ACA COMPLIANCE BULLETIN

HIGHLIGHTS

- The market stabilization proposed rule includes new reforms intended to stabilize the individual and small group health insurance markets for the 2018 plan year.
- The rule would make changes to existing standards that aim to stabilize the Exchanges.
- The rule does not directly impact large group market plans.

IMPORTANT DATES

February 15, 2017
HHS issued a market stabilization proposed rule.

2018 Plan Year
The changes included in the proposed rule would be effective for the 2018 plan year.

Provided By:
Clark & Associates of Nevada, Inc.

MARKET STABILIZATION PROPOSED RULE ISSUED

OVERVIEW

On Feb. 15, 2017, the Department of Health and Human Services (HHS) issued a market stabilization proposed rule under the Affordable Care Act (ACA). The proposed rule includes new reforms intended to stabilize the individual and small group health insurance markets for the 2018 plan year.

Specifically, the rule proposes a variety of policy and operational changes to existing standards to stabilize the Exchanges, including changes to the annual open enrollment period and special enrollment periods.

ACTION STEPS

The proposed rule does not directly impact plans in the large group market. Instead, the proposed rule aims to stabilize the individual and small group health insurance markets in light of pending changes that may be made to the ACA.

If finalized, the changes made under the rule are proposed to be effective for the 2018 plan year.

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Overview of the Proposed Rule

The market stabilization proposed rule for 2018 includes new reforms that are aimed at stabilizing the individual and small group health insurance markets. Specifically, this proposed rule would make changes to:

- ✓ Special enrollment periods;
- ✓ The annual open enrollment period;
- ✓ Guaranteed availability;
- ✓ Network adequacy rules;
- ✓ Essential community providers; and
- ✓ Actuarial value requirements.

Under the proposed rule, for the 2018 plan year, the Exchange open enrollment period would run from Nov. 1, 2017, through Dec. 15, 2017.

The proposed rule also announces upcoming changes to the qualified health plan (QHP) certification timeline.

Open Enrollment Period for 2018

The rule proposes to **shorten the upcoming annual open enrollment period** for the individual market (for the 2018 plan year). Under a previous final rule, HHS established an open enrollment period for the 2018 plan year that runs from Nov. 1, 2017, through Jan. 31, 2018. However, that final rule sets a shortened open enrollment period for the 2019 and later plan years.

Under the proposed rule, this shortened open enrollment period would apply beginning with the 2018 plan year. Therefore, for the 2018 plan year, the open enrollment period would run from **Nov. 1, 2017, through Dec. 15, 2017**. This proposed change is intended to align the Exchanges with the employer-sponsored insurance market and Medicare, and help lower prices by reducing adverse selection.

Special Enrollment Period Pre-enrollment Verification

The proposed rule would expand pre-enrollment verification of eligibility to individuals who newly enroll through special enrollment periods (SEPs) in Exchanges using the federal platform. Previously, HHS allowed individuals to self-attest eligibility for most SEPs—and to enroll in coverage without further verification of eligibility—in an effort to minimize barriers for individuals to obtain coverage. However, this practice led to abuses of SEPs, allowing individuals to enroll in coverage that they would not otherwise qualify for.

To curb these abuses, the proposed rule would require HHS to conduct pre-enrollment verification of eligibility for all categories of SEPs for all new consumers in all Exchanges using the www.HealthCare.gov platform. According to HHS, this proposed change would help make sure that SEPs are available to all who are eligible for them, but will require individuals to submit supporting documentation—a common practice in the employer health insurance market. This is intended to help place downward pressure on premiums, curb abuses and encourage year-round enrollment.

Guaranteed Availability

The rule also proposes to address potential abuses of the ACA's "guaranteed availability" rules, which require insurers to offer coverage to any eligible consumer who applies for coverage. HHS has previously interpreted this requirement to mean that an insurer cannot refuse enrollment to an individual even in cases where the individual has failed to pay outstanding premiums for any prior coverage. According to HHS, issuers have complained that some individuals are taking advantage of this provision by, for example, declining to make premium payments for coverage at the end of a benefit year, and then enrolling in new coverage for the next year, thereby avoiding having to pay outstanding premiums for the previous year's coverage.

The proposed rule would attempt to curb these abuses by allowing an issuer to collect premiums for prior unpaid coverage before enrolling a patient in the next year's plan with the same issuer. This is intended to incentivize patients to avoid coverage lapses.

Determining the Level of Coverage

The ACA requires QHPs offered through an Exchange to meet certain levels of actuarial value, referred to as "metal levels." HHS regulations have allowed for a *de minimis* variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

The proposed rule would make adjustments to the *de minimis* range used for determining the level of coverage, allowing a variation of -4/+2 percentage points (rather than +/- 2 percentage points) for all non-grandfathered individual and small group market plans that are required to comply with actuarial value. As a result, the proposed rule would provide greater flexibility to issuers in the actuarial value *de minimis* range to provide patients with more coverage options.

Network Adequacy

The proposed rule would provide greater flexibility to states in the review of QHPs. Under the proposed rule, HHS would defer to the states' reviews in states with the authority and means to assess issuer network adequacy. According to HHS, states are best positioned to ensure their residents have access to high quality care networks.

Qualified Health Plan Certification Calendar

Finally, the proposed rule announces HHS' intention to release a revised proposed timeline for the QHP certification and rate review process for the 2018 plan year. The revised timeline would provide issuers with more time to implement proposed changes that are finalized prior to the 2018 coverage year. Therefore, the revised timeline would give issuers flexibility to incorporate benefit changes and maximize the number of coverage options available to patients.

Source: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services