ACA Implementation Update: Looking Back at Early 2015 – Preparing for 2016

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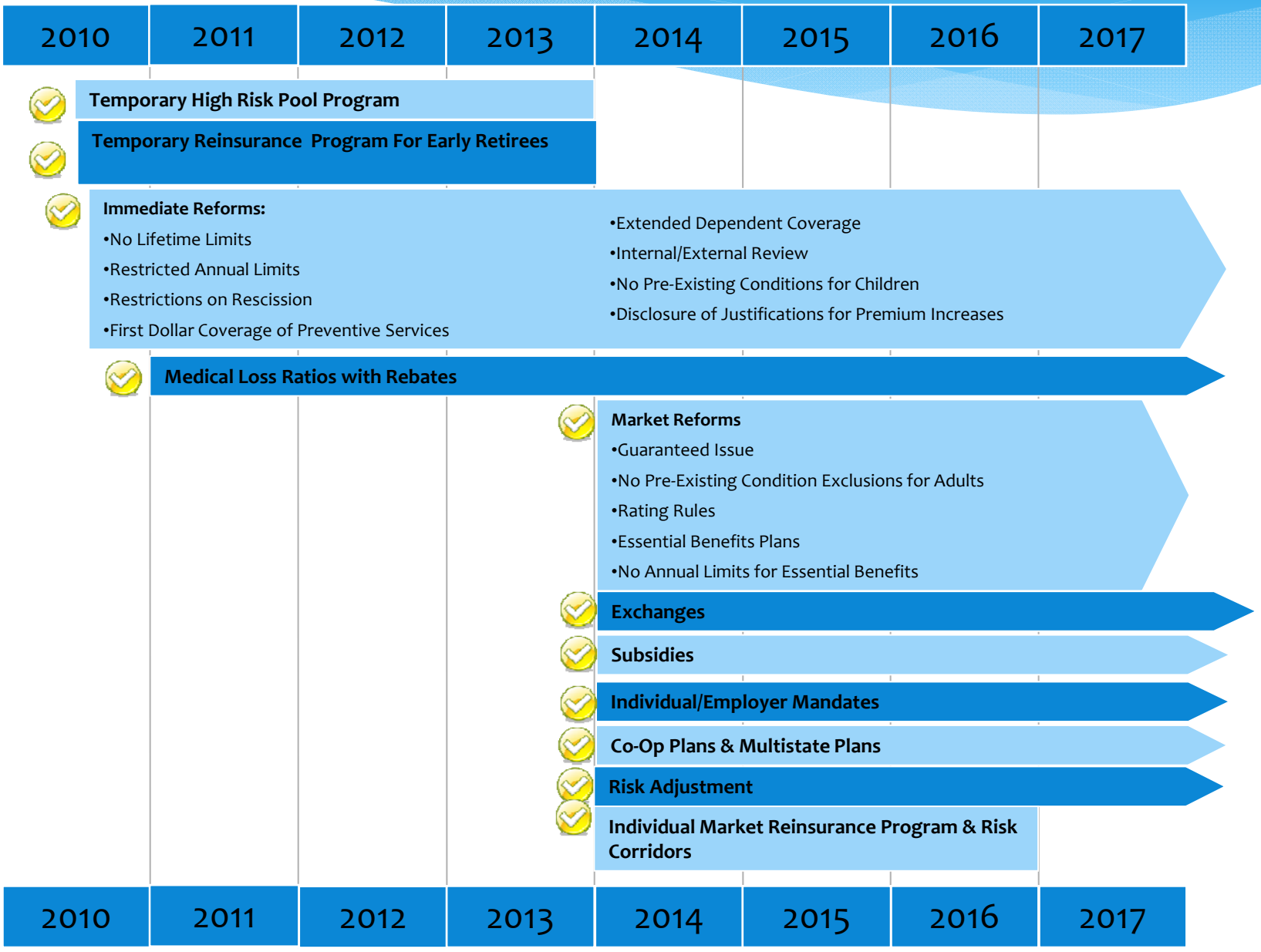
Implementation Timeline



Where are we now?

2015 Open Enrollment Ended Feb. 15.

The Numbers:

* Nearly 8.84 million selected plans or were auto-enrolled in plans through the FFMs.
* Nearly 2.8 million enrolled in plans through the SBMs.
* About 2 million were auto-enrolled in the same plan they had in 2014.
* 1.2 million switched plans from 2014 plan.
* Overall 4.17 million of those who selected plans in FFM during the 2nd open enrollment had also done so during the 1st open enrollment. About 4.7 million signed up for the first time.

