Memo

Subject: Market Stabilization – HHS Final Rules

On April 18, 2017, the Department of Health and Human Services published final rules addressing certain matters intending to provide stabilization in the individual and small group markets. Following are highlights of these rules.

Annual open enrollment period in individual market. For 2018 individual policies, the marketplace annual open enrollment period will begin November 1, 2017 and run through December 15, 2017 (for 2017 and 2016, the enrollment period was November 1 to January 31). This change is intended to more fully align enrollment periods with Medicare and the private market, and encourage individuals to enroll in coverage prior to the beginning of the year.

Special enrollment verification. Special enrollment periods are available through the marketplace upon the occurrence of certain events such as loss of employer-provided minimum essential coverage, or upon qualifying events such as marriage, or birth or adoption of a child. Currently, most individuals self-attest their eligibility for special enrollment and while they are required to provide some supporting documentation, they do not always undergo a pre-enrollment verification by the marketplace. This has resulted in some fraud, waste and abuse issues. The final market stabilization rules call for an increase in the scope of pre-enrollment verification, as well as impose additional parameters and tighten-up certain limitations on existing special enrollment periods. Thus, when these stabilization rules become effective on June 19, 2017, individuals will be required to undergo a more stringent pre-enrollment verification of eligibility when applying for coverage in the federally-facilitated marketplaces, as well as the joint state-federal marketplaces, due to a special enrollment event.

Guaranteed availability. The Affordable Care Act's guaranteed availability provision requires insurers offering health insurance coverage in the individual and group market to offer all approved products to individuals and employers. The final market stabilization rules make certain changes to these guaranteed availability standards beginning in 2018. Specifically, to promote personal responsibility, insurers are permitted to deny coverage when individuals fail to pay past due premiums owed to the insurer. This applies to both individual policies and plans issued to small and large group markets, whether obtained in or outside the marketplace.

Further, past due premium owed to one insurer of a controlled group would apply to all members of the controlled group. For purposes of communicating this change to enrollees and participants, insurers must include a detailed explanation in their policies and plans of the consequences of failure to pay premium on future enrollment.

Actuarial Valuation Calculation for determining level of coverage. The ACA requires non-grandfathered health plans offered to individuals and small employer group markets both in and outside an marketplace to meet the bronze, silver, gold, or platinum actuarial levels of benefits and coverage. A bronze plan is required to have an actuarial value (AV) of 60%; a silver plan, 70%; a gold plan, 80%; and a platinum plan, 90%. Actuarial value refers to a percentage measurement of expected health care costs covered by the plan and used to determine an overall measurement of the plan's generosity. As a companion piece to the market stabilization rules, HHS released a 2018 Actuarial Value Calculator, together with an Actuarial Value Calculator Methodology, for purposes of determining whether a plan's AV is based on a national standard population. The 2018 AV calculator reflects a modification to the so-called "de minimis range" of variation for all non-grandfathered individual and small group plans (other than certain bronze plans) offered through the marketplace that are required to comply with the AV standards. The goal is to provide additional flexibility for insurers to make adjustments to their plans within the same metal level.

Effective date. These regulations become effective on June 19, 2017. Unless otherwise noted, these rules apply to policies and plans issued or renewed on or after January 1, 2018.