CMS' Proposed Rule on ACA Market Stabilization

On February 17, 2017, the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to stabilize the health insurance market and address risks to the individual and small group markets. CMS proposes changes to guaranteed availability of coverage, network adequacy, essential community providers, open enrollment periods, special enrollment periods, continuous coverage, and standards for the Exchanges.

The proposed changes primarily affect the individual market. However, to the extent that employers have fully-insured plans, some of the proposed changes will affect those employers' plans because the changes affect standards that apply to issuers.

Public comments are due by March 7, 2017.

Guaranteed Availability of Coverage

The guaranteed availability provisions require health insurance issuers offering non-grandfathered coverage in the individual or group market to offer coverage to and accept every individual and employer that applies for such coverage unless an exception applies. Individuals and employers must usually pay the first month's premium to activate coverage.

CMS previously interpreted the guaranteed availability provisions so that a consumer would be allowed to purchase coverage under a different product without having to pay past due premiums. Further, if an individual tried to renew coverage in the same product with the same issuer, then the issuer could apply the enrollee's upcoming premium payments to prior non-payments.

Under the proposed rule, CMS modifies its interpretation of the guaranteed availability provisions so that an issuer may refuse to activate new coverage because of premium payment failure. This means that an issuer can require a policyholder whose coverage was terminated for premium non-payment in the individual or group market to pay all past due premiums owed to the issuer for coverage enrolled in the prior 12 months for that policyholder to resume coverage from that issuer. The issuer is required to apply its premium payment policy uniformly to all employers or individuals regardless of health status and consistent with non-discrimination requirements.

Network Adequacy

Under the Patient Protection and Affordable Care Act (ACA), health and dental plan issuers must meet minimum network adequacy criteria to be certified as qualified health plans (QHPs). The criteria require a QHP issuer to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

The Department of Health and Human Services (HHS) proposes to rely on state reviews for network adequacy in states where a federally-facilitated exchange is operating. For states that do not have the authority and means to conduct sufficient network adequacy reviews, HHS would rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity.

Essential Community Providers

Essential community providers (ECPs) include providers that serve predominantly low-income and medically underserved individuals; issuers must meet requirements for ECPs' inclusion in QHP provider networks.

HHS proposes to lower the minimum percentage of network participating practitioners; an issuer will satisfy the regulatory standard if the issuer contracts with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network.

Under current guidance, issuers may only identify providers in their network who are included on a list of available ECPs maintained by HHS. HHS proposes to allow issuers to identify ECPs through a write-in process to build up the HHS ECP list.

Annual Open Enrollment Periods

Currently, annual Exchange open enrollment begins on November 1, 2017, and ends on January 31, 2018, for plan year 2018. CMS proposes to shorten the open enrollment period to begin on November 1, 2017, and end on December 15, 2017.

Special Enrollment Periods

Starting in June 2017, CMS proposes to require pre-enrollment eligibility verification for all special enrollment periods of new consumers who seek QHP coverage through the federally-facilitated exchanges and state-based exchanges on the federal platform (Exchanges).

The proposed special enrollment period changes apply to the individual market only, not to special enrollment periods under the Small Business Health Options Program (SHOP).

Continuous Coverage

HHS seeks public comment on individual market policies to promote continuous health coverage enrollment and to discourage individuals from waiting to enroll in coverage until they become ill.

HHS provides examples of potential policies. One example is to require prior coverage evidence and require a longer look-back period for special enrollment period eligibility. Another example is to allow individuals who cannot provide prior coverage evidence during a look-back period, to be covered under a

special enrollment period, but to impose either at least a 90-day waiting period before activating enrollment or a late enrollment penalty.

HHS is also interested in public comment on whether the individual market needs policies such as waiting periods or maintaining continuous, creditable coverage to avoid pre-existing condition exclusions that were requirements imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Health Insurance Issuer Standards under the ACA, Including Standards Related to Exchanges

Under the ACA, issuers of non-grandfathered individual and small group health insurance plans, including qualified health plans, must ensure that the plans adhere to certain levels of coverage.

A plan's coverage level, or actuarial value (AV), is determined based on its coverage of the essential health benefits (EHBs) for a standard population. The ACA requires a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent, a gold plan to have an AV of 80 percent, and a platinum plan to have an AV of 90 percent. The HHS Secretary issues regulations on the calculation of AV and its application to coverage levels; the ACA authorizes the Secretary to develop guidelines to provide for a *de minimis* variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

CMS proposes to amend the definition of *de minimis* to a variation of -4/+2 percentage points, rather than +/- 2 percentage points for all non-grandfathered individual and small group market plans that are required to comply with AV. To implement the amended AV *de minimis* range, CMS would update its 2018 AV Calculator accordingly.

Conclusion

Per HHS, the proposed rule aims to ensure market stability and issuer participation in the Exchanges for the 2018 benefit year as issuers develop their proposed plan benefit structures and premiums for 2018.

With a nod to President Trump's Executive Order to minimize the economic burden of the ACA pending its repeal, the proposed rule states that it aims to reduce the fiscal and regulatory burden on individuals, families, health insurers, patients, recipients of health care services, and purchasers of health insurance. Further, the proposed rule seeks to lower insurance rates and ensure a competitive market by preventing and curbing potential abuses associated with special enrollment periods and gaming by individuals taking advantage of current regulations on grace periods and termination of coverage due to premium non-payment.

The proposed rule includes HHS' assessment of the benefits, costs, and transfers associated with its proposed regulatory action. Based on its impact estimates, HHS anticipates that the rule will reduce issuers' regulatory burden, reduce the impact of consumer adverse selection, stabilize premiums in the individual insurance market, and provide consumers with more affordable health insurance coverage.

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