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BENEFITS BRIEF

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CMS Releases Market Stabilization Guidance

The Centers for Medicare and Medicaid Services ("CMS") at the U.S. Department of Health and Human Services has had a busy start to the New Year and the new Administration. CMS has issued a new proposed rule and delayed critical qualified health plan ("QHP") certification dates on February 17, and on February 23 announced it was extending its transitional plan (also known as "grandmothered" or "Keep What You Have" or "KWYH" plans) policy through December 31, 2018.

The new Administration has been attempting to make administrative changes to make individual market risk pools more stable and viable in order to keep issuers in the markets in 2018. The changes have generally been welcomed by issuers and are consistent with ideas that were presented to the previous Administration but were not implemented. However, it is not clear that the changes will be enough to shore up the risk pools, particularly if the individual mandate is repealed legislatively. This is likely why CMS sought comment on several of its proposals, including those related to CMS authority with respect to continuous coverage options. Regardless of these attempts, there may be no clear silver bullets for administrative action in this area; therefore, the clearest path to improving the risk pools remains legislative.

I. Executive Summary

The proposed rule would:

- **Allow issuers to collect certain unpaid premiums.** The rule would allow health insurance issuers in the individual and group markets to collect premiums for prior unpaid coverage (for up to 12 months), before enrolling a policyholder in a plan with the same issuer.

- **Shorten the 2018 open enrollment period.** The proposed rule would shorten the 2018 open enrollment period to run from November 1, 2017 – December 15, 2017, instead of November 1, 2017 – January 31, 2018.

- **Narrow special enrollment periods ("SEPs").** CMS proposes to:

    - Expand pre-enrollment verification to all individuals attempting to enroll via a SEPs beginning June 2017.
    - Limit the ability of an existing Exchange enrollee to change plan metal levels mid-year if enrolling via an SEP due to adding a dependent.
    - Add additional parameters around the minimum essential coverage ("MEC"), marriage, permanent move, and exceptional circumstances SEPs.

- **Broaden actuarial value ("AV") de minimis ranges.** CMS proposes to adjust the de minimis ranges of AV levels from +/-2 percentage points to +2/-4 percentage points, for platinum, gold, and silver plans (other than silver CSR variations), and from +5/-2 percentage points to +5/-4 percentage points for some bronze plans.

- **Defer to states for network adequacy reviews.** For the 2018 plan year, CMS proposes to defer to the states network adequacy reviews where possible.

- **Relax Essential Community Providers ("ECPs") standards.** For the 2018 plan year, CMS proposes that an issuer must demonstrate that it has a network with at least 20 percent – as opposed to 30 percent – of participating ECPs. Issuers would also be able to write in ECPs under certain circumstances.

In addition, while CMS does not propose requirements to ensure continuous coverage, CMS asks for comment on policies to promote continuous coverage, while remaining consistent with existing law. **Comments are due March 7, 2017 on the proposed rule, and we expect that the rule will likely be finalized very quickly.** CMS also modified the QHP calendar and transitional policy guidance to:

- Delay the initial QHP application submission window to end on June 21, 2017.

- Require signed QHP agreements, confirmed plan lists, and final plan crosswalks be provided to CMS by September 27, 2017.

- Permit states to allow issuers to continue offering grandmothered plans for policy years beginning on or before October 1, 2018, provided that all policies end by December 31, 2018.

Below, we summarize the key points from the proposed rule, the revised QHP certification calendar, and the transitional plan guidance.

II. Proposed Rule

While potential legislative changes to the Affordable Care Act are on the horizon, the Market Stabilization Proposed Rule, 82 Fed. Reg. 10980 (Feb. 17, 2017), is an administrative attempt to provide more flexibility to states and health insurance issuers and encourage issuers to participate in the individual and group markets in 2018. The provisions proposed in this rule attempt to stabilize the health insurance market, in an effort to ensure continuity of care until legislative revisions occur.

Guaranteed Availability

CMS proposes to allow an issuer to require a policyholder (individual or employer) whose coverage is terminated for non-payment of premiums to pay all past due premium owed to that issuer before the issuer resumes coverage for that policyholder. If a policyholder does not pay past premiums, an issuer could deny coverage. This provision would apply to non-payment of premiums in the prior 12 months; however, CMS believes most individuals would generally owe no more than three months of premiums, because of the Exchange and state grace period and termination of coverage rules. Notably, policyholders could still effectuate coverage with another issuer without paying back these premiums. This provision would apply on and off the Federally-faciliated Marketplace (a.k.a. the Federally-faciliated

Exchange or "FFE"), and CMS encourages states to adopt a similar approach for State-based Marketplaces (a.k.a. State-based Exchanges or "SBEs").

