Memo to the Biden Administration Transition Team

From: Trish Riley, National Academy for State Health Policy Executive Director
Re: State-based marketplace strategies for insurance market stabilization and improvement
Nov. 20, 2020

The National Academy for State Health Policy (NASHP), in close consultation with executives from state-based health insurance marketplaces (SBMs), has developed a list of priority actions that may:

- Lower costs and bring stability to individual and small group health insurance markets;
- Improve access to health insurance coverage; and/or
- Improve consumer experience when purchasing small group or individual market coverage.

NASHP is home to the State Health Exchange Leadership Network, a consortium of state leaders and staff dedicated to operation of the SBMs. This list draws upon the experience of SBM leaders who have spent the past decade building and operating successful platforms for the procurement of health insurance coverage.

These recommendations reflect NASHP's collective discussions with SBM leaders, but do not reflect consensus across all SBMs. States value flexibility to design their programs to meet local needs and circumstances. For additional information specific to each state, please see Appendix A, which includes references to comments submitted by SBMs in response to various policy changes. We have also included the contact information for SBM executives who can provide additional information specific to their states.

NASHP is ready to provide any additional information that may be helpful as you deliberate critically important issues related to health care coverage. Thank you for your time and consideration.

Sincerely,

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State-Based Marketplace Recommended Areas for Priority Administrative Action in 2021

I. Issues of Greatest Urgency

The following issues invite immediate attention to mitigate significant negative effects on consumers or insurance markets in 2021; and/or reverse regulations or administrative actions that have yet to be fully implemented but are slated for effectuation in 2021.

Internal Revenue Service Flexibility on Reconciliation

Summary

Advanced premium tax credits (APTCs) are delivered to enrollees based on their estimated income for the year they will be covered. Traditionally, this is based on the historic income data of the individual or household applying for coverage.

Employment, income, and other household disruptions caused by the COVID-19 pandemic will lead to extreme difficulty in enrollees' ability to predict income for the foreseeable future. This unpredictability is exacerbated by the inconsistent, and time-limited provision of federal financial assistance, including the temporary enhanced unemployment insurance provided under the CARES Act and the August 2020 presidential order providing for additional temporary benefits. Federal assistance programs further complicate accurate calculations, in part due to discrepancies in how supplemental unemployment income is counted toward different federal programs, including APTCs and Medicaid.

The difficulty predicting income means that taxpayers who receive APTCs risk substantial unexpected tax liability when reconciling income and APTCs received during the tax year.

Proposed action

- Immediate action by the Treasury Department and Internal Revenue Service (IRS) to provide the maximum relief possible related to reconciliation of APTC for the 2020 and 2021 tax years. This includes a complete exemption from financial liability incurred because of income miscalculations.

Access to Coverage for Qualified Immigrant Populations

Summary

Federal rules finalized in September 2019 significantly expanded the list of non-cash public benefit programs that the Department of Homeland Security (DHS) can consider in its public charge determinations to include Medicaid for certain immigrants seeking permanent citizenship status.

Proclamations issued in 2019 imposed additional barriers on immigrants including requiring proof of insurance and reinforcing requirements that immigrant sponsor financial benefits be included as part of calculations for immigrants seeking benefits.

Implementation of these policies has had a chilling effect on legal immigrants seeking services for which they are qualified, including subsidized coverage through the health insurance marketplaces even though receipt of APTC is not considered a public benefit under public charge criteria. Immediate action is needed to prevent further uncertainty among individuals and families who qualify for coverage assistance.

Under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), most qualified, legally residing immigrants are subject to a five-year waiting period (known as the five-year bar) before they are eligible to enroll in Medicaid.
Under the ACA, health insurance marketplaces are able to offer benefits, including APTCs as soon as an immigrant is deemed "lawfully present". In this case, the marketplace may be able to extend benefits to low-income individuals who otherwise may have qualified for Medicaid, including immigrants below 100 percent of the federal poverty level (FPL).

Proposed action:

- Immediate repeal of the public charge rule.
- Immediate consideration of policies or programs to support outreach to and coverage of qualifying immigrant populations.
- Reconsider policies to enable access to coverage for immigrant populations.

Relevant regulations and guidance

- Inadmissibility on Public Charge Grounds, August 2019
- Memorandum on Enforcing the Legal Responsibilities of Sponsors of Aliens, May 2019
- Presidential Proclamation on the Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System, October 2019
- Notice of Information Collection Under OMB Emergency Review: Immigrant Health Insurance Coverage, October 2019

Reversal of the 1557 Nondiscrimination Regulations

Summary

Section 1557 of the ACA prohibits discrimination on the bases of race, color, national origin, sex, age, and disability for any health program which receives federal financial assistance or is administered by a federal agency under the ACA.
A rule issued by the Office of Civil Rights in June 2020 significantly revised anti-discrimination protections, eliminating essential protections against discrimination on the basis of sex, including protections related to gender identity and sexual orientation, directly harming members of the LGBTQ community and women.
The rule also removed previously existing requirements aimed at bolstering language accessibility of notices, as well as compliance requirements for grievances related to 1557 violations.
The rule dramatically scaled back how non-discrimination protections apply to health insurance carriers.
Several court cases have been brought forward against the changes made under the June 2020 rule. As of September 2020, a federal district court has issued a preliminary injunction against the rule, giving opportunity to rescind the rule prior to its full implementation.

Proposed action

- Immediately rescind the June 2020 regulations. Reinstate regulations governing interpretation of 1557 protections issued in May 2016.
- Issue updated guidance with further clarity on definition of sex and gender as applied to non-discrimination protections.

Relevant regulations and guidance

- Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, June 2020
- Nondiscrimination in Health Programs and Activities, May 2016

Rescind the "Double-Billing" Requirement for Non-Hyde Abortion Services

Summary

A December 2019 rule requires insurers to send a separate bill to account for premiums related to non-Hyde abortion services. The bill must be separate and distinct from the normal monthly premium bill received by a consumer.

