FEBRUARY, 2017

"Patient Protection and Affordable Care Act; Market Stabilization" Proposed Rule

SUMMARY

On February 15, 2017 the Centers for Medicare & Medicaid Services (CMS) released a proposed rule entitled, "Patient Protection and Affordable Care Act; Market Stabilization."[1]

In general, the proposed rule is designed to bring stability to the Exchange marketplace in light of issuer exits and increases in rates in many areas of the country,[2] while Congress works on drafting potential Affordable Care Act (ACA) replacement package(s).[3] While a legislative package could potentially come together as early as mid-March, this expedited timeframe is subject to a great deal of uncertainty.

The proposed rule includes a number of modifications to existing policies designed to stabilize the risk pool in the individual health insurance market and limit issuers' financial risks in the Exchange marketplace, including, for example, changing the dates for the open enrollment period and adopting new documentation requirements for special enrollment periods. The rule also includes proposed changes that are intended to affirm the role of States in overseeing the health insurance markets, including modifications related to network adequacy and to the number of participating community providers included within an issuer's network.

We note that in the proposed rule, in accordance with President Trump's January 30, 2017 Executive Order (EO) 13771, "Reducing Regulation and Controlling Regulatory Costs," CMS states that:

"It has been determined that this proposed rule is not a "significant regulatory action that imposes costs" and thus does not trigger the [] requirements of Executive Order 13771."

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[1] CMS, Patient Protection and Affordable Care Act; Market Stabilization, Proposed Rule (CMS-9929-P); Display Copy available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-03027.pdf (filed Feb. 15, 2017; to be published in the Federal Register on February 17, 2017).

[2] We note that the proposed rule comes one day after Humana announced that it will completely exit the Exchange market in 11 states next year; on February 15th, Aetna signaled a possible similar intention, citing the "death spiral" of the Exchange marketplace.

[3] We also note that the proposed rule includes many of the recommendations recently circulated by America's Health Insurance Plans (AHIP). A number of other AHIP's proposals, including modifications to the age-band ratings, however, were not included in this proposed rule.

EO 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency proposes for notice and comment a new regulation. In addition, the executive order requires that new incremental costs associated with the new regulations are to be offset by the elimination of existing costs associated with at least two prior regulations. As CMS does not view the current proposed rule as a "significant regulatory action that imposes costs," it has not identified two existing regulations to be repealed.

Comments on this proposed rule are due to CMS no later than 5 p.m. on March 7, 2017. Note that this is a much shorter timeframe to comment than most CMS proposed rules.

Below we highlight key policy changes proposed in the rule.

Changes to Open Enrollment Periods. The proposed rule shortens the open enrollment window for the 2018 plan year and for all future plan years (previously, this reduced window was to be implemented in plan year 2019). Currently, the open enrollment window runs from November 1st through January 31st (a 90-day enrollment window.) To reduce the chance that individuals will enroll in coverage only after they discover they require services, the proposed rule shortens the annual open enrollment window to run from November 1st through December 15th (a 45-day enrollment window).

CMS is seeking comments on whether State-based exchanges will be able to make this change in time for the 2018 open enrollment period. CMS also seeks comment on any difficulties agents and brokers may have enrolling individuals during this shorter enrollment window.

Changes to Special Enrollment Periods. The proposed rule also makes changes to "special enrollment periods," which are exceptions to the general requirement to enroll during the open enrollment window, and permits individuals to enroll in coverage when experiencing a qualifying life event, such as marriage or the birth of a child.

Under current policy, individuals are generally permitted to self-attest to a qualifying life event, permitting an individual to enroll during a special enrollment period without any verification that the qualifying event actually occurred. In light of concerns by issuers that individuals may be using these special enrollment periods to enroll in coverage only when they require services, CMS is proposing to extend the current pre-enrollment verification of eligibility to *all* individuals enrolling through Healthcare.gov. Beginning in June 2017, CMS will launch pre-enrollment verification for all individuals enrolling in Exchanges through special enrollment periods (current pre-enrollment verification applies only to select special enrollment periods). These individuals will have their enrollment "pended" until verification of their special enrollment eligibility is completed. Under the proposal, consumers will have 30 days to provide documentation through Healthcare.gov or through the mail before their coverage is effectuated.

CMS is seeking comments on the proposed method for pre-enrollment verification, whether any special enrollment periods should be excluded, and whether state-based exchanges should also be required to participate in this process.

Furthermore, in response to issuer concerns that some enrollees are gaming special enrollment periods in order to change their plan metal levels based on ongoing health needs during the coverage year, CMS

is proposing to limit the ability of Exchange enrollees to change plan metal levels during the year. Specifically, under the proposal enrollees would only be permitted to make changes to their enrollment in the same qualified health plan (QHP) or to change to another QHP within the same level of coverage.

