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The First New Health Care Regulations in the Trump Administration: Final "Market Stabilization" Rules

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On April 13, 2017, the federal Department of Health and Human Services (HHS) issued final regulations designed to help stabilize the individual and small-group health insurance markets. The new rules generally do not impact large-group plans. The rules also do not impact self-funded plans (whether large group or small group), grandfathered plans or insurance not subject to the Affordable Care Act (ACA) requirements, such as supplemental health benefits (including hospital indemnity and other fixed indemnity coverage and coverage for a specified disease or illness) or other excepted benefit coverage (such as dental, vision, accident or disability benefits). This article provides a high-level summary of key provisions in the final market stabilization rule.

Shortened 2018 Open Enrollment Period in the Individual Market

Under the final regulation, the 2018 open enrollment period for the individual market both on and off Exchanges started on Nov. 1, 2017, and ran through Dec. 15, 2017. This conformed the open enrollment period for 2018 to the open enrollment period for 2019 and later years. Before this change, the 2018 open enrollment period would have been longer (starting Nov. 1, 2017, and running through Jan. 31, 2018). This longer period had been provided on a transition basis leading up to the shorter period that would apply in 2019 and later years. In making the change, HHS determined that there has been enough experience with Exchange coverage so that a longer open enrollment period was not needed. HHS was also concerned that the longer open enrollment period inappropriately encouraged some people to wait until they are sick to sign up for insurance coverage.

Adjustment of Metal Tiers to Provide More Consumer Choice in the Individual and Small Group Market

Nongrandfathered individual and fully insured small-group market plans are subject to actuarial value (AV) requirements that are represented by metal tiers. The AV is an estimate of the expected payments by the plan for essential health benefits. There are four metal tiers:

- Bronze (60 percent actuarial value)
- Silver (70 percent actuarial value)
- Gold (80 percent actuarial value)
- Platinum (90 percent actuarial value)

Prior rules had allowed plans some variation from the precise AV percentages, while still meeting the metal tier requirements. The new final regulations allow greater variation, thus allowing insurers greater flexibility to adjust benefits and provide consumers with additional options and potentially lower premiums.

Under the final rule, starting with the 2018 benefit year, plans will be considered to meet the metal tier requirements if the plan's AV is no more than 2 percentage points above and no more than 4 percentage points below the specified AV level. For example, a plan with an AV between 66 percent and 72 percent would qualify as a silver plan and a plan with an AV between 56 percent and 62 percent would qualify as a bronze plan.

A special rule allows additional variation for certain bronze plans. If a bronze plan is either an HSA-compatible high-deductible health plan (HDHP) or covers and pays for at least one major service other than preventive services before the deductible is met, then a variation of 5 percentage points above the AV and 4 percentage points below is permitted. For example, an HSA-compatible HDHP can have an AV of between 56 percent and 65 percent and still be considered a bronze plan. This provides greater flexibility for insurers that offer HDHPs.

Allowing Insurers Greater Flexibility to Recoup Past-Due Premiums in the Individual and Large- and Small-Group Markets

The final rule allows insurers to collect past-due premiums from individuals for the prior 12 months before re-enrolling the individual for the next year, if permitted under state law and consistent with applicable nondiscrimination rules. This rule is designed to encourage individuals to maintain continuous coverage throughout the year. Although the rule applies in the group market as well as the individual market, an insurer cannot refuse to effectuate an individual's coverage for a year due to the employer's failure to pay past-due premiums.

Changes Relating to Special Enrollment Periods for Exchanges

Special enrollment periods allow individuals who experience certain events, such as loss of employment-based health coverage, marriage or birth of a child, to enroll in or change coverage outside of the open enrollment period. The final rule includes a number of provisions regarding special enrollment periods, including additional verification requirements for special enrollments through the Exchanges and limiting the ability of Exchange enrollees to change metal tier levels during a special enrollment period. These changes are intended to help avoid fraudulent claims of eligibility for special enrollment periods by individuals who have waited until they are sick to enroll in insurance coverage.