The rule also requires that consumers pay premiums for non-Hyde coverage separately, rather than in one aggregated payment that insurers split on the backend.

Cost to implement this additional billing procedure is estimated to be hundreds of millions of dollars per year.

The provision was originally slated to be implemented in June 2020. However, regulations are currently pending litigation, which has delayed implementation of the billing requirement.

Proposed Action

- Repeal regulatory language requiring double billing for non-Hyde abortion services.

Relevant regulations and guidance

- Patient Protection and Affordable Care Act; Exchange Program Integrity, December 2019

Prohibition of Arrangements Created under the Data Marketing Partnership Case

Summary

A federal district court in Texas overturned a US Department of Labor (DOL) Advisory Opinion to allow a data-mining company to establish a single employer group health plan for individuals whose only relationship with the business is an agreement to share their internet activity. This decision overturns decades of DOL standards used to determine what entities are single employer plans under the Employee Retirement Income Security Act (ERISA). This decision will allow for the proliferation of fraudulent entities acting as unlicensed insurance companies.

This decision goes even further than regulations issued in 2018 that provide flexibility to allow for greater flexibility on the formation of association health plans (AHPs). The court held that Data Marketing Partnership is a single employer plan, raising ERISA preemption concerns.

If allowed to stand, this would result in the proliferation of fraudulent group health plans that can raise ERISA preemption to challenge any attempt at state regulation. This decision would also allow these entities to cherry-pick healthy risk from the individual and small group markets, which would result in rising premiums, market destabilization and possibly market exit.

Proposed action

- If consistent with the Final Order, DOL will issue regulations codifying standards set forth in Advisory Opinion 2020-01A.

- If regulations are not possible in light of the Final Order, seek legislative correction.

Relevant regulations and guidance

- September 28, 2020 Final Judgment, Data Marketing Partnership v. U.S. Department of Labor
- U.S. Department of Labor, Employee Benefits Security Administration, Advisory Opinion 2020-01A January 24, 2020
- Definition of "Employer Under Section 3(5) of ERISA—Association Health Plans, June 2019

Reporting of State-Mandated Benefits in Addition to Essential Health Benefits (EHBs)

Summary

Federal law requires that health insurance plans sold in the individual and small group markets cover all EHBs. States may impose benefits requirements in addition to the federal EHB requirement.

To insulate the federal government from increased expenditures on health insurance subsidies, which are calculated based on the cost of insurance premiums, states must defray the cost of any state-mandated benefits issued after Dec. 31, 2011.

Regulations issued in May 2020 sets a new requirement for states to submit an annual report on their state-mandated benefits. The first reports are supposed to be issued in July 2021.

The requirement imposes excessive reporting burden on states, especially as no evidence has been provided to assert the need for enhanced oversight of and reporting by states.

Proposed Action

Rescind annual reporting requirements regarding state-mandated benefits before July 2021 deadline.

Relevant regulations and guidance

- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, May 2020

Additional Special Enrollment Periods (SEPs) Responsive to Loss of Employment or Income

Summary

Under currently available SEPs, an individual may enroll in marketplace coverage if they experience loss of minimum essential coverage (MEC), including MEC offered by an employer. However, there is no SEP specific to job loss.

There is also no SEP available related to a change in income, unless the individual was already enrolled in MEC.

Considering the potential for rapid changes in employment and income exacerbated under the COVID-19 pandemic and economic crisis, more flexibility is necessary to ensure the consumers are able to access the coverage they may need.

Proposed Action

- Enact new SEPs specific to consumers who experience job-loss and/or change in income.
- Maintain flexibility so that SBMs may implement SEPs relevant to the needs of their markets and consumers.

II. Issues of High Priority

The following actions may have the greatest impact on improving insurance markets, access to coverage, and/or consumer experience when shopping for coverage.

Simplifying Eligibility

Encourage alignment of eligibility between coverage programs including APTCs/CSRs and Medicaid

Summary

The health insurance marketplaces are designed to provide a seamless eligibility and enrollment experience to all consumers regardless of coverage program.

Discrepancies in how eligibility is determined between programs causes significant challenges in fostering a seamless consumer experience and spurs confusion, especially for vulnerable populations at the cusp of eligibility.

Proposed action

- Leverage maximum flexibility wherever possible related to regulatory changes to eligibility calculations or processes to promote greater alignment between programs.

Eliminate the Family Glitch

Summary

Individuals may not qualify for APTCs if their employers offer "affordable" coverage. The individual's spouse and dependents are barred from qualifying for APTCs if they are eligible to enroll in the individual's employer-sponsored insurance (ESI).

Affordability of coverage is based on an "employee's required contribution," meaning the employee's share of the cost of the employer plan cannot exceed 9.78 percent of the employee's household income.

Legislative language stipulates that the "required contribution" for the employee be based on the cost of self-only coverage, there is no consideration of how affordability may change if individuals must purchase coverage for their dependents. The addition of dependent coverage usually incurs a significant increase in monthly premium expenses, meaning the employer coverage may not actually be affordable for the household.

The affordability of employer coverage affects not only eligibility for the APTC but also a potential exemption from the individual mandate. Even though the same statutory definition of "required contribution" is referenced for both purposes, currently adopted regulations have set one interpretation of the meaning of "required contribution" for determining affordability of

employer coverage for the APTC and a different interpretation for the exemption from the individual mandate. For purposes of this individual mandate penalty exemption, the required contribution for spouses and dependents is based on family premiums.
It is possible that the regulatory interpretation of required contribution for the APTC could be revised to look to the family premium for purposes of determining the affordability of employer coverage.

Proposed action

- Without a clear legislative fix to encourage revision of the employer affordability standard, the federal government could utilize regulatory interpretative authority to apply the standard of the required contribution used for the individual mandate to employer affordability.

