Individual Market Stabilization and Benefit and Payment Parameters

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TODAY'S PRESENTER

Nicholas A. Moriello, R.H.U.

Director, Business Development, Savoy Associates

Under Nick's leadership, Health Insurance Associates (HIA) grew to one of the largest independent health insurance agencies in the tri-state area of Delaware, Pennsylvania, and Maryland. HIA has served that regional community for over 40 years. In January of 2016, Nick merged HIA with Savoy Associates, a regional General Agency and Wholesaler headquartered in northern New Jersey, and Ascela Partners, a retail agency based in southeastern Pennsylvania.

Nick's 23 years of industry experience started in 1993, and he earned the designation of Registered Health Underwriter (RHU) from The American College in 2003.

Industry Involvement, Leadership, and Achievements:

- Serves on the National Association of Health Underwriter's (NAHU) National Legislative Council, is in the incoming Vice Chair of the Council; Chair of the National Individual Working group; NAHU's Delaware Legislative Chair; Delaware Exchange Coordinator; and Leading Producing Round Table's highest award of Lifetime & Qualifying Soaring Eagle recipient 12 years & counting
- Serves on the Board of the Delaware Chapter of the National Association of Insurance & Financial Advisors (NAIFA) as Health Chair. NAIFA's 2013 Carl Hill Memorial Award recipient for dedication to the industry & community
- Serves on the Board of Directors for the Delaware Center For Health Innovation
- Serves on the Delaware State Chamber of Commerce Board of Governors, and serves on the Chamber's Health Care Committee
- Serves as the Chair of the Agent Advisory Board to Delaware Insurance Commissioner Trinidad Navarro
- Served on the Delaware Department of Insurance's Life and Health Content Development team for producer licensing
- Served on former Delaware Insurance Commissioner Karen Weldin Stewart's Agent Advisory Board
- Nick is one of the more respected health insurance advisors in his field. His technical expertise in health insurance, along with his ability of conveying complex insurance topics into everyday common language, is what draws agents & clients to him at his agencies, Health Insurance Associates, Ascela Partners, and Savoy Associates.

Final Rule, 4/13/17

- There was a Notice of Proposed Rule Marking (NPRM) on 2/15/17 which intended to stabilize the individual health insurance markets prior to any repeal or replace
- This became a Final Rule on 4/13/17
- First proposed rule under HHS' new Secretary Tom Price
- Attempts to address concerns voiced by insurance carriers about the volatility of the individual insurance market
  - Doesn't address reinsurance payments

Guaranteed Availability

- A carrier could refuse to effectuate coverage if the consumer is delinquent on payment of prior year's plan

Open Enrollment 2018

- Shortened open enrollment for 2018 plans of November 1st through December 15th moves up to begin in November 2017.
- Hopes to eliminate adverse selection into the New Year and align enrollment periods
- Resources are the concern
  - Access to agents/brokers
  - Time commitment per consumer
- Suggestion: increased outreach to raise awareness
- State-based Exchanges that can't meet the new OEP timing will be allowed to supplement with a SEP as a transitional measure

Special Enrollment Periods

- HHS took a number of steps during 2016 to address insurer complaints, which included eliminating some minor SEPs, redefining the SEP for consumers who experience a move to only apply to those who were covered before the move, and requiring documentation for some SEPs.
- The final rule provides additional tightening of SEPs to incent consumers to maintain continuous coverage, and to discourage adverse selection through inappropriate or fraudulent SEPs.

Special Enrollment Periods (continued)

- Requires pre-enrollment verification of eligibility for SEPs
- When a consumer submits an application for enrollment, it would be pended for verification of the SEP
- Consumers would then be given 30 days to provide documentation of the SEP
  - Needs appeal process for special circumstances (NAHU comment)
- Once the consumer provides the documentation, and the SEP is verified, the coverage would go into effect retro-actively to the date of the plan selection
- State-based Exchanges encouraged to follow these same SEP pre-verification guidelines, however, not required
- NAHU comment letter suggested standardized CMS document for loss of MEC

Metal Coverage Upgrades

- A second set of rule changes for SEPs is to limit metal level change options. In particular, for a person with a SEP on a current metallic plan, they would not be able to upgrade the metal level when experiencing a SEP.
  - Example: birth of child, no metal change for family without change of tax credit eligibility

Eligibility Limits

- The rule also considered allowing HHS to collect and store records of consumers who lost coverage due to non-payment of premiums to eliminate consumers losing coverage for non-payment to gain a SEP for eligibility
- The rule limits the SEP for marriage to only allow enrollment if at least one partner had minimum essential coverage or lived outside the United States or in a United States territory for one or more days during the previous 60 days.
- Consumers claiming a SEP due to a move would also have to show proof of prior coverage for one or more days within the 60 days prior to the move.
  - Documentation of the move would be required as well showing both the previous address and the new permanent address.