CMS is also proposing changes to several specific special enrollment periods, including those relating to marriage, permanent moves, exceptional circumstances, and loss of minimum essential coverage. Notably for loss of minimum essential coverage, CMS is proposing to allow issuers to reject an enrollment for which the issuer has a record of termination due to non-payment of premiums, unless the enrollee pays their premium obligations from prior coverage. To facilitate the implementation of this provision, CMS proposes to allow Exchanges to collect and store information from issuers about whether consumers have been terminated from Exchange coverage due to non-payment of premiums, in which case the Exchanges would automatically prevent these individuals from qualifying for the special enrollment period for loss of minimum essential coverage. This would apply to individuals who attempt to renew their Exchange coverage within 60 days of being terminated.

Changes to Guaranteed Availability. Current guaranteed availability rules require issuers offering non-grandfathered coverage (in both the individual and group markets) to offer coverage to and accept every individual that applies for such coverage. Current rules require individuals to pay the first month's premium in order to effectuate such coverage. Under existing policy, if an individual fails to make a premium payment (for example, at the end of a coverage year) and then applies for new coverage for a different product offered by that same issuer, the issuer may not apply the new premium payment to the past debt. Issuers in recent years have complained to CMS that individuals will stop paying their premiums at the end of the year, accumulate a debt to the issuer, and then apply for coverage for a new product to which the issuer must then accept payment and offer coverage (note: currently, if the individual seeks to renew under the same product, the issuer may apply the payment to past debts.)

To remove economic incentives for individuals to pay premiums only when they require healthcare services, CMS is proposing to permit issuers to apply a premium payment to an individual's past debt owed for coverage from the same issuer enrolled within the prior 12 months, even if the individual applies for coverage for a new product. Under this proposed policy, if an individual policyholder owes a premium payment for a prior-year's coverage, an issuer may require that policyholder to pay all past due premiums owed to that issuer in order to resume coverage from that issuer in the new plan year.

CMS is seeking comments on this proposed policy, including whether or not issuers should be able to implement this policy with a premium payment threshold, wherein individuals are able to effectuate coverage once a threshold of past-due premiums is paid.

Changes to Actuarial Values. Under the ACA, issuers are required to ensure that plans offered adhere to certain levels of coverage (referred to as 'metal levels.') For example, under the ACA, a bronze plan is required to have an actuarial value of 60%, while a platinum plan must have an actuarial value of 90%. Under current regulations, plans are generally permitted to have a variation in the actuarial value of the plan of +/- 2 percentage points. The purpose of this variation was generally to permit plans to have some flexibility in benefit design, and in particular to permit plans to offer the same coverage each year without a need for annual plan redesign.

CMS proposes to increase the variation in the actuarial values used to determine metal levels of coverage for the 2018 plan year in order to permit plans greater flexibility in benefit design, as well as to allow more plans to keep their cost sharing the same from year to year. In particular, CMS proposes to permit plans to have a variation in the actuarial value of the plan of -4/+2 percentage points, rather than +/- 2 percentage points. Notably, however, this proposal *does not* apply to silver plan *variations*

Changes to Network Adequacy Review for QHPs. Under current policy, CMS requires QHP issuers to maintain a network that is sufficient in number and types of provider. To ensure compliance with this policy, CMS currently conducts reviews of plan compliance in Federally-facilitated Exchange ("FFE") states. In the proposed rule, in recognition of the traditional role states have played in insurance market regulation, CMS is proposing to rely on State reviews for network adequacy in States in which an FFE is operating, provided that a state has a sufficient process in place. In cases where a state does not have a sufficient process in place, CMS is also proposing to change its review process to permit reliance on an issuer's accreditation from an HHS-recognized accrediting agency (this process was also used in 2014).

Changes to Essential Community Provider Rules. The ACA included a provision designed to ensure that plans offer a sufficient number of, and access to, "essential community providers." Essential community providers ("ECPs") are providers, such as community health centers, that service predominantly low-income and medically underserved individuals.

Current rules specify a minimum standard of community ECPs that must be included as participating providers, currently set at 30%. For 2018, CMS is proposing to lower this percentage to 20% to permit more plan flexibility. Finally, CMS is also proposing to change which providers issuers may identify as ECPs within their provider networks. Currently ECPs identified must be included on a list circulated by HHS. In previous years, CMS permitted issuers to use a write-in process to identify ECPs who are not on the HHS list of ECPs. For 2018, CMS is again permitting issuers to use the write-in process, as long as the issuers arrange for the written-in provider to submit an ECP petition to HHS no later than the deadline for issuer submission of changes to the QHP application.

Additional Changes to Promote Continuous Coverage. Finally, CMS is seeking comments on additional policies that are not proposed in this rule, but could be considered for future rulemaking and may promote continuous coverage and discourage individuals from dropping out of coverage. For example, CMS is seeking comment on a potential change to the "look back" period for the special enrollment period that requires evidence of prior coverage, so that individuals are required to have prior coverage for 6 to 12 months. CMS is also seeking comment on whether HIPAA-like policies are needed in the individual insurance market, such as requirements for maintenance of continuous, creditable coverage without a 63-day break if an individual wishes to avoid the pre-existing condition exclusions, and permitting waiting periods to be imposed under certain circumstances.