LEGAL ADVICE FOR HEALTH PLANS

HEALTH LAW ALERT
April 18, 2017

HHS Amendments to Promote "Market Stabilization"

Enrollment Periods and Verification Requirements Affected; Insurers Permitted to Collect Past Due Amounts Prior to Re-Enrollment

The Department of Health and Human Services formally[1] published final rules adopting a variety of amendments to Rules affecting health insurers designed to promote "market stabilization" as well as to "affirm the traditional role of State regulators." The amendments shorten the annual open enrollment period for 2018, require enrollees to provide verification to qualify for special enrollment periods, and allow insurers to apply an applicant's premium payment to past-due amounts before the current month's premium. Other changes give State regulators authority to evaluate network adequacy and allow insurers greater flexibility in the Actuarial Value of Levels of Coverage (*i.e.*, the de minimis range for metal levels). Generally, the amendments are intended to address the "stability and competitiveness of the Exchanges, as well as that of the individual and small group markets," which "have recently been threatened by issuer exits and increasing rates in many geographic areas."

The final amendments are effective on June 19, 2017 and are published at 82 *Federal Register* 18346 (click here). My compilation of Selected Federal Health Insurance Provisions incorporating the amendments into previously-published rules may be accessed here (*see* first two links under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com).

Enrollment Period Amendments

The amendments cut the length of the annual open enrollment period for calendar year 2018 in half by making the last date on which individuals may enroll for coverage December 15, 2017—previously, the last date was January 31, 2018. The shorter annual open enrollment period had been scheduled to go into effect in 2019, so this change affects only enrollment for 2018. This change is intended to "reduc[e] opportunities for adverse selection by those who learn they will need medical services in late December and January."

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[1] The Department informally published the Rules and released them to the public on April 13 when they were filed with the Office of the Federal Register.

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In response to "concerns from issuers about potential misuse and abuse of special enrollment periods in the individual market," HHS intends to require pre-enrollment verification of all new consumers' eligibility for special enrollment periods in the Federally-Facilitated Exchanges and the Stated-based Exchanges on the Federal platform. Thus, HHS will require, for example, documentation that an individual has lost minimum essential coverage, made a permanent move, gotten marriage, or adopted a child when the individual applies for a special enrollment period. HHS intends to phase this process in, "focusing first on the categories [of special enrollment periods] with the highest volume and of most concern." In addition, to reduce adverse selection, HHS will modify the special enrollment period for marriage by requiring that at least one spouse have minimum essential coverage prior to qualifying for coverage under the special enrollment period.

Past Due Amounts

In another policy change designed to minimize adverse selection and prevent "gaming," HHS has revised its interpretation of the Affordable Care Act's guaranteed issue provisions to permit issuers to collect past-due amounts from applicants prior to allowing them to re-enroll in coverage. An issuer must provide notice of this past-debt-collection policy in its application materials and apply the policy uniformly, in compliance with applicable non-discrimination requirements (including, but not limited to the HIPAA non-discrimination provisions). An insurer may collect a debt that is no more than 12-months old, provided that the debt is to the insurer itself or another company within a controlled group—*i.e.*, an affiliate; an insurer cannot, however, collect a debt to an unrelated insurer.

Network Adequacy

With respect to of oversight of Qualified Health Plans operating in Federally-Facilitated Exchanges, HHS will permit States that have sufficient regulatory authority to review the adequacy of the QHPs' provider networks to do so in "recognition of the traditional role States have in developing and enforcing" such standards. For States without such regulatory authority, HHS will permit the QHPs to demonstrate compliance with network adequacy standards based on accreditation by NCQA, URAC, or the Accreditation Association for Ambulatory Care—three organizations on which HHS relied for such accreditation in the 2014 plan year. Issuers in these States that are not accredited will be required to submit an access plan with the QHP application.

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