Amend the Annual Premium Adjustment Percentage Measure

Summary
The annual premium adjustment percentage is a measure of insurance premium growth used to set the annual limit on cost-sharing, penalties under the employer mandate, and required contribution percentages to qualify for eligibility exemptions.
The premium adjustment percentage had been calculated based on premiums for insurance sold in the employer-sponsored market as reported in the National Health Expenditure Account.
In 2020, the Centers for Medicare & Medicaid Services (CMS) adopted a new method that factors in premiums from the individual market.
The change resulted in increases in allowable out-of-pocket spending, and higher premium contributions from consumers before being eligible for eligibility exemptions.

Proposed action
Revert to methodology used prior to 2020.

Relevant regulations and guidance

- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, April 2020)

No Modifications that Lower the Poverty Threshold

Summary
In May 2019, the Office of Management and Budget (OMB) solicited comments on standards used to calculate the Official Poverty Measure (OPM).
OPM is critical for determining eligibility for benefits including APTCs and Medicaid.
The request included a proposal to use a lower measure of inflation when calculating OPM. Specifically, the proposal suggests changing the measure from the Consumer Price Index for All Urban Consumers (CPI-U) to either the Chained Consumer Price Index (C-CPI) or the Personal Consumption Expenditure Price Index (PCEPI). Both of the latter indexes use a more conservative estimate for inflation growth from year-to-year, calculations which may not fully reflect the disproportionate effects of inflation on lower-income households. The change to either of these methods could put hundreds of thousands of individuals at risk of losing benefits.

Proposed action

- No changes to the OPM that would lower poverty thresholds and/or reduce eligibility for coverage programs.

Relevant regulation and guidance

- Request for Comment on the Consumer Inflation Measures Produced by Federal Statistical Agencies, May 2019

Increasing Affordability

Maintain state flexibility over response to the elimination of federal cost-sharing reduction (CSR) payments

Summary

The CSR program mandates that insurers cover cost-sharing for consumers between 100-250% FPL who purchase silver-plans through the marketplace.
In October 2017, the Administration ceased providing federal reimbursement to cover costs of CSR expenditures.
Several states directed issuers to "load" the financial losses into silver-level plans (silver loading), leading to significant increases in premiums for silver-level benchmark plans used to calculate APTC.
Resulting increases in APTC led to greater affordability for consumers who qualify for the tax credits.

Proposed action

- Maintain state flexibility over insurer response to elimination of CSR funding, including ability to mandate "silver loading."
- Revisit APTC calculations if CSR funding is reinstated to ensure coverage remains affordable to those that otherwise had benefitted from APTC increases.

Relevant regulation and guidance

- 2017 Memo eliminating CSR payments to insurers

Reducing Market Segmentation

Limits to Short-term, Limited Duration Plans

Summary

Short-term, limited duration plans (short-term plans) are alternative, limited benefit, coverage options, largely designed to be a temporary solution for consumers who experience gaps in coverage.
Short-term plans are exempt from the federal requirements placed on health insurance coverage including pre-existing condition protections, required benefit offerings, and caps on consumer out-of-pocket spending.

Regulations codified in August 2018 enabled widespread availability of short-term plans by extending the allowable duration of these plans from 3 months to 364 days, allowing for the renewability of plans up to 36 months.
Availability of these products drive consumers out of the individual market risk pool, increasing premium costs and leaving consumers vulnerable to financial risk in the case they do need comprehensive health services.

Proposed action

- Maintain maximum state flexibility to regulate and impose limits on short-term plans.
- Restore regulations limiting short-term plan duration to a period of three months and prohibit their renewability.
- Enforce transparency requirements to ensure that short-term plans clearly communicate their limitations to consumers.

Relevant regulation and guidance

- Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited Duration Insurance, October 2016

Association Health Plans (AHPs)

Summary

Regulations issued by the DOL in June 2018 revised requirements to promote the proliferation of AHPs. Specifically, the regulations overturn long-established prior restrictions on AHPs to allow for:

- AHPs to operate as unregulated health insurance companies, many of which do not meet ACA coverage standards;
- Formation of AHPs for the primary purpose of procuring health insurance; and
- Formation of AHPs by single employers.

AHPs are not subject to many of the ACA's requirements on health insurance, including the requirement to offer EHBs. This enables AHPs to offer less comprehensive coverage to their enrollees and to manipulate benefit design to discourage enrollment by consumers considered high risk. AHPs are not subject to the rating rules applicable in the individual and small group markets, meaning they can charge more based on gender, group size, industry, and age (without restrictions).
Availability of these products drive consumers out of the individual and small group risk pools, increasing premium costs and leaving consumers vulnerable to financial risk in the case they do need a comprehensive health plan. They also may lead to risk of market destabilization in individual and small group markets, including premium increases and health insurance carrier exits.
AHPs have a long history of fraud and insolvencies, creating unnecessary risk for consumers and state regulators alike.
These regulations are currently under injunction, but the District Court's decision is currently on appeal. An adverse decision from the appeals court could result in the rapid proliferation of unlicensed insurance carriers.

Proposed action

- Increase regulations and oversight to restrict formation of associations especially to exclude associations that may engage in discriminatory practices and or adversely impact insurance markets (e.g., associations that may target only low market risk populations.
- Remove regulations that allow for formation of associations primarily for the purpose of procuring health insurance.
- Restatement of current state authority to regulate AHPs, including requirements that AHPs be licensed, meet solvency requirements, and meet requirements for plan design.

Relevant regulation and guidance

- Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, June 2019

Limiting Exemptions Allowed to Opt-Out of Contraceptive/Abortion Coverage

Summary

Regulations issued in 2018 expand ability for entities and individuals to be exempted from the ACA's requirements to offer contraceptive coverage as part of health insurance benefits. Entities that could be exempt include non-governmental employers, not-for-profits, non-governmental institutions of higher education, insurers, and individuals with sincerely held religious objections to all or a subset of contraceptives or related patient education.
Previous exemptions had applied only to churches and similar religious organizations.

Proposed action

- Repeal 2018 regulations.

