HCR ALERT

April 16, 2018

ACA 2019 Notice of Benefit and Payment Parameters & Individual Mandate Exemptions

On April, 9 2018, the Department of Health and Human Services (HHS) released two pieces of regulatory guidance related to the Affordable Care Act (ACA). First is the Notice of Benefit and Payment Parameters for 2019 Final Rule with corresponding Fact Sheet, which addresses various Affordable Care Act (ACA) provisions affecting group plans and the individual market. Second is a memo regarding Hardship Exemptions from the Individual Shared Responsibility Provision. Below is an overview of some key provisions of the guidance.

NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2019

2019 Cost-Sharing Limits

For non-grandfathered health plans, out-of-pocket (OOP) maximums applicable to essential health benefits (EHB) may not exceed allowable limits, which will increase from $7,350 for self-only coverage and $14,700 for other-than-self-only coverage in 2018 to $7,900 and $15,800, respectively, in 2019. Plans may structure a benefit design using separate OOP maximums for different benefits, such as medical and Rx benefits; however, the total of the separate OOP maximums *combined* cannot exceed the ACA limit. Additionally, the self-only ACA limit will continue to apply to all individuals, even if enrolled in other-than-self-only coverage (e.g., if a plan's OOP maximum for family coverage is $10,000, OOP costs for each individual member of an enrolled family cannot exceed $7,900 in 2019).

Note: These ACA OOP limits are different than the IRS-imposed OOP limits for HSA-eligible high deductible health plans (HDHPs), which have been lower than ACA OOP limits in recent years (IRS limits for 2019 will not be available until a later date). In general, the lower IRS OOP limits supersede ACA OOP limits with regard to HSA-eligible HDHPs. However, although the IRS HDHP self-only OOP limit is not applicable on an individual basis to members enrolled in other-than-self-only coverage ("embedded OOP limit"), if a HDHP's other-than-self-only OOP limit is greater than the ACA self-only OOP limit, the ACA self-only limit is applicable to each individual. For example, if in 2019 an HSA-eligible HDHP has OOP limits of $6,000 for self-only coverage and $12,000 for other-than-self-only coverage, the OOP expenses for EHB for any individual within an other-than-self-only coverage family unit cannot exceed $7,900.

Essential Health Benefit Benchmark Plan for Self-Insured Plans

Since 2014, non-grandfathered self-insured and large market plans are not permitted to apply annual or lifetime dollar limits to EHB covered by the plan. To define which services are EHB (i.e., which services can be subjected to dollar limits and which cannot), self-insured plan sponsors are permitted to select any state's EHB benchmark plan as the plan's reference.

For plan years beginning on or after January 1, 2017, states were required to choose one of four health insurance plan options as a benchmark plan for the state:

- The largest plan by enrollment in any of the state's three largest small group products in 2014.
- Any of the three largest state employee health plan options by enrollment in 2014.
- Any of the three largest federal employee health plan options by enrollment in 2014.
- The largest HMO plan offered in the state's commercial market in 2014.

For plan years beginning on or after January 1, 2020, states will have more flexibility in selecting EHB benchmark plans. In general, each state will be permitted to:

- Maintain its own 2017 benchmark plan in its entirety.
- Choose another state's 2017 benchmark plan in its entirety.
- Replace some of the 10 EHB categories in its 2017 benchmark plan with the same category of benefits from another state's 2017 benchmark plan.
- Otherwise select a set of benefits to become is EHB benchmark plan, provided it meets scope of benefits and other specified requirements.

The options above are subject to additional requirements, including two scope of benefits requirements. States that wish to make changes to their EHB plans for plan years beginning on or after January 1, 2020 must submit documentation to the Department of Health and Human Services (HHS) by July 2, 2018. However, HHS has not yet indicated when it will publish the new state benchmark plan information. When that information becomes available, self-insured plan sponsors should review the 2020 plan design for the state EHB benchmark they originally selected and confirm whether there are changes that conflict with benefit dollar limits imposed by their plans.

Other Provisions

In addition to the provisions noted above, the Notice of Benefit and Payment Parameters for 2019 Final Rule addresses several other provisions which are not discussed in detail in this communication, as they do not have a direct or immediate impact on employers or employer-sponsored health plans. Those provisions affect matters including:

- ACA marketplace network adequacy reviews for qualified health plan certification.
- ACA marketplace audit process for agents, brokers, and issuers participating in direct enrollment.
- ACA marketplace risk adjustment model for insurers with high-cost enrollees.
- ACA marketplace advance premium tax credit (APTC) eligibility for individuals failing to file tax return reconciling prior APTCs.
- ACA marketplace employer-sponsored coverage verification requirements.
- ACA marketplace special enrollment rules for dependents and pregnant women.
- ACA marketplace determination of individual lack of affordable coverage exemptions.

- ACA marketplace same-day coverage termination.
- ACA marketplace SHOP online enrollment.
- Individual market medical loss ratio (MLR) standards.
- Individual and small market rate review.

GUIDANCE ON HARDSHIP EXEMPTIONS FROM THE INDIVIDUAL SHARED RESPONSIBILITY PROVISION

The ACA's individual shared responsibility provision imposes a tax penalty on individuals who do not have minimum essential coverage, unless they qualify for a hardship exemption. The ACA statute delegates responsibility for defining the circumstances that constitute a qualifying hardship to HHS. This memo expands on existing guidance by extending hardship exemption to individuals who live in a county, borough, or parish in which:

- No qualified health plan is offered, or
- There is only one issuer offering coverage and can show that the lack of choice resulted in failure to obtain coverage.

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Your Trion Strategic Account Managers are here to answer any questions you might have as you prepare to comply with upcoming ACA requirements. If you are not currently a Trion client and would like assistance navigating the changes required by health care reform, please contact us today by emailing trionsales@trion-mma.com.

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