ACA COMPLIANCE BULLETIN

HIGHLIGHTS

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

IMPORTANT DATES

April 14, 2017
HHS issued a market stabilization final rule.

2018 Plan Year
The changes included in the final rule are effective for the 2018 plan year.

Provided By:
Dickerson Employee Benefits

MARKET STABILIZATION FINAL RULE ISSUED

OVERVIEW

On April 14, 2017, the Department of Health and Human Services (HHS) issued a market stabilization final rule under the Affordable Care Act (ACA). The final rule includes new reforms intended to help lower premiums, stabilize the individual and small group health insurance markets and increase choices for the 2018 plan year.

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

The changes made under the final rule are effective for the 2018 plan year.

Dickerson Employee Benefits
Insurance Services
AUTHORIZED GENERAL AGENT

Overview of the Final Rule

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

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

Under the market stabilization final rule, for the 2018 plan year, the Exchange open enrollment period will run from Nov. 1, 2017, through Dec. 15, 2017.

HHS also issued separate guidance concurrently with the final rule to update the qualified health plan (QHP) certification timeline.

Open Enrollment Period for 2018

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

This shortened open enrollment period applies in all Exchanges. However, HHS recognizes that some state-based Exchanges may have operational difficulties this year in transitioning to the shorter open enrollment period. As a result, HHS notes that existing regulatory authority allows state-based Exchanges the option of supplementing the open enrollment period with a special enrollment period, as a transitional measure, to account for those operational difficulties.

Special Enrollment Period Pre-enrollment Verification

The final rule expands 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 final rule requires 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 change will 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 final rule also addresses potential abuses of the ACA's "guaranteed availability" rules, which require insurers to offer coverage to any eligible consumer who applies for coverage. HHS 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 final rule attempts to curb these abuses by allowing issuers to collect unpaid premiums for prior 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 final rule adjusts the *de minimis* range that is 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 (except bronze plans, which can vary -4/+5 percentage points). As a result, the final rule provides greater flexibility to issuers in the actuarial value *de minimis* range to provide patients with more coverage options.

Network Adequacy

The final rule provides greater flexibility to states in the review of QHPs. Under the final rule, beginning with the 2018 plan year, HHS will 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, HHS issued separate guidance concurrently with the final rule to update the QHP certification calendar and the rate review submission deadlines. In light of the need for issuers to make modifications to their

products and applications to accommodate the changes finalized in the market stabilization rule, the updated calendar and deadlines are intended to give additional time for issuers to develop, and states to review, form and rate filings for the 2018 plan year that reflect these changes.

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