ACA COMPLIANCE BULLETIN

HIGHLIGHTS

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

IMPORTANT DATES

April 9, 2018
The 2019 Final Notice of Benefit and Payment Parameters was issued.

2019 Benefit Year
The changes included in the final rule generally apply for the 2019 benefit year (unless otherwise noted).

Provided By:
New England Employee Benefits Co., Inc.

Final Notice of Benefit and Payment Parameters for 2019

OVERVIEW

On April 9, 2018, the Department of Health and Human Services (HHS) released its **final Notice of Benefit and Payment Parameters for 2019**. This final rule describes benefit and payment parameters under the Affordable Care Act (ACA) that apply for the 2019 benefit year. Standards included in the final rule relate to:

- ✔ Annual limitations on cost sharing;
- ✔ The individual mandate's affordability exemption;
- ✔ Special enrollment periods in the Exchange; and
- ✔ Essential health benefit (EHB) benchmark plan options.

Although the tax reform bill effectively eliminated the individual mandate penalty beginning in 2019, the final rule notes that individuals may still need the affordability exemption to determine eligibility for catastrophic coverage.

The final rule also makes changes to certain standards for enrollment in the Small Business Health Options Program (SHOP) Exchange. Finally, the rule eliminates standardized plan options in the federally facilitated Exchanges (FFEs).

NEEBCo
New England Employee Benefits Company
15 Chenell Drive, Concord, New Hampshire 03301
603.228.1133 Fax 603.225.1960 www.neebco.com

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 EHBs. 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.
- For 2019, the out-of-pocket maximum will increase to **$7,900 for self-only coverage** and **$15,800 for family coverage**.

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**.

The tax reform bill, called the Tax Cuts and Jobs Act, **reduced the ACA's individual mandate penalty to zero, effective beginning in 2019**. As a result, beginning in 2019, individuals will no longer be penalized for failing to obtain acceptable health insurance coverage. However, the final rule notes that individuals may still need to seek this exemption for 2019 and future years (for example, in order to be eligible for catastrophic coverage).

As a result, the final rule **increases the required contribution percentage in 2019**. For 2019, an individual qualifies for this affordability exemption 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 final rule establishes a new SEP that allows pregnant women who are receiving health care

services through Children's Health Insurance Program (CHIP) coverage for their unborn child to qualify for a 60-day 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 plan options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program 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.

Beginning with the 2020 plan year, the final rule allows states to select a new EHB-benchmark plan on an annual basis, and provides substantially more options in what they can select as an EHB-benchmark plan. Under the final rule, states may:

- 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.

However, in all cases, states cannot select an EHB-benchmark plan that is more generous than the most generous comparison plan.

In addition, the final rule allows states to maintain their current 2017 EHB-benchmark plan without taking any action. In previous years, states that did not take any action with respect to their EHB-benchmark plan defaulted to the federal benchmark plan option.

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 final rule eliminates the online enrollment process through the SHOP Exchange, and instead allows employers to enroll through a SHOP plan issuer or a SHOP-registered agent or broker (called "direct enrollment").

As a result, SHOP Exchanges are no longer required to provide employee eligibility, premium aggregation and online enrollment functionality. For plan years beginning on or after Jan. 1, 2018, federally facilitated SHOPs (FF-SHOPs) and state-based SHOPs using the federal platform will no longer provide these services.

State-based SHOP Exchanges have the flexibility to maintain current operations of their online SHOP enrollment platforms, or take advantage of the regulatory flexibilities available through the final rule to design a SHOP that best meets the needs of the small group market in their state. The Small Business Health Care Tax Credit will 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 EHBs 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 final rule **eliminates the standardized plan options in the FFE for the 2019 plan year**, due to concern that providing differential display for these plans may limit enrollment in coverage with nonstandardized option plan designs, removing incentives for issuers to offer coverage with innovative plan designs.

Source: Department of Health and Human Services