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# HEALTH CARE REFORM WORK GROUP REGULATORY UPDATE

April 14, 2017

## SUMMARY OF HHS MARKET STABILIZATION FINAL RULE

On April 13, 2017, the Department of Health and Human Services (HHS) issued a final rule<sup>1</sup>, making several changes to regulations for the individual and small-group health insurance markets. The rule was created in response to the increasing number of insurers leaving the exchanges in certain states and counties, in large part due to their inability to attract and keep the healthy consumers necessary for a stable **risk pool**. As insurers leave markets, consumers have less choice for affordable health plans, destabilizing the risk pools even further.

The final rule seeks to stabilize risk pools for insurers in hopes of stemming their exit from the market, while increasing competition and, therefore, consumer choice and affordability. To accomplish these goals, the rule increases incentives for individuals to remain continuously enrolled, while decreasing the ability of individuals to enroll only after becoming sick. The final rule affects the regulations for individual and small-group markets located at 45 C.F.R. parts 147, 155, and 156 by:

- Shortening the **open enrollment** period for the 2018 plan year so that it runs from November 1, 2017 to December 15, 2017 (currently, the end date is January 31, 2018), with an effective plan start date of January 1. Because this shortened enrollment period was scheduled to begin for plan year 2019, this change only moves up by a year the goal for more people to be covered for an entire plan year. This shortened period is also consistent with open enrollment for Medicare, as well as many employer-sponsored plans.
- Requiring formal verification of eligibility for all individuals seeking a **special enrollment** period, based on a **qualifying event**. Previously, HHS required formal verification of only half of the special

enrollment applicants, allowing the remaining half to verify eligibility by simply self-certifying that they were eligible. By requiring a higher level of verification, the rule seeks to make it more difficult for individuals to wait until they get sick before enrolling in health insurance.

- Allowing insurers to apply current **premium** payments to past-due premiums for coverage provided during the preceding 12 months by the same insurer.
- Increasing the minor variations allowed for determining **actuarial value** (AV) of the four **“metal” levels of coverage** (bronze, silver, gold, and platinum). Current regulations allow minor variation of AV (i.e., plans must be within two percentage points of 70%, 80%, or 90% to qualify as silver, gold, or platinum plans, respectively). The final rule slightly increases the variation allowed to give more flexibility to insurers in designing new plans and providing more options to keep cost sharing the same from year to year. The rule does not change the variation for silver plans with cost-sharing reductions.

The final rule also affirms the traditional role of states in regulating health insurance by making the following changes to the regulations:

- HHS will rely on states to determine **network adequacy** in states that have federally facilitated exchanges if those states already have a sufficient network adequacy review process. For the 2018 plan year, HHS will defer to states, regardless of the type of exchange, that have a requirement that is at least equal to the “reasonable access standard” of

<sup>1</sup><https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization>

This brief was created by members of the Georgia Health Policy Center's Health Law Group in collaboration with the [Health Reform Work Group](#).

45 C.F.R. §156.230. For states without the ability to conduct adequacy reviews, the Centers for Medicare and Medicaid Services will rely on accreditation from an HHS-recognized accrediting entity.

- Insurers will only have to show that 20% of the providers in their networks qualify as **essential community providers** (ECPs). HHS will also allow insurers to write into their networks ECPs not currently recognized by HHS if those ECPs have applied to HHS for recognition as HHS-qualified.

In addition to these changes, HHS solicited comments during the proposal period on other changes being considered but not proposed:

- For special enrollment periods that require evidence of prior coverage, HHS is considering requiring individuals to show proof of prior coverage for six to 12 months rather than the current 60-day requirement. Alternatively, HHS is considering imposing a waiting period of 90 days for those unable to prove prior coverage.
- For policies in the individual market, HHS is considering whether certain Health Insurance Portability and Accountability Act (HIPAA) requirements of the large-group market should be applied to the individual market, such as maintenance of continuous coverage to avoid pre-existing condition underwriting and waiting periods for certain circumstances. These policies would encourage those who already have coverage to maintain continuous coverage throughout the year.

The final rule will be published in the Federal Register on April 18, 2017 and will take effect 60 days later. No action has been taken on other changes considered, but not proposed, by CMS.

## DEFINITIONS

### Risk Pool

Groups of individuals whose actual and projected medical costs are combined to determine premiums. Larger and more stable pools result in steady premium levels. However, regardless of pool size, the larger the proportion of high-risk individuals, the higher the premiums.<sup>2</sup>

### Open Enrollment

Yearly period when individuals may enroll in health insurance.

### Special Enrollment

If individuals have had a qualifying event, they may enroll in health insurance outside of the regular open enrollment period. In the Health Insurance Marketplace, this is typically up to 60 days after the qualifying event.<sup>3</sup>

### Qualifying Event

A certain event that allows individuals to enroll in health insurance outside of the regular open enrollment, during special enrollment. Qualifying events for the Health Insurance Marketplace include birth, adoption, marriage, divorce, moving, health coverage loss, and death in the family.

### Premium

Amount individuals pay for an insurance policy, usually expressed as a monthly or annual amount.

### Actuarial Value (AV)

Distinguishes plans by the average amount of medical costs a plan will pay for. The higher the AV, the lower the out-of-pocket costs for plan members (and the higher the plan premiums). For example, an AV of 90% means the plan, on average, will cover 90% of an insured individual's medical expenses, and for most of the covered benefits, the insured will be responsible for paying 10% of the cost.

### "Metal" Levels of Coverage

In the Health Insurance Marketplace, one of four "metal" levels is attached to plans based on their actuarial value. "Platinum" plans have an AV of 90%, "gold" plans have an AV of 80%, "silver" plans have an AV of 70%, and "bronze" plans have an AV of 60%.

### Network Adequacy

Health plans sold in the Health Insurance Marketplace must have provider networks that allow sufficient access to and choice of primary care providers, specialists, and other ancillary health care providers, as well as essential community providers. Access includes time and distance to get to providers, as well as ability to get appointments, care, and services.

### Essential Community Provider

Safety-net providers serving predominantly low-income, medically underserved individuals, including health centers, hospitals, public health departments, and community mental health or family planning clinics. Insurance providers on the Health Insurance Marketplace must include a sufficient number and geographic distribution of these providers.<sup>4</sup>

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<sup>2</sup>[http://www.actuary.org/pdf/health/pool\\_july09.pdf](http://www.actuary.org/pdf/health/pool_july09.pdf)

<sup>3</sup><https://www.healthcare.gov/glossary/>

<sup>4</sup><http://kff.org/womens-health-policy/issue-brief/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/>