Continuous Coverage

- The proposed rule sought comments on establishing continuous coverage requirements
  - Waiting period of 90 days
  - Or, late enrollment penalty
- The final rule did not add a waiting period nor a late enrollment penalty

Actuarial Value

- Current AVs:
  - Bronze = 60%
  - Silver* = 70%
  - Gold = 80%
  - Platinum = 90%
    - *silver plans with cost sharing reduction subsidies can have 94%, 87%, or 73%
- Variations allowed at +/- 2% (+5%/-2% for bronze)

Actuarial Value (continued)

- The final rule allows -4 to +2% for platinum, gold, and silver
- -4% to +5% for bronze

Network Adequacy

- The final rule relies on state regulators to ensure network adequacy if the states had authority to do so. If the state does not have the authority to do so, then HHS would rely on insurers accreditation.

Essential Community Providers

- The final rules changes the requirement from 30% to 20% lessening regulatory burden for QHPs

Issuers Time Frames

- It should be noted that issuers have until 6/21/17 to determine if they will offer plans in the individual exchanges for 2018 (previously, the deadline was 5/3/17)

NAHU Comment Letter Suggestions – 3/7/2017

- "Grandmothering" remain in effect until further notice
  - Reminder – "grandfathering" is for plans in place as of 3/23/10, and "grandmothering" is for plans in place in 2013, and is a carrier choice if the state allows it
- Allow for the return of small group composite rates (state by state)
- Broker compensation and fraud prevention to be removed from MLR
- Marriage SEPs be treated the same as in the group market
- Age changes for children in the Benefit Payment and Parameters Rule be considered

Benefit and Payment Parameters Rule for 2018

- December 16, 2016, CMS finalized the Benefit and Payment Parameters rule for 2018. CMS also released the final 2018 Letter to Issuers in the Federally Facilitated Marketplaces (FFM).

Market Withdrawal

- This final rule loosens the restriction of an insurance carrier being banned from a market for five years for pulling out of a market.

Child Age Rating

- The ACA allows for age rating on a ratio of 3 to 1 for adults, and a single age band for children ages 0-20 that is allowed to be .635 of the ratio.
- The final rule increases the current age factor for children up to age 14 from .635 to .765 and then gradually increases the age factor year by year from age 15 to age 20.
- NAHU comment letter suggested leaving 0-20 alone, and addressing 3:1 to greater ratio

Guaranteed Availability

- This requires network adequacy for employees in their residence regardless of the employer principal location

Transition to Medicare

- An individual carrier may not enroll an individual enrolled in Medicare Part A or Part B into an individual Marketplace plan. They may renew a consumer who already has the plan, but not into a new plan.

MLR

- Allows carriers to choose a single year for MLR calculation (vs. three year average), for new carriers to a market and those with rapid growth. The one year calculation would then need to be recalculated over the next two years by the total time period

Risk Adjustment Program

- Although sequestered, changes were detailed in this rule:
  - Allow for state law determination of large vs. small employer as long as non-full-time taken into account
  - Total amount collected from issuers for risk adjustment in 2017 will be reduced by 7.1% before any payments to issuers
  - Partial year enrollments from 1 to 11 months will be considered as a factor
  - Prescription drug data will be added for 2018
  - Very high cost conditions taken into account in 2018
  - Change in fee to issuers: Uses billable member months rather than enrollee member months, thus excluding from the charge children who do not count toward family rates or premiums. For 2018, CMS will impose a user fee of $1.68 per billable member per year.

Standardized Plans

- Changes to three sets of six for standardization of plans. Each state would have one of these options:
  - Current model: Six plans (one for each variation of metal level)
  - Model specific to states that:
    - 1) require that cost sharing for physical, occupational, or speech therapy be no greater than cost sharing for primary care visits;
    - 2) limit the amount charged for each drug tier; or
    - 3) require that drug tiers have copayments rather than coinsurance
  - Model for New Jersey, which has maximum deductible requirements and other cost-sharing standards

Enhanced Direct Enrollment

- For web entities for consumers to stay on the web entity's website (vs. web entity to healthcare.gov back to web entity)

Out of Pocket Exposure

- The maximum cost sharing exposure for 2018 will be $7,350 for self-only coverage and $14,700 for other than self-only coverage

SHOP

- Newly eligible SHOP employees will have 30 days to make an enrollment decision from the date that the SHOP is notified of their eligibility
- The rule eliminates the “tying” provision requiring insurers selling individual to also sell small group
- The requirement to offer at least one silver and one gold on the SHOP was eliminated
- Waiting periods in the SHOP cannot exceed 60 days

Websites

- Prohibits agents/brokers maintaining websites that mislead the public meaning they cannot use the word “marketplace”

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Thank You!

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