Relevant regulation and guidance

- Moral Exemption and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, November 2018
- Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, November 2018

Consumer Protections

Meaningful Difference Standards for Qualified Health Plans (QHPs)
Summary

In order to reduce consumer confusion, and streamline choice, HHS required that health plan offerings be "meaningfully different" in order to be certified as QHPs.
For a plan to be considered meaningfully different a "reasonable" consumer must be able to identify one or more material differences between the plan and any other sold through the marketplace.
Regulations issued in May 2020 eliminated meaningfully different requirements for plans sold through the marketplaces, allowing for the proliferation of extremely similar or duplicative insurance products.

Proposed action

- Reinstate meaningfully different standards to reduce the potential for duplicative plans and increased consumer confusion.

Relevant regulations and guidance

- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, May 2020

Supporting State and Administrative Flexibility

1332 Waiver Guidance

Summary

1332 waivers allow states to waive any or all requirements related to the ACA's regulation of insurance plans, health insurance marketplaces, APTC and CSR programs, and coverage purchasing requirements.

Although 1332 waivers may directly affect other programs (including Medicaid), budget requirements do not allow for coordination of Medicaid 1115 waivers and 1332 waivers.

Legislatively established guardrails mandate that waiver changes can only be made as long as the coverage provided would be as comprehensive and affordable as that available under the ACA and that a comparable number of individuals would be covered. Additionally, waivers may not lead to an increase in the federal deficit.

Changes promulgated in October 2018 change the interpretation of the guardrails to allow for adoption of options that to not meet minimum essential coverage (MEC) standards including short-term plans and health sharing ministries.

The changes also alter how states may consider trade-offs in affordability and coverage standards, meaning that options made available through the waiver may not necessarily be as comprehensive or affordable for some populations as they might have been under the ACA.

Proposed action

- Rescind 2018 guidance on 1332 waivers, and reinstate prior interpretation requiring that all coverage be as accessible, affordable, and comprehensive under the waiver as required under the ACA.
- Increase flexibility over budget calculations to enable states to coordinate 1332 and 1115 waivers.
- Continue expedited processes for applications that follow a similar framework to previously approved waivers.
- Allow for budget neutrality over a period of years, rather than strictly over the specific course of the waiver, or year-by-year.
- Ease administrative processes related to requesting 1332 funding renewals and extensions.
- Issue guidance clarifying that if, at the end of a 1332 waiver, there are unspent 1332 waiver pass-through funds and the waiver is renewed/extended, the pass-through funding may be rolled forward to be used during the renewal/extension period.

Relevant regulations and guidance

- State Relief and Empowerment Waivers, October 2018
- Centers for Medicare or Medicaid Services, Section 1332 State Relief and Empowerment Waiver Concepts Discussion Paper, November 2018

III. Issues of Moderate Priority

The following policies may help support or improve health insurance markets, access to coverage, and/or consumer experience when shopping for coverage, but could be addressed over an extended timeline, including changes that could be incorporated into the next Notice of Benefit and Payment Parameters (the annual rule governing individual and small group health insurance plans).

Increasing Affordability

Clarity over options related to use of health reimbursement arrangements to purchase marketplace coverage (QSEHRAs and ICHRAs)

Summary

Under current law, most health reimbursement arrangements (HRAs) are considered group health coverage, limiting the ability of employers to offer HRAs that do not include comprehensive health insurance coverage.

The Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) enacted under the 21st Century Cures Act allows employers with fewer than 50 employees to pay into an employee health reimbursement arrangement (the QSEHRA). The QSEHRA does not qualify as group coverage, and funds from the QSEHRA can be used to purchase health insurance coverage through the individual market.

In June 2019, a new option was created for employers to offer an HRA in a way that can be integrated with coverage sold on the individual market (ICHRA). Money available through an ICHRA can be used to pay for health insurance premiums.

Employees who are offered an affordable ICHRA are prohibited from receiving APTCs. In some cases, employees would have received more affordable coverage if they remained eligible for APTCs rather than being offered the alternative HRA program. Employees who are offered an affordable QSEHRA have their APTC eligibility reduced, often to zero, by the amount of the QSEHRA.

Complicated eligibility rules and a lack of support tools may lead to confusion and imperfect decisions by employers and employees regarding what coverage options are best.

Proposed action

- Develop comprehensive tools to help consumers and employers assess the risks and benefits of adopting QSEHRAs or ICHRAs. Include enhanced education about financial trade-offs as well as limitations to benefit offerings or other consumers protections.
- Tighten oversight over requirements that ICHRA and QSEHRA recipients enroll in compliant insurance coverage.
- Revisit policies to enable receipt of modified APTCs in cases where money made available through the ICHRA would not make health plans sufficiently affordable.

Relevant regulations and guidance

- Health Reimbursement Arrangements and Other Account-Based Group Health Plans, June 2019

Flexibility to Enroll in Plans across Metal Levels

Summary

Current rules place restrictions on which health plans a consumer may choose when qualifying for a special enrollment period (SEP). Specifically, the rules:

- Restrict enrollment in anything except an enrollees' current QHP when a dependent is added through an SEP
- Only allow for enrollment in a plan of the same metal level if a current enrollee qualifies for an SEP.

By limiting movement to other metal levels, the rules aim to restrict possible "gaming" by enrollees who may attempt to move into higher metal levels only in response to a mid-year change in coverage need.

However, restricting options may lead consumers to enroll in plans that may not meet their needs given the change in circumstance that triggered the SEP.

By restricting consumer options, the regulations may prohibit enrollment into a health plan with different cost-sharing, provider networks, benefit design, or other qualities that may be better suited to the needs of the consumer. This is especially true when the circumstance triggering the SEP is also associated with a change in income, geographic location, or family structure.

Greater flexibility to allow for enrollment across plan options better enables consumers to enroll in health insurance plans best suited to their needs.

Proposed action

- Rescind regulations that limit enrollment options for consumer enrolling through an SEP.
- Promulgate new regulations to maximize availability of appropriate options to consumers who enroll during an SEP.

