Sibson Consulting

update

Compliance News for Plan Sponsors

May 4, 2017

New Final Rule Aims to Provide Some Stability to the Individual Health Insurance Market

The Department of Health and Human Services (HHS) recently published a final rule that is designed to provide some stability to the individual health insurance market, especially the coverage that is available through the federal Marketplace/ state Exchanges.[1] Although the rule does not apply to employer-sponsored coverage, employers may be affected by some of the requirements. This *Update* highlights key aspects of the new final rule and notes the implications for sponsors of group health plans.

Key Provisions of the Market-Stabilization Rule

A primary aim of the Affordable Care Act's market-stabilization rule is to help insurers attract and retain healthy customers, thus broadening the risk pool, which could lower the rates insurers charge for coverage. To do this, the final rule makes a number of changes intended to promote full-year coverage and provide insurers with additional flexibility.

Special Enrollment

The new final rule makes changes to special enrollment rules governing the circumstances under which people can enroll in coverage in the federal Marketplace or a state Exchange. (It also makes changes to the annual open enrollment period as summarized in the text box below). The rules that govern special enrollment into group health plans are not changing.

Changes to Open Enrollment for Individual Market Coverage, Including in the Federal Marketplace or a State Exchange

The final rule aims to promote full-year coverage by shortening the annual open enrollment period for 2018 by half, to six weeks (from November 1, 2017 through December 15, 2017) instead of three months (November 1, 2017 through January 31, 2018). People who enroll during this time frame will have coverage effective on January 1, 2018.

The enrollment period is designed to more closely reflect the open enrollment period commonly used by employment-based plans and Medicare (October 15 through December 7).

Health Compliance News Highlights:

- Part-time employees, retirees, or their family members may purchase coverage in the individual health insurance market.
- HHS is tightening the rules on access to the federal Marketplace and state Exchanges in order to promote full-year coverage.
- The federal Marketplace/ state Exchanges' open enrollment period for 2018 is shortened from three months to six weeks (November 1, 2017 through December 15, 2017).

[1] The final rule was published in the April 18, 2017 *Federal Register*.

The most significant change, which will start in June 2017, is the new verification requirement for those seeking special enrollment in federal Marketplace plans.[2] The Marketplace will have to verify that new enrollees are eligible for special enrollment *before* they will be allowed to enroll. The rule also limits the types of plans in which individuals may enroll in order to prevent them from moving from lower-level plans to one with better coverage.

The requirement to document eligibility may result in employees who lose group coverage asking for some type of documentation from their employer. Previously, plan sponsors provided Health Insurance Portability and Accountability Act (HIPAA) Certificates of Creditable Coverage. While those Certificates are no longer required, plans may want to provide a similar form. The election notice under the Consolidated Omnibus Budget Reconciliation Act (COBRA), which includes the coverage termination date and reason for the loss of coverage, should suffice for this purpose.

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Ability to Recoup Unpaid Premiums

Insurers had been concerned about people who did not pay some of their premiums in one year, yet they remained entitled to enroll for the next year's coverage. They reported that some customers were essentially able to secure 12 months of coverage without paying 12 months of premiums. The final rule permits an insurer to collect unpaid premiums owed to it for the previous 12-month period before enrolling people for the next year's coverage in any of the insurer's plans.

Insurers that adopt this policy must apply it uniformly to all customers, regardless of their health status, and must provide notice of this payment policy in enrollment and other materials. As this amends existing rules that govern the individual, small-group and large-group markets, the new policy applies across all of these markets.[3]

More Variation in Plan Values

Plans in the individual and small-group market are categorized by metal level (bronze, silver, gold and platinum) based on their actuarial value. Actuarial value is the measure of the percentage of claims that a plan is expected to pay on average. For example, a silver plan is expected to pay on average 70 percent of claims costs, with the covered person or family paying the remaining 30 percent in the form of deductibles, copayments and coinsurance.

Under current rules, the actuarial value of individual and small group market plans can vary slightly from the set metal level. For example, a 70 percent silver plan could have an actuarial value ranging from 68 percent to 72 percent. The new rule allows insurers to offer additional lower value plan options. Under the new final rule, the lower end of the value could be as low as 66 percent (with the upper end remaining at 72 percent).[4] This change will apply to plans starting in 2018. The changes in actuarial value do not affect employer-sponsored plans, which must calculate whether they provide 60 percent "minimum value" coverage.

No Federal Standards for Determining Adequacy of Networks

HHS has decided to defer to the states when it comes to deciding if plan networks are adequate. For states that lack either the authority or the means to conduct sufficient reviews of network adequacy, HHS will rely on an insurer's accreditation from an HHS-recognized entity. Insurers that lack accreditation would have to submit an access plan as part of their application to participate in the Marketplace.

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[2] State-based Exchanges that do not use healthcare.gov are encouraged to adopt similar rules.

[3] Due to operational constraints, the small business Exchanges that are run by the federal government will not adopt this policy at this time.

[4] Slightly different rules will apply to certain bronze plans that either pay for at least one major service (other than preventive services) before meeting the deductible or are high-deductible health plans paired with Health Savings Accounts (HSAs).

Implications for Plan Sponsors

Although employer-sponsored coverage is not subject to the rules discussed here, the individual insurance market provides coverage opportunities for people who are connected to the workforce in a variety of ways. This may include those who are not yet eligible for group coverage (in a waiting period for group coverage); those who may not be eligible at all (part-time workers, those with intermittent work schedules); and those who lose their group coverage (due to retirement, layoff or termination). For example, former plan participants (or their family members) might view the individual market, with the potential for premium subsidies, as an alternative to continuation coverage under COBRA.

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Employers with employees or retirees that use the individual market for coverage should understand that the enrollment process for coverage will be slightly more difficult, and be prepared to answer questions that may arise from employees, retirees and their families.

How Sibson Can Help

Sibson will keep you informed about developments related to the Affordable Care Act. As always, trustees should rely on fund counsel for authoritative advice on laws and regulations.

Questions?

For more information about how these new rules may affect your plan, please contact your Sibson consultant or the Sibson office nearest you.

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