More Sign-Ups Possible

Newly Announced Special Open Enrollment Period for FFMs:

March 15 through April 30.

For individuals who:

* Did not know about the individual mandate penalties until filed taxes;
* Pay the penalties for not having coverage in 2014; and
* Do not have health plans purchased through HealthCare.gov.

SBMs can establish a similar special open enrollment period.

Special open enrollment period after Feb. 15 for some SBMs: CA, MN, VT and WA.

What's Really in a Number?

Same Questions for 2015 Enrollments:

* How many Exchange enrollees have paid premiums, and will continue doing so?
* How many enrollees were previously uninsured?
* What percent of enrollees have a pre-existing condition or are having a baby?
* Who will enter the market during the year through special enrollment periods?
* What are the numbers in each state? For each carrier?

What Worked Better in 2015?

A smoother open enrollment.

In looking at second open enrollment period, certain areas apparently improved due to little discussion about problems:

* Very little technical issues reported in FFMs and SBMs
* Information on provider networks clearer (time will tell, however)
* The "back end" processes seemingly worked better (time will tell, however)
* Consumers a bit more accustomed to the marketplaces and enrollment

What Will 2016 Bring?

* QHP submission dates
* Open Enrollment
* HHS Final Notice of Benefits and Payment Parameters for 2016

QHP Submission Timeline/ Open Enrollment

Deadlines: First Initial FFM QHP App Submission Window = April 15 – May 15

Final Deadline for Submission of QHP Submission Data = Aug. 25

Agreements Signed = Sept. 21 -25

SBMs set own timelines.

Open Enrollment: Nov. 1, 2015 – Jan. 31, 2016

Final HHS Notice of Benefit and Payment Parameters for 2016

* Provider directories updated at least once monthly.
* Plan drug formulary information on insurer website and updated real time. "Machine-readable" files required.
* Prescription drug exceptions process review within 72 hours; option of 24-hour review.
* Clarifies that cost-sharing for meds approved in exceptions process count toward annual out-of-pocket limits.

Key Issues for State Regulators

* State-Federal Coordination
* Network Adequacy
* Stop-Loss and Small Group Market
* Essential Health Benefits for 2016
* State Innovation Waivers for 2017
* *King v. Burwell*

State-Federal Coordination

* **State-Based Exchanges = federal role is limited**

* **Federally-Facilitated Exchanges = complicated:**
  * A state can choose to "partner" with the federal government and perform all of the plan management functions – review of forms and rates – and/or consumer assistance
  * A state can choose to perform the functions, but not officially "partner" with the feds
  * A state can choose to not perform the functions, but still do reviews of rates and forms
  * A state can choose not to enforce the federal rules
* **Exactly how oversight is coordinated continues to be a problem**

Network Adequacy

* In 2014, for FFMs, CMS relied on State network adequacy review or if no State review, then accepted accreditation. If no accreditation, then accepted issuer access plan.
* In 2015, CMS relied on the "reasonable access standard" and any reviews were to inform future rule-making.
* In preamble for final Payment Parameter rules for 2016, CMS states that it is deferring any significant changes to its network adequacy standards until the NAIC completes its work on updating the *Managed Care Plan Network Adequacy Model Act* (#74)

Stop-Loss Coverage in the Small Group Market

* Stop-loss coverage used as a means to self-insure and avoid some ACA requirements.
* Small Group typically has young, healthy employees.
* Concerns with low attachment points (which is the level above which the insurer is liable for payment) and adverse selection.
* Adverse selection when small employer group becomes unhealthy and jumps back into the risk pool.
* Concerns increase in 2016 when small group definition goes from 1-50 employees to 1-100 employees with groups of 51-100 employees more likely to self-insure.

Essential Health Benefits for 2016

* Current Essential Health Benefits regulation sunsets at the end of 2015.
* Final Payment Parameters Rule, makes no significant changes to the EHBs for 2016.
* States can change the benchmark plan for 2017 and beyond, but can only choose from plans sold in 2014.
* No details on the process to be used by the States in choosing the benchmark plan for 2017 and no deadlines for decisions by the States.
* States and carriers need this information in order to make the changes and necessary plan amendments in their 2017 form submissions in early 2016.

State Innovation Wavers for 2017

* Added to the ACA by Sen. Ron Wyden (D-OR) during Senate Finance Committee consideration.

  "to encourage additional innovative approaches in States, approaches that meet the needs of States' own residents, that will help us, in my view, to promote choice and competition in the American health care system."