Relevant regulations and guidance

- Patient Protection and Affordable Care Act; Market Stabilization, April 2017
- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Adjusting Actuarial Value Calculators to Allow Greater Flexibility for the Sale of Bronze Plans

Summary

Plans sold through the health insurance marketplaces must meet a certain actuarial value (AV), the calculation used to estimate likely out-of-pocket spending a consumer may face if they opt to purchase that plan. AV is used to sort plans into one of four metal tiers—bronze, silver, gold and platinum.

Each year, CMS releases a modified calculator used to assess the AV of health insurance plans. The calculator is developed based on national data on cost-sharing and utilization available from commercial health insurance.
Changes in both market conditions and how AV is calculated have placed excessive strain on the ability of health insurers to offer bronze plans within the full range of AV acceptable for bronze, meaning insurers are limited to offering plans at the highest AV possible for bronze. It is possible if cost trends continue, it may not be at all feasible for insurers to offer any plan at the bronze-level.
Bronze plans offer the lowest monthly premiums for many consumers and are especially popular among the "young invincible" population. Elimination of bronze plan options may deter many from enrolling in marketplace coverage.

Proposed action
Reevaluate the annual AV calculator to enable greater flexibility for bronze offerings.
Explore regulatory levers to open flexibility for additional bronze offerings through the marketplaces.

Relevant regulations and guidance
- Letter from the Center for Medicare and Medicaid Services on the Final 2021 Actuarial Calculator Methodology, March 2020

Consumer Protections

Reinstate guaranteed issue protections for individuals who lose coverage due to non-payment of premiums.

Summary
Under the ACA, health plans are required to enroll all individuals regardless of health status or other factors that may be relevant to predicting a persons' use of health services (guaranteed issue).
Rules issued in April 2017 included language clarifying that insurers could prohibit new enrollments by individuals who owe past-due premiums in both the individual and small group markets.
The change serves as a de facto exemption to guaranteed issue in the case of non-payment. It also imposes barriers to coverage especially in markets with only one available insurer.

Proposed action
- Rescind preamble text allowing insurers to prohibit enrollments in the case of non-payment of past-due premiums.

Relevant regulations and guidance
- Patient Protection and Affordable Care Act; Market Stabilization, April 2017

Stricter Oversight of and Requirements for Direct Enrollment Entities

Summary

In 2017, new regulations granted greater flexibility for a direct enrollment (DE) pathway, enabling consumers to determine their eligibility for coverage through certified, third-party websites.
Additional regulations promulgated in 2019 imposed standards on DE entities and enabled the ability of insurers to participate as DE entities.
Since implementation of these regulations, the number of direct enrollment entities has increased exponentially—all but 7 of the current DE entities are insurers.
DE entities are not required to display all available plans sold through the marketplace, nor are they required to display comparable information about each plan. Their platforms may provide consumers with incomplete or biased information about available options, leading consumers to select coverage that may not be best suited to the consumer's needs.

Proposed action

- Set stricter standards for DE entities to prohibit participation by entities that may actively direct consumers to imperfect coverage options, or biased information.
- Set higher standards for consumer-choice architecture to ensure that consumers receive information appropriate to their needs and priorities, rather than those of the direct enrollment entity.
- Set stricter oversight requirements on direct enrollment entities to ensure they are meeting and maintain standards set in place related to plan display, and education regarding available insurance options.

Relevant regulations and guidance

- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, April 2019
- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, May 2020

IV. Other Notable Issues

The following actions may serve to improve markets and consumer experience with purchasing health insurance, but do not require immediate action.

Reducing Market Segmentation

Limit other non-compliant products including healthcare sharing ministries and direct primary care arrangements

Summary

A 2019 executive order proposed increasing tax advantages for two types of products, direct primary care arrangements and health sharing ministries. Both are considered by some an alternative to traditional insurance coverage, yet only provide limited benefits.
Such alternatives may draw individuals out of insurance markets, while not offering many consumer protections including financial protections.

Proposed action

- Rescind orders that may lead to promulgation of insurance alternatives.

Relevant regulation and guidance

- Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First, June 2019
- President Donald J. Trump Is Implementing His America First Healthcare Agenda, September 2020

Limit Wellness Program Incentives

Summary

Actions taken under this current administration have encouraged promulgation of wellness programs in the individual market.
A state demonstration program was announced in September 2019 to develop wellness programs that grant incentives to individual who achieve health outcomes (such as lower premiums).
Rules issued in May 2020 allow for greater flexibility in counting wellness costs as part of allowable quality improvement activities that may be factored into medical loss ratio (MLR) calculations.
Evidence has not shown significant benefits to attest to the effectiveness of wellness programs.
Wellness programs risk imposing discrimination on individuals based on health status.

Proposed action

- Revise/ limit allowable consideration of spending on wellness programs as part of MLR calculations.
- Limit promulgation of wellness programs and incentives offered by health insurers. Promote evidence-based practices for effective and efficient benefit requirements and offerings.

Relevant regulations and guidance

- Centers for Medicare and Medicaid Services Bulletin: Opportunity for States to Participate in a Wellness Program Demonstration Project to Implement Health-Contingent Wellness Programs in the Individual Market, September 2019

Consumer Protections

Improve Consumer Access to 1095-B and 1095-C Forms

Summary

1095-B and C forms are issued to individuals to document proof of insurance coverage.
Forms are issued by health insurers or employers (for businesses with less than 50 full-time employees).
The primary purpose of the form was to establish proof that consumers met MEC and are in compliance with the federal individual shared responsibility payment.

Congressional elimination of the responsibility payment has diminished the federal necessity of 1095-B and C forms. However, the forms are still a critical means for states to identify individuals with MEC. This is especially important for states that have implemented their own individual responsibility requirement.

Proposed action

- Continue requirements for insurers and employers to issue 1095-B and C forms in a timely and comprehensive manner.
- Ensure that forms are provided in an easily accessible manner to individuals including provision by mail, or through online portals available from insurers and employers.
- Continue to allow SBMs to provide 1095-Bs electronically upon request.

