On April 13, 2017, the Department of Health and Human Services (HHS) issued a final rule, making several changes to regulations for the individual and small-group health insurance markets. The rule was created in response to the increasing number of insurers leaving the exchanges in certain states and counties, in large part due to their inability to attract and keep the healthy consumers necessary for a stable risk pool. As insurers leave markets, consumers have less choice for affordable health plans, destabilizing the risk pools even further.

The final rule seeks to stabilize risk pools for insurers in hopes of stemming their exit from the market, while increasing competition and, therefore, consumer choice and affordability. To accomplish these goals, the rule increases incentives for individuals to remain continuously enrolled, while decreasing the ability of individuals to enroll only after becoming sick. The final rule affects the regulations for individual and small-group markets located at 45 C.F.R. parts 147, 155, and 156 by:

- Shortening the open enrollment period for the 2018 plan year so that it runs from November 1, 2017 to December 15, 2017 (currently, the end date is January 31, 2018), with an effective plan start date of January 1. Because this shortened enrollment period was scheduled to begin for plan year 2019, this change only moves up by a year the goal for more people to be covered for an entire plan year. This shortened period is also consistent with open enrollment for Medicare, as well as many employer-sponsored plans.

- Allowing insurers to apply current premium payments to past-due premiums for coverage provided during the preceding 12 months by the same insurer.

- Increasing the minor variations allowed for determining actuarial value (AV) of the four “metal” levels of coverage (bronze, silver, gold, and platinum). Current regulations allow minor variation of AV (i.e., plans must be within two percentage points of 70%, 80%, or 90% to qualify as silver, gold, or platinum plans, respectively). The final rule slightly increases the variation allowed to give more flexibility to insurers in designing new plans and providing more options to keep cost sharing the same from year to year. The rule does not change the variation for silver plans with cost-sharing reductions.

The final rule also affirms the traditional role of states in regulating health insurance by making the following changes to the regulations:

- HHS will rely on states to determine network adequacy in states that have federally facilitated exchanges if those states already have a sufficient network adequacy review process. For the 2018 plan year, HHS will defer to states, regardless of the type of exchange, that have a requirement that is at least equal to the “reasonable access standard” of
Special Enrollment
If individuals have had a qualifying event, they may enroll in health insurance outside of the regular open enrollment period. In the Health Insurance Marketplace, this is typically up to 60 days after the qualifying event.\(^3\)

Qualifying Event
A certain event that allows individuals to enroll in health insurance outside of the regular open enrollment, during special enrollment. Qualifying events for the Health Insurance Marketplace include birth, adoption, marriage, divorce, moving, health coverage loss, and death in the family.

Premium
Amount individuals pay for an insurance policy, usually expressed as a monthly or annual amount.

Actuarial Value (AV)
Distinguishes plans by the average amount of medical costs a plan will pay for. The higher the AV, the lower the out-of-pocket costs for plan members (and the higher the plan premiums). For example, an AV of 90% means the plan, on average, will cover 90% of an insured individual’s medical expenses, and for most of the covered benefits, the insured will be responsible for paying 10% of the cost.

“Metal” Levels of Coverage
In the Health Insurance Marketplace, one of four “metal” levels is attached to plans based on their actuarial value. “Platinum” plans have an AV of 90%, “gold” plans have an AV of 80%, “silver” plans have an AV of 70%, and “bronze” plans have an AV of 60%.

Network Adequacy
Health plans sold in the Health Insurance Marketplace must have provider networks that allow sufficient access to and choice of primary care providers, specialists, and other ancillary health care providers, as well as essential community providers. Access includes time and distance to get to providers, as well as ability to get appointments, care, and services.

Essential Community Provider
Safety-net providers serving predominantly low-income, medically underserved individuals, including health centers, hospitals, public health departments, and community mental health or family planning clinics. Insurance providers on the Health Insurance Marketplace must include a sufficient number and geographic distribution of these providers.\(^4\)

Definitions
Risk Pool
Groups of individuals whose actual and projected medical costs are combined to determine premiums. Larger and more stable pools result in steady premium levels. However, regardless of pool size, the larger the proportion of high-risk individuals, the higher the premiums.\(^2\)

Open Enrollment
Yearly period when individuals may enroll in health insurance.

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\(^{3}\)http://www.healthcare.gov/glossary/