Small Business Health Options Program (SHOP) Administrative Activities

SHOPs will operate in a leaner fashion, with fewer functionalities – no longer performing employee eligibility determinations, employee enrollment tracking, employee notifications, premium aggregation services, premium billing of employees and online enrollment functionality – for plan years beginning on or after January 1, 2018.[20]

No New State SHOP Exchanges

A state may no longer establish a new State SHOP Exchange.[21]

Increasing Regulatory Oversight

Special Enrollments Are Tightened Up

Special enrollments by dependents will be more restrictive in terms of the coverage options available to enrollees and dependents.[22]

Special enrollments due to marriage or a permanent move continue to require prior coverage, but the Final Rule provides for certain exceptions.[23]

In an expansion of special enrollments, women who lose pregnancy-related CHIP coverage due to the birth of a child will qualify for a special enrollment.[24]

HHS Will Increase Verification of Eligibility for Subsidies

If income data reported by the consumer is greater than income data received from other sources, the Exchange may request documentation. The Exchange will no longer simply accept a consumer's attestation.[25]

Mid-Year Income Changes May Result in Mid-Year Subsidy Adjustments

HHS intends to address certain program integrity issues in future rulemaking and guidance, including rules concerning eligibility for subsidies in the event of mid-year changes to income.[26]

Insurers Must Accurately Report Risk Adjustment Data or Face Penalties

The Final Rule revises the formula for reducing risk adjustment payments to insurers that have data validation problems, and for imposing civil money penalties for substantial noncompliance.[27]

Contacts

For more information about HHS's *Notice of Benefit and Payment Parameters for 2019* Rule, including how it may impact health insurance companies, regulatory compliance and health benefit plans, please contact one of the lawyers cited below.

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14 83 Fed. Reg. 16972 (Apr. 17, 2017), to be codified at 45 C.F.R. §154.200(a)(1) (effective for the 2019 plan year).
15 83 Fed. Reg. 16972 (Apr. 17, 2017), to be codified at 45 C.F.R. §154.103(b)(3) (effective for coverage on or after July 1, 2018).
16 83 Fed. Reg. 16974-16975 (Apr. 17, 2017).
17 83 Fed. Reg. 17027 (Apr. 17, 2017) (repealing 45 C.F.R. §158.298 effective for the 2019 plan year).
18 83 Fed. Reg. 16939-16944 (Apr. 17, 2017).
19 83 Fed. Reg. 16981-16982 (Apr. 17, 2017); 45 C.F.R. §155.221 (effective for the 2019 open enrollment period).
20 83 Fed. Reg. 16999 (Apr. 17, 2018), to be codified at 45 C.F.R. § 155.706 (effective for plan years beginning on or after January 1, 2018).
21 83 Fed. Reg. 16976-16977 (Apr. 17, 2018), to be codified at 45 C.F.R. § 155.106(c).
22 83 Fed. Reg. 16989 (Apr. 17, 2018, to be codified at 45 C.F.R. § 155.420(a).
23 83 Fed. Reg. 16938 (Apr. 17, 2018, to be codified at 45 C.F.R. § 155.420(a)(5) (effective for the 2018 plan year).
24 83 Fed. Reg. 16993 (Apr. 17, 2018), to be codified at 45 C.F.R. 155.420(d)(1)(iii).
25 83 Fed. Reg. 16985 (Apr. 17, 2018), to be codified at 45 C.F.R. § 155.320(c) (effective for the 2018 plan year).
26 83 Fed. Reg. 16985-16986 (Apr. 17, 2017).
27 83 Fed. Reg. 16961-16972 (Apr. 17, 2018), to be codified at 45 C.F.R. § 153.350 and 153.630.

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