Relevant regulations and guidance

- Internal Revenue Service Notice 2020-76, Transition Relief Related to Health Coverage Reporting Required by Sections 6055 and 6056 for 2020

Supporting State and Administrative Flexibility

Preserve Historical Documentation and Data

Summary

A 2020 executive order requires federal agencies to establish an online guidance portal and rescind or eliminate guidance documents that are no longer active or valid.
Preservation of historical information is necessary to understand and evaluate programs and policies.

Proposed action

- Rescind 2020 order.

Relevant regulations and guidance

- Notice on Promoting the Rule of Law Through Improved Agency Guidance Documents, July 2020

Continue state flexibility over financing for marketplace operations

Summary

Health insurance marketplaces are required by law to be financially self-sustaining. In order to finance their operations, SBMs have leveraged a variety of funding strategies for their operations, including an assessment on insurers.
In recent years, many SBMs have been able to lower assessment rates charged to their issuers as they have achieved greater efficiency and ability to operate at lower cost.

Proposed action

- Maintain ability for SBMs to develop and implement their own financing strategies, including maximum flexibility on policies to place an assessment on insurers.

Recommended Best Practices Learned from SBMs

Federal Funding and Standards for Navigators

Summary

Health insurance navigators established under the ACA are trained to provide fair and impartial guidance to individuals and small employers shopping for health insurance coverage.
Despite increasing capacity for self-serving through marketplace websites, marketplace consumers exhibit a demonstrated need/ desire for in-person assistance.
The current administration has cut funding to navigator programs by 84%, with only $10 million provided for the 2021 open enrollment period.
Current HHS standards for selecting and funding navigator programs is based on unreliable data (Government Accountability Office, July 2018).

Proposed action

- Restore federal funding to support a robust Navigator program providing necessary, and unbiased, in-person enrollment assistance to consumers.
- Reconsider standards used to evaluate navigator programs including alternatives to consumer application data and clearer standards for setting and evaluating goals of navigator award recipients.
- Revert guidance encouraging that navigators guide individuals to coverage options inclusive of alternative plans such as short-term health plans.

Relevant regulations and guidance

- Centers for Medicare and Medicaid Services, Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period, August 2017
- Centers for Medicare and Medicaid Services, CMS Issues 2020 Federally-Facilitated Exchange Navigator Awards, August 2020

Maintain State Flexibility over Open Enrollment Windows

Summary

The federally designated open enrollment period extends from November 1-December 15.
Citing the need for prolonged shopping periods for individual market consumers, some SBMs have leveraged flexibility to extend their enrollment deadlines into January. This has led to success in increasing enrollment.
Technological advances have enabled quicker turn arounds for insurers to effectuate coverage, meaning many insurers have the capacity to begin coverage on the first of the month, even if a consumer enrolls on a date later than the 25th of the prior month.

Proposed action

- Maintain flexibility so that SBMs can establish open enrollment windows per the needs of their markets and consumers.

Appendix A: Key Contact Information for State-Based Marketplaces

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Appendix B: State-Based Marketplace Comments on Relevant Federal Regulations

This appendix includes a list of public comments submitted by state-based marketplaces (SBMs) in response to federal regulatory or other administrative changes affecting the marketplaces and/or health insurance.

Issues of Greatest Urgency

IRS Flexibility on Reconciliation
Relevant document: Letter from State-based Marketplace to the Department of the Treasury Supporting COVID-19 Flexibilities, June 2020

Access to Coverage for Immigrant Populations
Relevant regulation: Inadmissibility of Public Charge Grounds, August 2019
Connect for Health Colorado
Massachusetts Health Connector
MNsure
DC Health Benefit Exchange
Vermont Health Access
Washington Health Benefit Exchange

Relevant notice: Notice of Information Collection Under OMB Emergency Review: Immigrant Health Insurance Coverage, October 2019
Covered California
Connect for Health Colorado
DC Health Benefit Exchange
Massachusetts Health Connector
MNsure
Nevada Health Link
Oregon Health Insurance Marketplace

Reversal of 1557 Nondiscrimination Regulations
Relevant regulation: Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, June 2020
Covered California
Connect for Health Colorado
DC Health Benefit Exchange
Massachusetts Health Connector
MNsure
Washington Health Benefit Exchange

Rescind "double-billing" requirement for non-Hyde abortion services
Relevant regulation: Patient Protection and Affordable Care Act; Exchange Program Integrity, December 2019
Covered California
Connect for Health Colorado
Access Health CT
DC Health Benefit Exchange
Massachusetts Health Connector
MNsure
HealthSource RI
NY State of Health
Washington Health Benefit Exchange

Reporting of state-mandated benefits in addition to essential health benefits
Relevant regulation: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, May 2020

Covered California
Connect for Health Colorado
Access Health CT
DC Health Benefit Exchange
Your Health Idaho
Massachusetts Health Connector
MNsure
Nevada Health Link
NY State of Health
Pennsylvania Health Insurance Exchange
Insurance Authority
HealthSource RI
Washington Health Benefit Exchange

Issues of High Priority

Amend Annual Premium Adjustment percentage measure
Relevant regulation: Patient Protection and Affordable Care Act; HHS Notice and Benefit and Payment Parameters for 2020, April 2019
Covered California
Connect for Health Colorado
Access Health CT
DC Health Benefit Exchange
Your Health Idaho
Massachusetts Health Connector
MNsure
Nevada Health Link
NY State of Health
HealthSource RI
Washington Health Benefit Exchange

No modifications that lower poverty threshold
Relevant regulation: Request for Comment on the Consumer Inflation Measures Produced by Federal Statistical Agencies, May 2019
Covered California
Connect for Health Colorado
DC Health Benefit Exchange
Massachusetts Health Connector
MNsure
Washington Health Benefit Exchange

