Bernie Lowe & Associates, Inc.
"Beyond the Product"

Health Care Reform Update

IMPORTANT NOTICE REGARDING HEALTHCARE REFORM

Update #83 **April, 2018**

Finalizes 2019 Benefit and Payment Parameters and Extends Transition Policy Allowing Certain Noncompliant Policies

CMS has released final regulations that include the benefit and payment parameters for 2019, which modify insurance market and Exchange-related rules under the Affordable Care Act (ACA). Below are highlights of interest for group health plans:

Increased Annual Cost-Sharing Limits

CMS finalized an increase in the maximum annual limitation on cost-sharing for 2019 to $7,900 for self-only coverage and $15,800 for other than self-only coverage (compared to $7,350 and $14,700, respectively, for 2018). We released Heath Care Reform Update #74 in November outlining the proposed maximum annual limitation on cost-sharing changes. The amounts have not been changed.

Revised Essential Health Benefits (EHB) Options.

States will have more flexibility in designating EHB-benchmark plans beginning with the 2020 benefit year, one year later than proposed. States will be able to select a new EHB-benchmark plan annually and will have more options to choose from. Specifically, a state may:

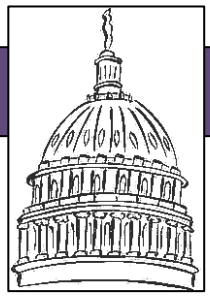
1. Choose an EHB-benchmark plan used by any state for the 2017 benefit year;

2. Construct an EHB-benchmark plan that incorporates the ten required EHB categories by replacing any EHB category with the comparable category in another state's benchmark plan, taking different categories from different states, as desired; or

3. Select a set of benefits to become the state's EHB-benchmark plan.

Complex rules are intended to ensure that the EHB-benchmark plan provides a scope of benefits that is at least equal to a typical, insured employer plan providing minimum value, but does not exceed the "most generous" comparison plan. Criteria are established for selecting a comparison plan, which could be, for example, the state's EHB-benchmark plan for the 2017 plan year. HHS has issued a memorandum with an example of an acceptable methodology to demonstrate compliance with the scope-of-benefits requirements. The deadline for states to select a 2020 EHB-benchmark plan is July 2, 2018.

Please note while self-insured health plans and insured large group health plans are not required to offer EHB, they cannot impose annual or lifetime dollar limits on EHB they do offer.



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New Rules for Small Business Health Options Programs (SHOPs)

SHOPs are no longer required, for plan years beginning on or after January 1, 2018, to provide employee eligibility determinations (or appeals), premium aggregation, and online enrollment. SHOPs will still be required to determine employer eligibility for the SHOP (including employer eligibility appeals) and certify each qualified health plan (QHP) available through the SHOP, but enrollment will be handled by SHOP-registered agents or brokers, or the insurer offering the QHP. The small business health care tax credit remains available to qualifying employers using this enrollment process. SHOPs also will feature a website providing QHP information, a premium calculator with estimated QHP prices and a call center to answer questions about the SHOP. Federal regulations will not require SHOP insurers to offer group health plans the option to pay premiums based on average enrollee premiums, but rather will defer to state law. The "rolling enrollment" rule permitting purchase of SHOP coverage at any point during the year continues to apply, subject to minimum participation rules outside the November 15 to December 15 annual enrollment period. The minimum participation rate will still be determined at the employer level, but SHOPs will not be required to calculate it.

Note that SHOP enrollment has not met expectations, leading HHS to conclude that it is not cost-effective for the federal government to perform administrative functions not expressly required by the ACA. However, state-based SHOPs retain the flexibility to maintain current operations. In federal SHOPs and state SHOPs adopting the scaled-back model, employers, brokers, and insurers will play a larger role in determining employee eligibility, conducting enrollment, and collecting premiums.

Default Threshold for Rate Increase Review

The ACA requires an automatic reasonableness review of annual rate increases above a certain threshold in the small group or individual insurance markets. The default threshold will increase from 10% to 15% for rate filings submitted for plan years beginning on or after January 1, 2019. States may request approval from CMS for higher state-specific thresholds. Other administrative changes are made to the rate review program.

Separately, CMS has announced another extension of the transition policy allowing states to permit insurers in the individual and small group markets to renew health insurance policies they would otherwise have to cancel due to noncompliance with certain insurance market reforms under the ACA. CMS generally continues the terms and conditions applicable to last year's extension of the transition policy first announced in 2013, but with date adjustments. Thus, under the latest guidance, states may permit insurers that have continually renewed eligible non-grandfathered individual and small group policies since January 1, 2014, to again renew such coverage for a policy year beginning on or before October 1, 2019, provided that the policies end by December 31, 2019. Health insurers relying on the transitional policy must send an informational notice, the content of which has not changed from last year, to affected individuals and employers.

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As in prior iterations of the benefit and payment parameters, these regulations address a wide range of Exchange and insurance market reform rules. A lengthy discussion in the preamble explains the Exchanges' ongoing challenges in developing a reliable database to verify availability of employer-sponsored coverage for individuals seeking advance payment of premium tax credits, a topic of interest to employers subject to employer shared responsibility. HHS also received a wide range of comments in response to its request for input on ways to incentivize value-based and consumer-driven health plans, including encouraging insurers to offer HSA-eligible high deductible health plans, but took no specific action to promote these designs.

For more information follow the links below:

Notice

Fact Sheet

Bulletin

Bernie Lowe & Associates, Inc. is not providing any legal advice with regard to compliance with the requirements of the Affordable Care Act ("ACA"). Bernie Lowe & Associates, Inc. makes no representation as to the impact of plan changes on a plan's grandfathered status or interpretation or implementation of any other provisions of ACA. Bernie Lowe & Associates, Inc. will not determine whether coverage is discriminatory or otherwise in violation of Internal Revenue Code Section 105(h).