What Next for Health Reform?

After years of hearing the political cry of “repeal and replace,” Republicans were considered to be in a position where they could achieve this goal – or can they? With the “repeal” bill pulled from consideration, the fate of the ACA remains unclear.

But, changes are in the offing from the regulatory arena. This issue of Legislative Review outlines the recent proposed market stabilization rule.

Background

The insurance industry has been vocal with the prior and current administration regarding their concerns about the ACA, particularly as it relates to the individual insurance market. And, these concerns are evident in the exchanges. Fewer carriers are participating in the exchanges. Networks have become very restrictive, rather than the broader networks of years past. And, premiums and deductibles have been rising.

While the Trump administration had hoped to replace the ACA, they now find themselves in even more urgent need to take regulatory steps to keep coverage available for millions of Americans. The proposed rule is the first step to keep the market viable.

The urgency was reflected in the fact that the comment period for the proposed rule was a mere 20 days long. Typical comment periods run from 30 to 90 days, with 30 being the usual minimum. The final rule is expected to follow shortly thereafter.

continued on page 2

Letter from Karen Knippen

There was quite a bit of drama watching C-SPAN with the American Health Care Act (AHCA). Alas to no avail.

I leave it to the pundits – and history – to determine if the AHCA should have been passed. Who knows, with Congress it may even reappear.

However, without a new law, changes through regulation may be the best way to keep the individual and small group health insurance market “healthy.” To that end, the steps in this proposed rule to reduce adverse selection are welcome.

Sincerely yours,

Karen Knippen, RHU, REBC, CLTC
Senior Vice President

EUCLID MANAGERS has been serving the independent agent since 1976 with a portfolio of group health, professional liability and individual health, life, annuity and long-term care products. We proudly represent UnitedHealthcare, Delta Dental of Illinois, MetLife and UnitedHealthOne Individual. We encourage your feedback and suggestions. Please call your EUCLID MANAGERS Marketing Representative or Marcy Graefen at (630) 238-2915 for more information. Outside Chicagoland, call (800) 345-7868. Website: www.euclidmanagers.com
The urgency of the proposed rule is also a reflection of the fact that carriers are determining whether they will participate in the exchange in 2018. The proposed rule provides a delay in the insurer filing deadline for 2018 but carriers are already assessing their options and will use the added time to fine tune their decisions.

**Guaranteed Availability of Coverage**

One of the problems that carriers have experienced is the rule that allows a person to avoid paying for a full year of coverage. Due to the guaranteed availability provision, an individual or group could have had their coverage terminated for non-payment of premium and then reapply to the carrier during open enrollment. The carrier was not allowed to attribute a premium payment under the “new” plan to offset outstanding debt.

The proposed rule would allow an insurer to establish a premium payment policy to all employers and individuals that requires payment of past due premiums owed to the insurer in order to resume coverage. The individual or group can, however, apply for coverage by a different carrier.

This proposal would not apply to SHOP plans.

**Initial and Open Enrollment Periods**

The open enrollment period for the benefit year beginning on January 1, 2018 had previously been announced as November 1, 2017 through January 31, 2018. Subsequent periods were to be shorter, from November 1 through December 15.

The proposed rule would implement the shorter enrollment period for plan year 2018, a year earlier than previously announced. Therefore, the open enrollment period for 2018 would begin on November 1, 2017 and end on December 15, 2017 for January 1, 2018 effective dates.

**Special Enrollment Periods**

Pre-enrollment verification will be required for special enrollments to verify eligibility. This would take effect in June 2017.

Consumers would submit an application and select a plan. But, coverage would be “pended” until verification of special enrollment eligibility was completed. Consumers would have 30 days to provide documents and would be able to upload documents or send them in the mail. When possible, electronic means of verification would be used such as verifying a birth or denial of Medicaid.
Individuals already enrolled in exchange plans would also face limits on changing metal levels during the coverage year. There may be some flexibility if the enrollee becomes newly eligible for cost-sharing reductions that would allow a change to a silver level plan to utilize these benefits. This restriction would not apply in the group market.

When the SEP is due to marriage, one partner must have already had minimum essential coverage or lived outside of the US for one or more days during the previous 60 days. Applicants claiming a permanent move as reason for an SEP must submit documentation of previous and new addresses as well as previous coverage.

**Continuous Coverage**

The proposed rule ask for comments to encourage continuous coverage. For example, the rule suggests that someone might have to show that they had coverage except for a short gap to qualify for a special enrollment period.

The proposed rule notes that absent ACA revisions, imposing a continuous coverage requirement may not be legal.

**Actuarial Value**

In order to qualify for a metal level, plans had to meet tightly defined actuarial values. For example, a bronze plan had to have an actuarial value (AV) of 60 percent with a possible de minimis variation of +/-2 percentage points.

The proposal would allow for greater flexibility. The de minimis variation would be -4/+2 percentage points for individual and small group plans subject to AV requirements. Bronze plans would have a range of -4/+5 percentage points. Silver plan variations would not change from the current practice.

**Network Adequacy**

States would be charged with determining network adequacy standards for plans, if they have an adequate review process. Part of the goal of this approach would be to eliminate duplication of regulation by both the federal and state government to determine compliance with adequacy standards.

The proposed rule also would relax the requirement for a plan to include essential community providers in their networks. Plans would be required to include only 20 percent of such providers versus 30 percent.
Inside:

What Next for Health Reform?