

# REFORM UPDATE

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## PROPOSED RULES FOR MARKET STABILIZATION

The Department of Health and Human Services (DHHS) has proposed new rules to stabilize the individual insurance market. The proposed regulations focus on administration rules under the Marketplaces.

President Trump clearly intends to repeal and replace the Affordable Care Act (ACA). A first draft of replacement legislation is currently working its way through the legislative process. Insurance carriers in the Marketplace need to understand what this means. It will impact their decision to continue to offer coverage in the Marketplace. The ACA's primary goal was to increase coverage and access to coverage for all Americans through a series of actions:

- **Individual mandate** – requiring everyone to obtain health coverage or pay a tax penalty.
- **Market reform rules** – changing insurance regulations to remove medical underwriting, pre-existing condition limitations, and lifetime dollar limitations. The ACA also standardized rate setting rules in the individual and the small group market.
- **Expanded access to Medicaid** – standardizing eligibility and expanding access to low-income adults.
- **Marketplaces** – launching one-stop shopping for purchasing health care coverage.
- **Premium subsidies** – providing tax subsidies to help those with low or moderate incomes pay for health coverage.

All of these actions provided the ability, avenues and incentives for everyone to purchase health insurance. These actions also had a significant impact on the insurance market. They affected insurance rates in the individual and group markets.

As the Republicans discuss their strategy to repeal and replace the ACA, the stability of insurance carriers is a key issue. Carriers are now starting to determine what plans to offer in 2018, the preliminary rates of those plans and whether to continue offering coverage in the Marketplace. They are facing a lot of unknowns with the new administration.

These proposed regulations that change some of the administrative aspects of the Marketplace as well as coverage rules are intended to help insurance carriers operate in a more predictable market. DHHS is seeking comments on many of the proposed provisions.

This *Reform Update* summarizes the key changes to Marketplace administration and coverage including:

- Changes to the de minimis range in determining metal coverage tier
- Documentation required for mid-year special enrollment
- Changes to open enrollment time period for 2018
- Ability to collect past due premiums

The replacement legislation working its way through the legislative process proposes additional changes to the Marketplace administration and the individual insurance market.

### CHANGES TO THE DE MINIMIS RANGE IN DETERMINING METAL COVERAGE TIER

The Marketplaces offer plans in four metal tiers. The metal tier is tied to actuarial value of the plan:

Type of Plan	Actuarial Value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

The initial regulations allowed a de minimis variation of +/- 2%. For example, a gold plan could have a value between 78% and 82%.

The proposed rule changes the de minimis range to -4% or +2%. Under these new rules, a silver plan could have a value between 66% and 72%.

The proposed rules allow a -4 to +5 percent variation in the range for bronze plans that either cover and pay for at least one major service other than preventive services before the deductible or meet the requirements of a high-deductible health plan.

By increasing the lower variation, insurance carriers could offer lower value plans in each metal tier to decrease premiums. In addition, it may result in lower premium subsidies. Premium subsidies are set using the second lowest cost silver plan. Lower premiums are expected if silver plans are closer to 66 percent of actuarial value.

### DOCUMENTATION REQUIRED FOR MID-YEAR SPECIAL ENROLLMENT

Insurance carriers in the Marketplace have struggled with adverse selection. Marketplaces have not always required those who have special enrollment events mid-year to provide proof of the event. In many cases, the Marketplace would simply allow them to state they were eligible because of a mid-year special enrollment event. Some individuals, however, were enrolling mid-year when they needed services and then terminating coverage once they received treatment.

The proposed rules expand the pre-enrollment verification of eligibility to new enrollees through special enrollment periods in Marketplaces using the [HealthCare.gov](http://HealthCare.gov) platform. The new requirement to prove the special enrollment event occurred will apply as of June 2017 for all mid-year enrollment events. Individuals can still apply for coverage mid-year, but they will need to provide proof of the special enrollment event before their application can be approved. Applicants will have 30 days to produce documentation either electronically through the [healthcare.gov](http://healthcare.gov) account or by mail.

The proposed rules recommend state-based Marketplaces require verification as well.

The proposed rules also limit when individuals can change their policies mid-year because of a special enrollment event:

- New dependents may only be added to a participant's current plan, unless the existing plan doesn't offer dependent coverage
- Enrollees becoming newly eligible for cost-sharing reductions may enroll only in a silver-level QHP
- Enrollees for all other special enrollment events may only make changes to their enrollment in the same plan or change to another plan within the same level of coverage
- The following situations are exempt from this proposal:
  - Erroneous enrollment
  - Native American or Alaska Natives and their dependents
  - Exceptional circumstances
  - Domestic abuse or spousal abandonment

These changes should help reduce premiums, curb abuses, and encourage year-round enrollment.

The preamble to these rules specifically asks for comments on approaches to promote continuous coverage. One approach would require individuals to show proof of coverage for a longer lookback period, for example 6 or 12 months. A small gap in coverage, for example 60 days, would be allowed. For those who could not provide proof of coverage, a 90-day waiting period may apply before coverage becomes effective or they could be assessed a late enrollment penalty.

The preamble also asks for comments on whether the creditable coverage rules that applied under the Health Insurance Portability and Accountability Act (HIPAA) should be reinstated and applied to the individual market.

## CHANGES TO OPEN ENROLLMENT TIME PERIOD FOR 2018

CMS proposes an open enrollment period of November 1, 2017, to December 15, 2017, for the 2018 year. This is the open enrollment time period included in the original regulations. It was expanded initially to account for difficulties when the Marketplaces first launched.

This proposed change aligns the Marketplaces with many employer-sponsored health plans and Medicare. It should also reduce adverse selection since long open enrollment periods tend to widen the opportunity for people to enroll in the plan once they discover they are ill.

### ABILITY TO COLLECT PAST DUE PREMIUMS

The new rules will allow insurance carriers to collect past due premiums if the person re-enrolls with that carrier within 12 months. For example, assume an individual policy is terminated for failure to pay premiums on September 1, 2017. The policyholder then elects coverage at open enrollment from the same carrier as of January 1, 2018. The carrier could require the person to repay past due premiums from the coverage that ended in September before activating coverage for January 1, 2018.

This requirement applies only if the person reapplies for coverage within 12 months after losing coverage and with the same carrier.

Under the proposed rules anyone who loses coverage due to non-payment of premium has not experienced a special enrollment event in the Marketplace.

Under the current rules regarding grace periods and termination of coverage, anyone with past due premiums would generally owe no more than three months of back premium. If the person qualified for premium subsidies and the government paid the subsidy portion, the back premium would be the remaining amount.

These new rules would not apply to group health insurance coverage purchased through the Small Business Health Options Program (SHOP).

### CONCLUDING THOUGHTS

CMS intends to revise the proposed timeline for the Qualified Health Plan certification. It also intends to revise the rate review process timeline for the 2018 plan year. The timeline revisions will give insurance carriers more time to implement proposed changes that will become final before the 2018 coverage year. These changes will allow issuers the flexibility to incorporate benefit changes and maximize the number of coverage options available.

Comments on the proposed regulations were due by March 7, 2017.

There is no effective date on these proposed changes. Expect the HHS to issue final regulations soon, since insurance carriers will need final rules to set rates and plan options for 2018.

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