Issues of Moderate Priority

Clarity over options to related to use of health reimbursement arrangements to purchase marketplace coverage (QSEHRAs & ICHRAs)
Relevant regulation: Health Reimbursement Arrangement and Other Account-Based Group Health Plans, June 2019
Covered California
Connect for Health Colorado
DC Health Benefit Exchange
Massachusetts Health Connector
MNsure
Nevada Health Link
Vermont Health Access
Washington Health Benefit Exchange

Limits to short-term, limited duration plans
Relevant regulation: Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, October 2016
DC Health Benefit Exchange

Relevant regulation: Short-Term, Limited Duration Insurance, August 2018
Covered California
Connect for Health Colorado
DC Health Benefit Exchange
Massachusetts Health Connector

MNsure
Nevada Health Link
Washington Health Benefit Exchange

Association health plans
Relevant regulation: Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, June 2018
DC Health Benefit Exchange
Massachusetts Health Connector
MNsure
Washington Health Benefit Exchange

Meaningful difference standards for qualified health plans (QHP)
Relevant regulation: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, May 2020
Covered California
Connect for Health Colorado
Access Health CT
DC Health Benefit Exchange
Your Health Idaho
Massachusetts Health Connector
MNsure
Nevada Health Link
NY State of Health
Pennsylvania Health Insurance Exchange
Insurance Authority
HealthSource RI
Washington Health Benefit Exchange

Reinstate guaranteed issue protections for individuals who lose coverage due to non-payment of premiums
Relevant regulation: Patient Protection and Affordable Care Act; Market Stabilization, April 2017
Covered California
Connect for Health Colorado
Access Health CT
DC Health Benefit Exchange
Your Health Idaho
Massachusetts Health Connector
MNsure
Nevada Health Link
NY State of Health
HealthSource RI
Vermont Health Access
Washington Health Benefit Exchange

Stricter oversight of and requirements for direct enrollment entities
Relevant regulation: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, April 2019
Covered California
Connect for Health Colorado
Access Health CT
DC Health Benefit Exchange
Your Health Idaho
Massachusetts Health Connector
MNsure
HealthSource RI

1332 waiver guidance
Relevant regulation: State Relief and Empowerment Waivers, October 2018
DC Health Benefit Exchange
MNsure

Flexibility to enroll in plans across metal levels

Relevant regulations: Patient Protection and Affordable Care Act; Market Stabilization, April 2017

Covered California
Connect for Health Colorado
Access Health CT
DC Health Benefit Exchange
Your Health Idaho
Massachusetts Health Connector
MNsure
Nevada Health Link
NY State of Health
HealthSource RI
Vermont Health Access
Washington Health Benefit Exchange

Appendix C: Glossary of Terms

1095 forms: 1095s are the tax forms used to report on health insurance coverage. 1095-A forms are provided from the health insurance marketplaces to the IRS to report about individuals who enroll in QHPs through the marketplace.1095-B and C forms are sent by health insurers or employers to individuals to verify their enrollment in minimum essential coverage. 1095-B forms are sent by health insurers or small employers (with less than 50 employees) while 1095-C forms are sent by large employers.

1115 waiver: State demonstrations authorized by the Social Security Act to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP).

1332 waiver: State demonstrations authorized by the Affordable Care Act to pursue innovations providing access to comprehensive, affordable, quality health care via Marketplace qualified health plans without reducing the number of covered state residents; waivers have been approved by the Centers for Medicare & Medicaid Services (CMS) to implement reinsurance programs.

1332 guardrails: The Patient Protection and Affordable Care Act (ACA) outlines four requirements or "guardrails" that all proposals must fulfill in order to be approved for a 1332 waiver:

- Coverage must be "at least as comprehensive as the coverage" provided under the ACA and offered through the marketplaces;
- Coverage must be "at least as affordable" as under the ACA — including protections against excessive out-of-pocket spending;
- The proposal must provide coverage to "at least a comparable number of residents;" and
- The proposal may not increase the federal deficit.

Actuarial value: The percentage of total average costs for covered benefits that a health insurance plan will cover; for example, if a plan has an actuarial value of 70 percent the beneficiary would be responsible for 30 percent of the costs of all covered benefits in the plan.

Advanced premium tax credit (APTC): A federal tax credit offered in advance to those with a household earning between 100 percent to 400 percent of the federal poverty level (FPL) to lower their monthly health insurance premiums for marketplace plans.

Association health plans (AHPs): A type of group health insurance coverage where employer groups or similar associations may join together to purchase coverage, similar to the way coverage can be procured by a large employer.

Benchmark plan: (1) The second lowest cost qualified health plan sold at the silver metal tier in a specific geographic region. This plan is used as the basis for calculating the amount of APTCs that an enrollee may be eligible for. (2) The health insurance plan used as the standard for the provisions of essential health benefits as designated by a state.

CARES Act: The Coronavirus Aid, Relief, and Economic Security Act passed in March 2020 to provide both economic stimulus and public health protections in response to the growing COVID-19 pandemic. Among its many other provisions. the law provided an additional $600 per week in unemployment benefits from March 27 to July 26, 2020.

Cost-sharing: The share of covered service costs paid out-of-pocket by an enrollee. This generally includes deductibles, coinsurance, and copayments, or similar charges, but not premiums, surprise billing amounts, or the cost of non-covered services.

Cost-sharing reduction (CSR): An ACA mandated payment made my insurers to qualified individuals to cover out-of-pocket expenses (cost-sharing) for health care services including discounts on deductibles, copayments, and coinsurance. To qualify, individuals must earn between 100 to 250 percent of the FPL, must not be eligible for Medicaid, and must enroll in a silver-level qualified health plan through the health insurance marketplace.

Direct enrollment (DE): The process of signing up for a qualified health plan outside of a health insurance marketplace (usually directly through a health insurance company or a health insurance broker). An Enhanced Direct Enrollment (EDE) pathway, established in 2018, allows these entities to handle the entire application and enrollment process for consumers. In addition to qualified health plans, DE entities may offer non-ACA compliant coverage, may preferentially display coverage options based on the DE's business needs, and may exclude presenting all available coverage options to consumers.