2018 Open Enrollment Period

CMS proposes to shorten the annual 2018 open enrollment period for the Exchange to run from November 1, 2017 – December 15, 2017, instead of November 1, 2017 – January 31, 2018. Under current rules, the shortened open enrollment period was due to begin for 2019 open enrollment. It is important to note that the Exchange open enrollment period also applies in the individual market off-Exchange under guaranteed availability rules. The rule would apply to the FFE, and CMS has requested comments on whether SBEs have the capability to shorten the open enrollment period for the 2018 plan year.

Special Enrollment Periods

- **Expanding Pre-Enrollment Verification Pilot Program**

CMS had planned to implement a pilot program beginning June 2017, to conduct pre-enrollment verification of eligibility for Exchange coverage for certain SEPs, sampling about 50 percent of consumers. This rule proposes to expand this program to all categories of SEPs and to verify all new consumers applying for SEPs. CMS would pend enrollment for these consumers until it can verify their eligibility for the applicable SEP. This process would occur in the FFE and SBEs using the Federal Platform ("SBE-FPs"). CMS recommends that SBEs that do not currently conduct pre-enrollment verification of SEP eligibility consider following this approach and requests comments on whether – and when – SBEs should be required to use this process as well. To encourage healthier risk pools, CMS also seeks comment on what strategies it should take to encourage healthier individuals to complete the verification process.

- **Limiting Ability of Exchange Enrollees to Change Metal Levels Mid-Year**

CMS proposes to limit the ability of an existing Exchange enrollee to change metal levels mid-year. If the enrollee gains a new dependent and qualifies for an SEP, the Exchange may allow the enrollee to add the new dependent to the current QHP. If the QHP's business rules do not allow a new dependent, the Exchange may allow the enrollee and the new dependent to enroll in another QHP within the same metal level or in an adjacent metal level if a QHP in the same metal level is not available. This proposed change would apply in the individual market outside the Exchanges, but not in the group market, and it would apply to all Exchanges, although CMS understands that SBEs may not be able to implement these changes for 2017, and seeks comment on when SBEs would be able to implement and if this should be optional for SBEs.

For certain other SEPs (loss of MEC, violation of a material contract provision, access to a new QHP due to a permanent move, and material plan or benefit display error), CMS proposes to require the Exchange to allow enrollees and dependents to change their enrollment within the same QHP, or to change to another QHP within the same metal level, if available. CMS asks for comment regarding whether these changes should be at the option of the Exchanges, and, if SBEs are required to make these changes, how long they should have to operationalize them. CMS also requests comment on how these changes would be operationalized in the off-Exchange individual market, where they would also apply.

- **Effective Date of Coverage for Eligibility Verification Enrollment Delays**

CMS proposes to modify the existing regulation to allow consumers to begin coverage one month later than their effective date would have been if their SEP verification process results in enrollment delays causing them to pay two or more months of retroactive premiums to effectuate coverage.

- **Additional Parameters Around SEPs**

CMS proposes to add additional parameters around the following SEPs:

- Loss of MEC: The FFE (and SBE-FPs) would permit issuers to reject enrollment for particular enrollees if the issuer has a record of termination due to non-payment of premiums, unless the individual pays past premiums. CMS also proposes to allow Exchanges to collect information regarding whether consumers were terminated for non-payment, to enable the Exchange to prevent the consumer from renewing Exchange coverage automatically.

- Marriage: CMS proposes that, if consumers are newly enrolling in a QHP in the FFE because of marriage, at least one spouse must demonstrate having had MEC for at least one day during the 60 days before the marriage date. For individuals living outside the U.S. before marriage, at least one spouse must demonstrate having MEC, or that they lived outside of the U.S. or in a U.S. territory for at least one day during the 60 days before the marriage date. These individuals would have to show proof of having MEC or living outside the U.S. or in a U.S. territory. This change would only apply in the individual market.

- Permanent move: Currently, an individual who gains access to new QHPs as a result of a permanent move must either have had MEC for at least one day during the 60 days preceding the date of the permanent move, or was living outside of the U.S. or in a U.S. territory at the time of the move. This rule proposes to add a requirement that the individual submit documentation to the FFE/SBE-FPs to prove both their previous and new addresses, and evidence of prior coverage, if applicable. If this requirement is finalized, CMS plans to issue future guidance regarding acceptable documentation.

