April **2017**

April 2017 HHS Rule and Other Proposals to Stabilize the Health Insurance Marketplaces

Health plans are now determining whether to offer coverage in the Marketplace this fall and if so, which products and rates to offer. While there is continuing discussion about repealing and replacing the Affordable Care Act (ACA), legislative action does not appear imminent. To assure a robust ACA market, many have advocated for "repairs" to the ACA. These ideas range from the addition of a "public option" in areas with low competition, to fixing the "family glitch," to eliminating the Cadillac Tax.[1] On April 13, 2017, the U.S. Department of Health and Human Services (HHS) finalized a rule intended to stabilize the Health Insurance Marketplace for 2018. In this fact sheet, we summarize the final rule and highlight some of the potential repairs currently in discussion and are particularly relevant to health plans as they decide whether or not to participate in the 2018 Marketplace.

Proposal	Policy	Status	Implications
Fully Fund Cost-Sharing Reductions	Under current law, HHS reimburses insurers for cost-sharing reductions (CSRs) provided to individuals with incomes below 250% FPL who are enrolled in silver plans on the Marketplace. CSRs are intended to lower deductibles and other out-of-pocket costs for enrollees.	In 2014, the House of Representatives filed a lawsuit claiming the Obama Administration illegally reimbursed insurers for cost-sharing reductions because Congress had not explicitly appropriated the funds. The suit is currently "paused" and it is unclear how Congress or the Trump Administration will proceed.	• Without CSR payments, insurers would incur substantial financial losses and would be permitted to withdraw from the Marketplace immediately upon the termination of these payments. • The Kaiser Family Foundation has estimated that insurers would need to increase silver plan premiums by an average of 19% to compensate for lost funding if CSR payments were eliminated.[2] • 58% of Marketplace enrollees received cost sharing reductions in 2017.[3]
Extend and Fully Fund the Reinsurance Program	Temporary program (2014-2016) compensated insurers for a portion of the cost of particularly high-cost enrollees in the individual market.	The reinsurance program ended at the end of 2016. The American Health Care Act (AHCA) would have provided funding to states that could have been used for reinsurance. No other legislation has been considered to continue the program.	• According to the American Academy of Actuaries, the reinsurance program contributed to reductions in individual market premiums of 10-14% in 2014, 6-11% of 2015, and 4-6% in 2016.[4] • Payments from the reinsurance program have helped improve financial outcomes for individual market insurers with high claims costs for their enrollees.[5] • In 2014, insurers contributed $9.7 billion to the reinsurance program, and requested and received $7.9 billion in reinsurance payments.[6] In 2015, insurers received $7.8 billion in payments but requested $14.3 billion in payments from the program.[7]
Extend and Increase Funding for Risk Corridors program	Temporary program (2014-2016) compensated insurers who incurred unexpectedly high claims.	The risk corridors program ended at the end of 2016. As of March 30, 2017, 23 lawsuits have been filed against the federal government for funds owed to insurers under the risk corridors program for the period from 2014-16.[8] It is unclear how the Trump Administration will proceed. No legislation has been considered to continue this program.	In 2014, insurers received only 12.7% of the $2.87 billion in requested payments due to Congressional restrictions on the program's ability to pay out more than what is collected from insurers.[9] In total, insurers are owed $8.3 billion in risk corridor payments from 2014 and 2015.[10]
Require Pre-Enrollment Verification by HHS to Verify Eligibility for Special Enrollment Periods	Under current rules, some enrollees may enroll only when health care is needed.	HHS finalized a rule on April 13, 2017 to require verification of eligibility for a special enrollment period (SEP) before insurers make coverage effective.	• 1.6 million people enrolled on Healthcare.gov through SEPs in 2015 (11.7 million enrolled during open enrollment). 60% of SEP enrollees in 2015 qualified for an SEP due to loss of other health insurance coverage.[11] • The Center on Budget and Policy Priorities believes additional verification requirements may discourage healthier individuals from applying for coverage, which could negatively impact the risk pool.[12]
Limit Grace Period for Premium Payments	Current law is a 90-day grace period for those who receive tax credits.	HHS finalized a rule on April 13, 2017 to allow insurers to collect unpaid past premiums before making coverage effective.	• The current structure could allow some individuals to receive a full year of coverage but pay just 9 months of premiums. • Requiring enrollees to pay prior unpaid premiums before making coverage effective could encourage continuous coverage. • According to a 2013 Fiserv survey, young adults are 25 percent more likely to pay bills late than older adults.[13] If so, this provision could worsen the risk pool.
Shorten Open Enrollment Period	Current Marketplace open enrollment period is November 1-January 31. Medicare open enrollment is from October 15-December 7.	HHS finalized a rule on April 13, 2017 to shorten the open enrollment period to November 1-December 15.	• Insurers would be able to collect a full year's worth of premiums if open enrollment ends in December. • This could encourage continuous coverage, but if fewer young adults enroll (young adults are more likely to enroll right before the deadline[14]), it could negatively impact the risk pool. • 12.2 million people selected plans on the Marketplace during the 2017 open enrollment period.[15] Nearly 34% of plan selections, including automatic renewals, occurred between 12/18/16 and 1/31/17.[16,17]
Allow Increased variation in Actuarial Value Requirements	Current law allows the actuarial value of plans to vary up to two percentage points from the standard value for each metal level.	HHS finalized a rule on April 13, 2017 to allow increased variation to four percentage points below the standard actuarial value for each metal level.	• This proposal would provide insurance companies more flexibility in their benefit designs. • According to the Center for Budget and Policy Priorities, selling plans with lower actuarial values could lower premiums for benchmark silver plans. However, this could decrease premium tax credits, which are calculated based on benchmark silver plan premiums.[18]

Timeline for Insurer Qualified Health Plan (QHP) Filings

On Feb. 17, 2017, the Centers for Medicare and Medicaid Services (CMS) announced plans to revise its schedule for the 2018 Qualified Health Plan (QHP) filing and rate review process for insurers offering coverage on the federally-facilitated Health Insurance Marketplaces created under the Affordable Care Act (ACA). This change is intended to give insurers more time to determine their participation and prepare their 2018 filings.

2018 QHP Filing Process: Major Milestones

June 21	Aug. 1	Aug. 16	Sept. 27	Oct. 12	Nov. 1 – Dec. 15
Deadline for insurers to file 2018 Marketplace products and rates *(delayed from May 3)*	**CMS and states with effective rate review programs publish** proposed rate increases	**Deadline to** make changes to plan applications *(moved up from Aug. 21)*	**States send** final recommendations to CMS *(delayed from Sept. 15)*	**CMS sends** final plan certification notices to insurers	**2018 Open Enrollment Period**

ENDNOTES

1 https://tcf.org/content/report/key-proposals-to-strengthen-the-aca/
2 http://kff.org/health-reform/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/
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CHRT
Center for Healthcare Research & Transformation
2929 Plymouth Road, Suite 245 • Ann Arbor, MI 48105-3206
Phone: 734-998-7555 • chrt-info@umich.edu • www.chrt.org

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