Direct primary care arrangement: An arrangement made directly between a patient and their primary care provider in which the provider agrees to provide a certain set of services for a set annual or monthly fee.

Employee Retirement Income Security Act (ERISA): The federal law governing most health insurance plans obtained through private-sector employers, including all employers that offer pension plans. ERISA preempts most state laws regulating insurance obtained through the private sector. ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws.

Employer sponsored insurance (ESI): Health insurance obtained through an employer as opposed to through the Marketplace or through a public plan such as Medicaid, Medicare, or CHIP. Also known as employer sponsored coverage. ESI is deemed to be affordable for an employee as long as premiums are below 9.78 percent of the employee's household income.

Essential health benefits (EHB): A set of 10 categories of services (benefits) health insurance plans are required to cover. These include ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use services, prescription drug coverage, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services (including chronic disease management), and pediatric services.

Federal poverty level (FPL): A measure of annual income used to determine eligibility for certain federal benefits and programs. In 2020, the poverty line was set to $12,760 for an individual and $26,200 for a family of four.

Guaranteed issue: A requirement (guarantee) that health insurance coverage will be offered to an applicant regardless of their health status, or factors that may be relevant to their health status (ex. pre-existing conditions, sex, age)

Health reimbursement arrangements (HRAs): A tax-advantaged health benefit through which employers may finance or reimburse employees for out-of-pocket medical expenses.

Health care sharing ministry (HCSM): An organization in which members who share a common set of ethical or religious believes join together to share medical expenses of incurred by members of the group.

Hyde Amendment (for abortion services): Law which prohibits use of federal funds to pay for abortion services except in the case of rape, incest, or if the pregnancy would endanger the woman's life.

Individual mandate: A requirement for that individuals must obtain qualified health insurance coverage. Usually, those who do not comply with an individual mandate are subject to a financial penalty unless they receive a hardship exemption.

Market segmentation: When individuals or groups of individuals are separated from the main health insurance risk pool because they opt for alternative options (ex. short-term plans, health care ministries) that are not included as part of the market's single risk pool. The ACA requires insurers to use a single risk pool when calculating premiums for plans sold in the individual insurance market. This prohibits insurers from separating, and therefore charging, their enrollees based on different levels of health risk plans).

Meaningful difference: A requirement that qualified health plans must be materially different from any other plan in order to be sold through the health insurance marketplaces.

Medical loss ratio (MLR): The percentage of premium dollars that an insurer must use to pay for medical claims/ services or care quality improvement activities rather than administrative expenses and profits. The ACA sets a minimum MLR for insurance markets — 85 percent for the large group market, and 80 percent for small group and individual markets. If the MLR threshold is not met by the insurer, they must reimburse consumers for excess administrative spending.

Metal tier: One of four categories (bronze, silver, gold, or platinum) in which health insurance plans are classified based on their actuarial value.

Minimum essential coverage (MEC): Any insurance plan that meets the Affordable Care Act requirement for having health coverage; examples include Marketplace plans, job-based plans, Medicare, Medicaid, and CHIP. Sometimes called "qualifying health coverage."

Navigator programs: Programs run by the health insurance marketplaces of (usually) community-based individuals or organizations who are trained to help consumers shop for healthcare coverage.

Open enrollment period: The limited, annual time period during which consumers may elect health insurance coverage for the year.

Out-of-pocket (OOP) cost: Expenses for medical care that aren't paid for by the insurer; includes deductibles, coinsurance, and copayments for covered services plus all costs for non-covered services.

Premium adjustment percentage: A measure of insurance premium growth used to set the annual limit on cost sharing, penalties under the employer mandate, and required contribution percentages to qualify for eligibility exemptions.

Public benefit: Includes most federally funded benefits including Medicaid (with certain exclusions, Section 8 Assistance, Supplemental Security Income, Temporary Assistance for Needy Families (TANF), and the Supplemental Nutrition Assistance Program (SNAP).

Public charge: An immigrant who received one or more public benefits for more than 12 months within a 36-month period (such that, for instance, receipt of two benefits in one month counts as two months).

Qualified health plan (QHP): A certified health insurance plan that meets all of the insurance requirements set forth under the ACA including the provision of essential health benefits, limits on cost sharing, and protections for individuals with pre-existing conditions.

Rating rules: Requirements that limit the ability of health insurers to vary premiums based on certain qualities of enrollees including geographic location, gender, tobacco use, and age.

Reinsurance: A program that protects insurers from very high claims costs, by reimbursing insurers who incur excessively costly claims. The programs are administered by a third party — usually the state or federal government.

Risk pool: A group of individuals whose medical costs are combined to calculate health insurance premiums; "pools" the higher costs of the less healthy with the relatively lower costs of healthy individuals.

Section 1557: A section of the ACA that prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in the health insurance marketplaces, health plans that participate in the marketplaces and health programs that receive funding from or are administered by HHS.

Service area: The geographic area in which a health insurance plan accepts enrollees.

Short-term, limited duration insurance (STLDI): A health coverage option intended as a stop-gap alternative for individuals that are temporarily in need of coverage. STLDI is not required to meet QHP standards, meaning they are not required to cover EHBs, limit cost-sharing, or adhere to required pre-existing condition protections. These are also known as short-term plans.

Silver-loading: The practice wherein health insurers increase premiums of the benchmark silver-level QHPs to recoup the cost of federally required CSR reimbursements (see cost-sharing reductions).

Special enrollment period (SEP): A time outside the yearly open enrollment period during which an individual may qualify to enroll in health insurance triggered by a special life circumstance such as loss of prior health coverage, moving, getting married, having a baby, or adopting a child.

Wellness programs: Programs typically offered by employers and/or employee health plans intended to improve and promote health and fitness by incentivizing and tracking healthy activities such as smoking reduction, diabetes management programs, weight loss programs, and preventative health screening utilization.