- Exceptional circumstances: CMS proposes to significantly limit the use of the exceptional circumstances SEP in the FFE by applying a more rigorous test for this SEP and, at times, requiring supporting documentation where practicable. If this proposal is finalized, CMS intends to release guidance about what circumstances would be considered "exceptional" and what corresponding documentation consumers would have to provide, if requested by the FFE. CMS proposes that this change be effective for the remainder of 2017 and for future plan years.

Continuous Coverage

CMS does not make a specific proposal but asks for comment on policies to promote continuous coverage, while remaining consistent with existing law. For example, CMS asks for comment on requiring evidence of prior coverage for a longer period of time in the case of certain SEPs, with a 90-day waiting period or late enrollment penalty for individuals who cannot demonstrate prior coverage.

Actuarial Value

CMS proposes to alter the de minimis ranges for AV metal levels. Under the proposed rule, the de minimis ranges for platinum, gold, and silver metal levels would be +2/-4, as opposed to +/- 2 percentage points (however, CMS is not proposing to modify the de minimis ranges for silver CSR plan variations). For bronze plans, CMS proposes to change the de minimis variations from +5/-2 percentage points (as finalized in the 2018 Payment Notice) to +5/-4 percentage points if a bronze plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirement to be a high deductible health plan ("HDHP") as defined under the Internal Revenue Code. This change would apply both on and off the Exchange. CMS also proposes to update the AV calculator to reflect these changes. While CMS proposes to make this change for the 2018 plan or policy year, it asks whether making the change for 2019 is more feasible.

QHP Network Adequacy and ECPs

For the 2018 plan year, CMS proposes to defer to state network adequacy reviews in states with authority at least equal to the "reasonable access standard" and a sufficient network adequacy review process, regardless of whether the state is an SBE or FFE state. In states with no authority or ability to conduct sufficient network adequacy reviews, CMS would rely on an issuer's commercial or Medicaid accreditation from an HHS-recognized accrediting entity (similar to the 2014 standard). An unaccredited issuer would be required to submit an access plan in its QHP application, demonstrating it has standards and procedures in place to maintain an adequate network consistent with the NAIC Model Act. These changes would supersede the time and distance criteria in the 2018 Final Issuer Letter.

Also for the 2018 plan year, CMS proposes that a QHP issuer must demonstrate that it has a network with at least 20 percent – as opposed to the current requirement of 30 percent – of available ECPs in each plan's service area participating in the plan's provider network. CMS also proposes to allow issuers for plan year 2018 to write in additional ECPs to demonstrate compliance, as long as the written-in provider has submitted an ECP petition to CMS by no later than the deadline for issuer submission of changes to the QHP application.

III. Revised Key Dates for QHP Certification and Rate Review

CMS also released an updated QHP certification calendar and rate review submission timeline to give issuers additional time to make modifications to their products and applications, and states additional time to review form and rate filings for the 2018 plan year.

QHP Certification

CMS updated the QHP certification calendar so issuers can have additional time to submit QHP applications for the 2018 plan year. CMS extended the initial QHP application submission window to June 21, 2017, from May 3, 2017, but the deadline for issuer submission of changes to QHP application is August 16, 2017, moved up from August 21, 2017. Under the revised timeline, issuers must send signed QHP agreements, confirmed plan lists, and final plan crosswalks to CMS by September 27, as opposed to September 15.

Rate Review

CMS also updated the rate review submission timeline to allow issuers in a state without an Effective Rate Review Program to have additional time to submit rate filing justifications for single risk pool coverage to CMS by June 1, 2017, from May 3, 2017. The deadline for all rate filing justifications for single risk pool coverage that includes a QHP

to be in final status was moved up to August 16, 2017, from August 21. This date of August 16 is the same as the deadline for issuer submission of changes to a QHP application.

IV. Transitional Policy

In an effort to provide additional time for all non-grandfathered coverage in the individual and small group markets to come into compliance with the Public Health Service Act market reforms, CMS again extended their transitional policy to policy years beginning on or before October 1, 2018, provided that all policies end by December 31, 2018, at the option of the state. States can elect to extend the transitional policy for shorter periods, but may not extend beyond these time periods, and they may adopt the transitional policies for only the individual market, only the small group market, or both. Issuers can have policy years that are shorter, but not longer, than 12 months. In addition, issuers that renew coverage under this extended transitional policy must comply with the specific notice requirements.