* Originally allowed for waiver of any market reform and the individual mandate.
* Scaled back before enactment to only allow waivers of specified provisions.

State Innovation Wavers for 2017: What *Can* be Waived

- QHP Requirements (Part I of subtitle D)
  - Essential Health Benefits (EHBs)*
  - Annual limits on cost-sharing
  - Actuarial value (Metal tiers)
  - Definitions of large and small employers
- Exchanges (Part II of subtitle D)
  - Establishment of Exchanges
  - Single risk pool
  - Access to exchange limited to citizens and lawful residents
- Cost-Sharing Reductions (Section 1402)
- Premium Tax Credits (IRC Section 36B)
- Shared Responsibility for Employers (IRC Section 4980H)
- Requirement to Maintain Minimum Essential Coverage IRC Section 5000A)

State Innovation Wavers for 2017: What *Cannot* be Waived

- **Public Health Service Act Requirements**
  - Guaranteed issue and renewability
  - Prohibitions on annual and lifetime limits
  - Prohibition on preexisting condition exclusions
  - Adjusted community rating rules
  - Medical loss ratios
  - Extended dependent coverage of adult children up to age 26
  - Coverage of preventive services
- **Other ACA Provisions**
  - CO-OP plans
  - Multi-state plans
  - Small business tax credits
  - Nondiscrimination requirements

State Innovation Wavers for 2017

* The Secretary of Health and Human Services and Secretary of the Treasury review the state law and determine that the plan is:
  (a) At least as comprehensive as its residents would receive in the exchange;
  (b) At least as affordable;
  (c) Deficit neutral to the federal government; and,
  (d) Covers at least as many people.

King v. Burwell

* The Supreme Court heard oral arguments on the *King v. Burwell* case March 4th. Decision expected in late-June.
* The basic question before the Court is whether the ACA limits subsidies to individuals who enroll through a State-Based Exchange.
* The plain language of the ACA states that a person can receive a subsidy if they purchase coverage in a plan through an Exchange "established under Sec. 1311" (which is a State-Based Exchange).
* However, the Obama Administration argues that this was not the intent of the drafter and there are also other sections of the bill that plainly assume that individuals in Federally-Facilitated Exchanges can or are receiving the subsidies.

King v. Burwell: Possible Decisions

* Court finds that the IRS has acted appropriately and the regulation is confirmed – nobody loses subsidies.
* Court finds that the IRS has not accurately interpreted the law and subsidies for consumers in FFM states are found to be in violation of the law:
  * The court could eliminate subsidies immediately – retroactive is highly, highly unlikely;
  * The court could charge the IRS to modify the regulation and subsidies would end once the new regulation is implemented;
  * The court could eliminate the subsidies for the next tax year, giving IRS time to amend the regulation.

King v. Burwell: Possible Decisions

* Court finds that the law does not allow subsidies in FFM states, but also that such a law that applies the tax law differently by state is unconstitutional, and charges Congress to fix the law:
  * Subsidies could continue while Congress acts;
  * Could be a time limit after which all subsidies are eliminated

King v. Burwell: Possible Options for FFM States if Subsidies Eliminated

* Do nothing and wait for federal action.
* Become a State-Based Exchange:
  * Legislatively or by Executive Order (if allowed) create an entity that will act as the SBE.
  * Purchase an existing system from a State-Based Exchange, like CT or KY, or purchase the federal system, or develop own system (note: grant monies will not be available). Using an existing system would be most cost-effective as the development costs have already been covered by the federal government. This has worked well in NV and OR (federal system) and MD (CT system).
  * Perform the plan management, consumer assistance, and plan oversight functions (as most do now).
  * Have a plan for future funding of Exchange (may be some flexibility here).

Ongoing NAIC Health Insurance Committee Activities

* **Regulatory Framework Task Force**
  * Network Adequacy Model Review Subgroup
  * ERISA Working Group
* **Health Care Reform Regulatory Alternatives Working Group**

Regulatory Framework Task Force

* **Network Adequacy Model Review Subgroup** is working to revise the *Managed Care Plan Network Adequacy Model Review Model Act* (#74). Goal to complete no later than end of 2015.
* **ERISA Working Group** is working on a white paper considering the possible impact of small group self-insurance on the reformed marketplace. Finish by the end of 2015.

Health Care Reform Regulatory Alternatives Working Group

* **Health Care Reform Regulatory Alternatives Working Group** is looking at the 2017 ACA state innovation waiver process and has received testimony from states and outside groups that are considering waiver options.

Questions?

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