MARSH & McLENNAN AGENCY

REFORM UPDATE

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FINAL MARKET STABILIZATION RULES

The Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (DHHS) recently published the final rules to stabilize the individual Marketplace. The proposed rules were reviewed in our *Reform Update* at http://mcgrawwentworth.com/wp-content/uploads/Reform-Update-130.pdf.

The final regulations include many of the provisions covered by the proposed rules. This *Reform Update* summarizes the final changes to Marketplace administration and coverage including:

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

The House of Representatives has passed the American Health Care Act (AHCA), which includes additional changes to Marketplace operations, but the Senate will likely alter it in many respects. For that reason, the changes proposed by the AHCA are uncertain.

The changes included in these final regulations go into effect on June 19, 2017.

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 the actuarial value of the plan:

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

The final rules change the de minimis range to -4 percent or +2 percent for most metal tiers. For example, a silver plan could now have a value between 66 percent and 72 percent. The rules also allow a -4 percent 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 qualifying high-deductible health plan.

The increased lower variation allows insurance carriers to offer lower value plans in each metal tier to decrease premiums and perhaps 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 MIDYEAR SPECIAL ENROLLMENT

Anyone experiencing specific midyear events can enroll in a qualified health plan (QHP) midyear. Historically, the Marketplaces did not require proof in many of these cases. Special enrollments can happen midyear for a number of reasons. Two reasons mirror HIPAA special enrollment rights:

1. Involuntarily losing other coverage
2. Gaining a dependent through marriage, birth, or adoption

Allowing self-attestation for those requesting a midyear enrollment has caused adverse selection. Adverse selection occurs when people enroll midyear claiming a midyear special enrollment event because they need services and then drop their coverage after their claims are paid.

Under the final rules, anyone applying for Marketplace coverage midyear will have to verify the reason for special enrollment using the HealthCare.gov platform. This new requirement will apply as of June 2017 for all midyear enrollments. Applicants will have 30 days to produce documentation, either electronically through the healthcare.gov account or by mail. The coverage will not begin until they submit proof of the event. The Marketplace will make every effort to verify the enrollment event electronically.

Based on comments received, the final rules commit to provide the following:

- Training for internal and external stakeholders on the new process and rules
- Expedited reviews of documents to minimize any delays
- Frequent status updates to help answer questions at the call center
- Flexibility on the documentation this policy change requires

The final rules also limit special enrollment events:

- New dependents may only be added to a participant's current plan. The participant may only change plans if the existing plan doesn't cover dependents

- 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. If there is no other plan option in that metal tier, enrollees can select a plan from the adjacent metal tier.
- The following situations are exempt from the restrictions in this proposal:
  - Erroneous enrollment
  - Native American or Alaska Natives and their dependents
  - Exceptional circumstances
  - Domestic abuse or spousal abandonment

These requirements apply only to individual coverage purchased through the Marketplace. They do not apply to individual coverage purchased outside the Marketplace.

If an enrollment depends on verifying an enrollment event, the first payment must pay for coverage once the event is verified. Consumers can request a later effective coverage date if enrollment was delayed due to eligibility verification. The option to delay the effective date applies if the consumer would be required to pay two or more months of retroactive premiums to obtain coverage or avoid cancelation. Under the final rules, enrollees can delay coverage for only one month. If your original effective date was to be June 1 but your eligibility is not verified until August 15, your effective date could be delayed to July 1 but not later. CMS intends to verify eligibility quickly. Therefore, expect delayed effective dates to be quite rare.

The final rules also include guidelines to tighten other special enrollment elections:

- Special enrollment is not allowed if consumers lose minimum essential coverage because they didn't pay their premiums. HHS will determine the best process to verify that the midyear loss was not due to unpaid premiums.
- If a consumer wants to enroll in a QHP through the Marketplace because of marriage, at least one spouse must prove he or she had minimum essential coverage for 1 or more days in the 60 days preceding the marriage. If the consumer can prove one spouse had coverage, both can enroll for Marketplace coverage because of a marriage special enrollment event.
- Verification and rules are expanded for those enrolling as a result of a permanent move allowing access to new QHPs. To enroll for coverage under a new QHP midyear, the person must have had coverage at least 1 day in the 60-day period before the move. This requirement will not apply if the move is from a foreign country or a U.S. territory.

The rules note that CMS will work on how individuals will verify coverage at the point of marriage.

CHANGES TO OPEN ENROLLMENT TIME PERIOD FOR 2018

The final regulations change the open enrollment period for the 2018 plan year to November 1, 2017, to December 15, 2017. Open enrollment will run from November 1 to December 15 for all subsequent plan years as well.

CMS intends to ensure consumers are aware of the change in the open enrollment time period.

ABILITY TO COLLECT PAST DUE PREMIUMS

The new rules allow insurance carriers to collect past due premiums from anyone re-enrolling within 12 months. For example, assume a policyholder loses coverage 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 that person to repay past due premiums from the coverage that ended in September before it will activate coverage for January 1, 2018.

This requirement applies only if the person reapplies for coverage with the same carrier within 12 months after losing coverage. If the carrier is member of a controlled group, the issuer may attribute any past-due premiums owed to any carrier who is a member of the same control group.

The comments on this proposed change indicate this repayment rule would affect the guaranteed availability rules included in the Affordable Care Act (ACA). The rules note that the maximum pay back would generally be limited to three months of premium. To avoid paying back premiums, the person only needs to seek coverage from a different health insurance carrier. Also, the payback rule applies only to the person responsible for paying the premium. For example, assume that person covered family members in an individual contract that lapsed. At the next open enrollment, one of the family members applies for coverage with the same carrier at open enrollment. The family member would not have to pay past due premiums to obtain coverage. In other words, the family member is not obligated to pay the premium for previous family coverage.

The final rules also require a new notice. If a carrier or a member of the carrier's control group requires repayment, applicants and members must be informed of the repayment rules in application materials and any notice regarding non-payment of premium. The notice may be electronic or on paper. It must explain in detail the consequences of non-payment on future enrollment.

States and insurance carriers can consider extenuating circumstances and appeal processes for decisions on paying back premiums. Insurance carriers must pay claims for any time period when back premiums have been paid.

These repayment rules apply to insurance carriers offering coverage on or off the Marketplace.

CONCLUDING THOUGHTS

Many of the changes and limitations included in these final rules promote continuous coverage throughout the year. The thought is that the impact of adverse selection will be lessened if most people stay covered.

CMS revised the timelines for requirements to offer QHPs in the Marketplace. It will be interesting to see whether carriers concerned about remaining profitable will now stay in the market. The discussions about repealing and replacing the ACA highlight the uncertainties in the individual insurance market for 2018.

These final rules are effective as of June 19, 2017.