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CMS Benefit and Payment Rule: What is Success for the ACA?

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On Monday, CMS published a number of policies changing the dynamics of the individual market, including the Benefit and Payment Parameters for 2019 Final Rule, guidance on hardship exemptions, and a bulletin on transitional (grandmothered) plans. When interpreting all of these policies it's important to keep in mind the following: What is success? And who is defining it?

The Obama Administration managed ACA implementation with the clear intention of making sure the outcome met the goals of the law: more people covered, more choices of coverage for those people, and lower premiums. While the success of their efforts can be debated, the intention was always known.

For the Trump Administration, it is not necessarily clear how successful implementation of this next rule will be judged. Are they trying to maximize the number of people covered, maximize the number of choices available or lower premiums? What is the organizing principle? Is it as simple as providing additional regulatory flexibility?

There are two other stakeholders who also have to determine their definition of success in the face of this rule: states and insurers. For states, they will have to determine if and how they will use the additional flexibility granted to them under their rule. Insurers, with the loss of the individual mandate and CSRs, and the looming threat of STLDIs and AHPs, have to decide if the rule provides a stable environment for participation.

From now through the start of the next open enrollment period, we expect significant backstage drama as insurers, states, and the Administration answer these questions. The offerings and premiums available to Americans six days before the midterm elections depend on these decisions.

Now to the substance of the regulation …

We will start with essential health benefits (EHBs). Under the Benefits and Payment Final Rule, CMS is allowing states a variety of options to set EHB standards. CMS believes that this is an opportunity to increase state flexibility in how states select their EHB-benchmark plans. From the state perspective, this change grants them some flexibility to require fewer benefits to be covered in Marketplace plans, which could lower the costs of plans for consumers but ultimately provide less coverage. For some states, especially those with bare counties or those seeing rising premium costs, this could be an opportunity to bring lower cost plans to needed areas. However, it is important to note that this rule does not require states to change anything. States are still in control at setting the EHB-benchmark – they just have more choices to set the bar lower. It is likely that many states will continue their current benchmark levels. How insurers react will likely depend on what happens at the state level. Plan offerings will only change if the state chooses to make that decision.

Next up is the Navigator program. Under the Benefits and Payment Final Rule, CMS is removing the following requirements: 1) that each Marketplace have at least two Navigator entities, 2) that one of the Navigators entities be a community and consumer-focused nonprofit group, and 3) that each Navigator entity maintain a physical presence in the service area. From CMS's perspective, they drastically cut Marketplace Navigator advertising or outreach for plan year 2018 and there was not a significant change in enrollment. States also saw what happened despite limited funding for Navigators, and they watched grassroots groups take the lead in driving enrollment. This change can allow the provision of grant funding to groups that might not have been considered before. It can also can allow states to scale back their Navigator programs, which arguably may not be as useful as they were in the first few years of the ACA. However, insurers and consumer advocates will want Navigators to exist and be funded. They want people to have a stable and reliable place that they can go to get information regarding their coverage options.

Then there is the medical loss ratio (MLR). The ACA required plans on the individual market to spend at least 80% of income on actual patient care. The Benefits and Payment Final Rule will allow states to lower the MLR if they can prove that it will help stabilize the Marketplace. States could in theory argue that if they have limited plan options, lowering the MLR will bring more plans into the state. However, overall the Benefits and Payment Final brings us back to the place we were before the ACA. Depending on your perspective, is that a place you want to be?

On top of the Final Rule, CMS also issued guidance that expanded the Hardship Exemption, which allows individuals to basically be exempt from the individual mandate. So if you thought tax reform killed the individual mandate, CMS took an additional step to make sure the individual mandate is really dead. The Hardship Exemption was expanded to individuals who live in counties with no issuers or only one issuer, and those who live in areas where all plans cover abortion services.

And finally, we have the CMS Bulletin that extends transitional (or grandmothered) insurance plans for one more year (until December 31, 2019). These plans were intended to end in 2014, but were continued under Obama and now again under the Trump Administration. With STLDI and AHPs on the horizon and the changes in the Benefits and Payment Final Rule, the continuation of transitional plans is just one of the many options states, plans, and beneficiaries have to pick a non-ACA complaint plan.

We are beginning to find ourselves closer and closer to returning to the regulatory place we were a decade ago. How states make decisions regarding the flexibilities provided through these changes will not only drive distinct differences across states, but also drive insurer participation. How this all shakes out is not yet known. And what is a successful Marketplace depends on your perspective.