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To improve the risk pool and otherwise stabilize the individual insurance market, HHS published a Final rule changing several components of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) marketplace enrollment process and administration. The changes include modification of the dates for open enrollment, an enhanced pre-enrollment verification requirement for special enrollment periods (SEPs), alteration of federal requirements for the application of premiums to past debts, and a revision to the actuarial values (AVs) used to determine metal levels of coverage. The changes are designed to lessen uncertainty and ensure continued issuer participation (Final rule, 82 FR 18346, April 18, 2017).


Guaranteed availability of coverage. Section 1201 of the ACA requires health insurance issuers offering nongrandfathered coverage in the individual or group market to offer coverage to and accept every individual and employer in the state that applies for such coverage unless an exception applies. However, due to concerns of consumers gaming the system by not paying premiums at the end of a coverage year, under the Final rule, HHS revised its interpretation to allow issuers to collect premiums for prior unpaid coverage, before enrolling a patient in the next year’s plan with the same issuer.

Open enrollment periods. Section 1311(c)(6)(B) of the ACA gives HHS the authority to set the dates for annual enrollment periods. The Final rule changes the previous open enrollment period for the 2018 plan year—November 1, 2017 through January 31, 2018—by shortening it so that it will end on December 15, 2017. HHS believes the shortened enrollment period is sufficiently lengthy and reduces the risk of adverse selection by those who realize they need coverage in late December or early January.

Enrollment verification. The Final rule also increases pre-enrollment verification of new consumers seeking enrollment in the individual market through an SEP. The Final rule requires that the number of new SEP consumers subject to pre-enrollment verification—for states utilizing the HealthCare.gov platform—increase from 50 to 100 percent of new consumers.

Coverage level. Under section 1302(d)(1) of the ACA, a plan’s coverage level, or actuarial value (AV), is determined based on its coverage of the essential health benefits for a standard population. The ACA authorizes HHS to develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates. However, HHS determined that the current variation amount is too limited. Therefore, the Final rule amends the definition of de minimis to a variation of -4/+2 percentage points, rather than +/-2 percentage points for all non-grandfathered individual and small group market plans that are required to comply with AV. HHS believes the change will give issuers greater flexibility in designing new plans.