Setting the stage for the 2019 Health Insurance Marketplace

April 25, 2018

On April 9, 2018, the Centers for Medicare and Medicaid Services (CMS) issued new guidance for insurers offering Qualified Health Plan (QHP) coverage on the Health Insurance Marketplace created under the Affordable Care Act. In this guidance, CMS made several important changes intended to provide states with greater flexibility to regulate their individual and small group health insurance markets beginning in 2019.[1] This fact sheet describes the major provisions, as well as the anticipated implications for Michigan consumers.

Essential health benefits

Current rule	2019 rule	Implications
Under the current rule, QHPs must include coverage for 10 categories of services deemed Essential Health Benefits (EHBs). To determine coverage, states choose a benchmark plan from any of the following: • Any of the three largest state employee insurance plans by enrollment • Any of the three largest Federal Employees Health Benefits plans by enrollment • Largest commercial HMO plan by enrollment • Largest plan by enrollment in any of the three largest small group coverage options	The new rule provides states with greater flexibility in EHB benchmark plans. Starting in 2020, states can: • Use another state's EHB benchmark plan • Use certain categories of another state's benchmark plan • Choose a new benchmark plan comparable to a typical employer plan	The Michigan Department of Insurance and Financial Services (DIFS) has said that MI will continue to use its current EHB benchmark plan for 2019.[2] It is possible the state may determine a different EHB benchmark plan in 2020. Changes to the state's EHB benchmark plan could result in benefit and cost-sharing changes for consumers.

Health insurance navigators

Current rule	2019 rule	Implications
Local health insurance navigators provide outreach, education, and enrollment assistance for consumers who are trying to access Marketplace coverage. States receiving federal navigator funding must have at least two	Eliminates three navigator requirements: that each state must have at least two navigator entities, that one navigator entity must be a community and consumer-focused nonprofit, and that navigators must have a physical	These changes could result in fewer individuals being able to access in-person assistance from trained health insurance navigators, especially given recent reductions in navigator funding (in MI, federal funding for navigators decreased from

navigator entities, one a community and consumer-focused nonprofit, and navigators must have a physical presence in their service areas.	presence in their service areas. States will still be required to have at least one navigator, but it could be another type of entity (such as a trade association or chamber of commerce) and would not have to have a physical presence in the community it serves.	approximately $2.2 million in 2017 to $628,000 in 2018.[3]) At this stage, it is unclear whether Michigan will alter its navigator structure.

Maximum out-of-pocket limits

Current rule	2019 rule	Implications
The ACA set limits on consumer cost-sharing through deductibles, co-pays, etc. In 2018, the limit on out-of-pocket cost-sharing was $7,350 for individual coverage and $14,700 for family coverage.	Increases the limit on consumer cost-sharing to $7,900 (+$550) for individual coverage and $15,800 (+$1,100) for family coverage.	The 2019 rule increases maximum out-of-pocket cost-sharing by 7%. While these cost-sharing limits have increased every year since the Marketplace was launched, 2019 represents the largest increase since 2014.

Standardized plan options

Current rule	2019 rule	Implications
Healthcare.gov began offering "Simple Choice" standardized plan options in 2017. These plans are based on a standard cost-sharing structure with similar deductibles, co-pays, and co-insurance. In addition, some services covered by these plans were not subject to a deductible. The simple-choice options, highlighted on the Healthcare.gov page, were intended to make it easier for consumers to compare plans.	Eliminates the simple choice standardized plan options.	CMS's rationale is that highlighting simple choice plans on its website discourages enrollment in non-standardized plan options and that insurers will be more likely to develop innovative benefit designs under this change.[4]

Rate increase reviews

Current rule	2019 rule	Implications
Proposed rate increases that exceed 10% must be reviewed by state or federal regulators. Insurers are required to justify premium increases exceeding this threshold, and consumers are given an opportunity to comment on the proposed increases.	Increases the threshold for justifying rate increases to 15%.	In 2018, insurers in MI proposed an average 26.9% premium increase for individual market plans, and 83 plans proposed rate increases of 10% or higher.[5] This change would lead to fewer reviews of proposed rate increases.

Medical loss ratio (MLR)

Current rule	2019 rule	Implications
In the individual market, insurers must spend 80% of their premium revenue on health care and quality improvements. If insurers do not meet this threshold, they are required to rebate the difference to consumers.	Allows insurers to automatically claim a percentage of premium revenue as quality improvement expenses. Allows states to lower the medical loss ratio (MLR) threshold if they demonstrate that doing so would stabilize their individual markets.	CMS estimates that automatically claiming a percentage of premiums as quality improvement expenses will result in a $23 million decrease in MLR rebate payments to consumers. In addition, CMS expects 22 states will request an adjustment to their MLR thresholds, decreasing MLR rebates by $52-$64 million annually.[6] In 2016, almost 32,000 MI consumers received approximately $2.3 million in individual market MLR rebates.[7]

Risk adjustment

Current rule	2019 rule	Implications
The ACA established a permanent federal risk adjustment program to transfer funds from insurers with lower-than-average risk enrollment to insurers with higher-than-average risk enrollment. The program was intended to	Adjusts the models used to determine risk adjustment payments and allows states to reduce the amount insurers must pay into the program by 50%.	In the rule, CMS states that new and small insurers owed substantial and largely unanticipated risk adjustment payments. According to CMS, providing states with flexibility to limit the amount insurers must pay into the program

discourage insurers from enrolling only healthy individuals.		could help small insurers remain in the individual market.

