



## Looking Ahead to the 2018 Plan Year: Market Stabilization Final Rule & Plan Review Changes

April 2017

This fact sheet provides an overview of the [market stabilization final rule](#) and guidance released by the Centers for Medicare and Medicaid Services (CMS) regarding the individual health insurance market for the 2018 plan year (with some proposals going into effect immediately for the 2017 plan year). The rule will impact individual plans sold both on and off state and federal Marketplaces. For questions, please contact Amy Killelea ([akillelea@nastad.org](mailto:akillelea@nastad.org)) or Sean Dickson ([sdickson@nastad.org](mailto:sdickson@nastad.org)).

### Market Stabilization Rule

The following provisions included in the final rule are of particular importance for people living with and at risk for HIV and hepatitis:

#### ▪ **Open Enrollment Period**

- The rule shortens the 2018 open enrollment period to November 1, 2017 through December 15, 2017 (this a change from previous open enrollment periods that ran from November 1 through January 31 of the next calendar year). This means that client education, outreach, and enrollment activities will be critical to ensure that people sign up for coverage within the shorter timeframe.

#### ▪ **Special Enrollment Periods**

The rule limits availability of Special Enrollment Periods (SEPs) in 2018, including:

- Requiring pre-enrollment verification and documentation of eligibility for all SEP applicants
- Prohibiting use of SEPs to change metal level (i.e., enrollees using a SEP would have to enroll in a plan in the same metal level as one they are currently on)
- Prohibiting use of SEP for loss of minimum essential coverage if that coverage was lost because of failure to pay premiums, even if an individual qualifies for a different SEP
- Requiring demonstration of continuous coverage in the 60 days prior to the qualifying event for SEPs associated with a permanent move or marriage
- For the rest of the 2017 plan year and for the 2018 plan year, the rule significantly limits SEPs for “exceptional circumstances” (including eliminating availability of this SEP for lawfully present non-citizens subject to eligibility processing delays)

#### ▪ **Changes to Actuarial Value Requirements**

The rule allows issuers to increase consumer cost sharing for Qualified Health Plans (QHPs). Specifically, the proposal would allow issuers to decrease the Actuarial Value of plans by 2%, transferring an additional 2% of costs to enrollees. This would **not** apply to Cost-Sharing Reduction silver plans for enrollees between 100-250% of the Federal Poverty Level. Because the Advance Premium Tax Credit amount is based on the premiums for a benchmark silver-level plan, this change could reduce Advance Premium Tax Credit amounts for low-income individuals and increase net premium costs. The change will disproportionately impact people who choose higher level metal plans, including many people living with HIV and hepatitis who prefer plans with lower cost sharing. These enrollees will likely see greater premium costs associated with their plans.

- ***Network Adequacy and Essential Community Providers***

The rule reduces Federal network adequacy review to ensure that provider networks provide meaningful access to providers and care. Specifically, the rule shifts network adequacy review from Federal to State review when possible, allowing for issuers to demonstrate network adequacy through external accreditation in some circumstances. This reverts to the network adequacy standards in place in 2014. The rule also weakens the Essential Community Provider (ECP) standards. Specifically, the plan networks are only required to contain 20% of ECPs in the service area, a reduction from the 30% threshold established in 2015. Since Ryan White HIV/AIDS Program providers meet the definition of ECP, weakening the ECP requirement could exacerbate challenges in ensuring that plan networks include HIV providers.

- ***Back Payment of Premiums***

The rule allows plans to require individuals who owe premium payments to pay outstanding debt before enrolling in a new plan offered by the same issuer. This does not apply in a circumstance where an individual enrolls in a plan offered by a different issuer.

## **Qualified Health Plan Certification Changes**

In addition to finalizing the market stabilization rule, CMS also released guidance announcing a new approach to QHP review for the 2018 plan year. Highlights are as follows:

- Issuers must submit applications to sell QHPs on the federally facilitated Marketplaces for the 2018 plan year by **June 21, 2017** (many states are also pushing their deadlines back to give issuers more time set rates).
- CMS will rely more heavily on state review for QHP certification. In [guidance](#) released in April, CMS announced a significant change from past years for the 13 states using the federally facilitated Marketplace, but retaining plan management functions (including both partnership states and federally facilitated Marketplace states that retain plan management oversight). For these states, CMS will defer to state review of certain plan certification areas, most notably prescription drug coverage and discriminatory plan design. CMS will continue to review plan certification documents for the 21 states using the federally facilitated Marketplaces where the state does not retain any plan management function. As a reminder, CMS has always deferred to plan certification decisions of states with state-based Marketplaces. To see which category of Marketplace your state has, see the Commonwealth Fund's [interactive map](#).