Silver loading

Current rule	2019 rule	Implications
Insurers offering Marketplace coverage were required to reduce cost-sharing expenses for individuals earning less than 250% of the federal poverty line who enroll in silver Marketplace plans (where insurers pay an average of 70% of costs and consumers pay an average of 30%). Initially, the federal government reimbursed insurers the cost of these reductions, but these federal payments were discontinued in 2017. After 2017, insurers in many states increased premiums on silver Marketplace plans in order to compensate for the lost revenue, a practice referred to as "silver loading."	While this issue was not addressed in the 2019 payment rule, CMS is reportedly reviewing the practice of "silver loading" and could make changes for future years.[8]	For 2019, MI has counseled insurers to continue the silver loading practice.[9] This strategy insulates low- and moderate-income consumers from insurance premium rate increases and allows other consumers to enroll in a lower-priced, but otherwise identical, off-Marketplace silver plan. In 2018, silver plans accounted for 54 percent of plan selections in MI.

Individual mandate hardship exemptions

Current rule	2019 rule	Implications
Individuals can apply for hardship exemptions from the individual mandate penalty if they meet certain criteria. Individuals with hardship exemptions can qualify for catastrophic coverage offered on the Marketplace. With the individual mandate penalty repealed starting in 2019, hardship exemptions will primarily be used to qualify for catastrophic coverage.	Expand hardship exemptions to those who: • Live in an area with no Marketplace insurers • Live in an area with only one Marketplace insurer • Live in an area where the only available Marketplace plans cover abortion • Have personal circumstances preventing them from obtaining coverage	If more individuals choose to apply for hardship exemptions under the expanded rules, that could result in decreased overall Marketplace enrollment, or an increase in catastrophic coverage enrollment. However, in MI these effects may be limited. In 2018, every county in the state had at least two carriers offering Marketplace coverage. In 2018, catastrophic

Catastrophic plans cover essential health benefits and certain preventive services, but have very high deductibles ($7,350 in 2018).		coverage accounted for just 1% of plan selections in MI.

Projected premium and federal spending changes

On April 9, 2018, the Congressional Budget Office (CBO) released an updated economic report for 2018 through 2027.[10] In this report, the CBO projects that premiums for on-Marketplace silver plans will increase by an average of 34% in 2018, reflecting the widespread adoption of "silver loading" following the termination of federal payments for cost-sharing reductions. As a result of these premium increases, federal spending on premium tax credits is expected to increase by an estimated $10 billion in 2018 and $44 billion over the 2018-2027 period. At the same time, the CBO projects lower federal spending on premium tax credits as a result of the repeal of the individual mandate penalty under the Tax Cuts and Jobs Act. The CBO believes fewer people will enroll in Marketplace coverage following the repeal of the individual mandate. Some individuals will drop coverage in the absence of a financial penalty, while others will drop coverage in the face of higher premiums. Lower enrollment will lead to a projected $206 billion decrease in federal spending on premium tax credits from 2018 to 2027. The CBO plans to provide more detailed estimates in a future report.

Timeline for 2019 filing process in Michigan

On March 22, 2018, the Michigan Department of Insurance and Financial Services (DIFS) published its timeline for the 2019 QHP filing and review process.[11] 2018 dates for major milestones are described below.

June 14	Aug. 1	Aug. 22	Sep. 25	Oct. 5	Nov. 1-Dec. 15
Deadline for insurers to file individual market products and rate changes with DIFS	Target date for DIFS to publish proposed rate increases	Deadline for insurers to make changes to plan applications	Deadline for DIFS to send final recommend-ations to CMS	CMS sends final plan certification notices to insurers	**2019 Open Enrollment Period**

ENDNOTES

[1] "Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2019," 45 C.F.R. parts 147, 153, 154, 155, 156, 157, and 158 (Apr. 9, 2018): https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-benefit-and-payment-parameters-for-2019

[2] 2019 Form and Rate Filing Requirements for Medical Plans," Michigan Department of Insurance and Financial Services, Mar. 22, 2018: http://www.michigan.gov/documents/difs/Bulletin_2018-07-INS_618366_7.PDF

[3] K. Pollitz, J. Tolbert, and M. Diaz, Data Note: Changes in 2017 Federal Navigator Funding, Kaiser Family Foundation, Oct 2017: https://www.kff.org/health-reform/issue-brief/data-note-changes-in-2017-federal-navigator-funding/

[4] "Patient Projection and Affordable Care Act: Benefit and Payment Parameters for 2019."

[5] "2018 Michigan Health Insurance Rate Change Requests," Michigan Department of Insurance and Financial Services, Oct. 25, 2017: http://www.michigan.gov/documents/difs/2018_Rate_Changes_599575_7.pdf
[6] "Patient Projection and Affordable Care Act: Benefit and Payment Parameters for 2019."
[7] "Summary of 2016 Medical Loss Ratio Results," Centers for Medicare and Medicaid Services, Dec. 28, 2017: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Medical_Loss_Ratio_2016_Annual_Report.pdf
[8] A. Lotven, "Verma: Silver-Loading Policy 'Under Review' at CMS," *Inside Health Policy*, Apr. 9, 2018: https://insidehealthpolicy.com/daily-news/verma-silver-loading-policy-under-review-cms
[9] "2019 Form and Rate Filing Requirements for Medical Plans."
[10] "The Budget and Economic Outlook: 2018 to 2028," Congressional Budget Office, Apr. 9, 2018: https://www.cbo.gov/publication/53651
[11] "2019 Form and Rate Filing Requirements for Medical Plans."

Suggested Citation: Foster Friedman, Megan; Baum, Nancy; Udow-Phillips, Marianne. *Setting the stage for the 2019 Health Insurance Marketplace* (Ann Arbor, MI: Center for Healthcare Research & Transformation, 2018)