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CLIENT ALERT

CMS Releases Proposed Rule for ACA Market Stabilization

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Executive Summary

On February 15, 2017, the Centers for Medicare & Medicaid Services ("CMS"), at the direction of the Trump administration, released a long-expected proposed rule ("Market Stabilization Proposed Rule")[1] designed to help stabilize the individual and small group health insurance markets created by the Patient Protection and Affordable Care Act ("ACA"). Comments on the Market Stabilization Proposed Rule are due no later than **5 p.m. (EST) on March 7, 2017**.

Since the passage of the ACA and the creation of the health insurance exchanges, many health insurers ("issuers") have either increased rates or have pulled out of the exchanges due to concerns regarding low participation rates and consumers only enrolling in a plan when health care services are needed. With a growing number of issuers seriously considering withdrawing from the exchanges in 2018, the Market Stabilization Proposed Rule can be seen as a stopgap attempt to shore up the exchanges and encourage issuers to participate by addressing many long-standing criticisms.

The fact that the public comment period is only 20 days instead of the usual 30 days is evidence that CMS hopes to finalize the Market Stabilization Proposed Rule before issuers are required to file their 2018 plans and rates with the states this spring. Indeed, several days after issuing the Market Stabilization Proposed Rule, CMS issued a bulletin delaying various submission dates for issuers participating on the 2018 exchange.[2]

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[1] CMS, Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 10,980 (Feb. 17, 2017), *available at* https://www.federalregister.gov/documents/2017/02/17/2017-03027/patient-protection-and-affordable-care-act-market-stabilization.

[2] Key Dates for Calendar Year 2017: QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance Revised February 2017, *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Revised-Key-Dates-for-Calendar-Year-2017-2-17-17.pdf.

Five Key Changes

To improve the risk pool and promote stability in the individual market, the Market Stabilization Proposed Rule outlines five key changes designed to encourage individuals to maintain continuous enrollment in a plan and discourage individuals from enrolling in a plan only when coverage is needed. These key changes include:

1. **Shortening the 2018 open enrollment period to Nov. 1, 2017 – Dec. 15, 2017**

CMS was to begin using a shorter six-week period for the 2019 benefit year open enrollment. But, through the Market Stabilization Proposed Rule, the agency has proposed to begin using the shorter open enrollment period in 2018. The shorter open enrollment period allows enrollees to receive a full year of coverage due to the open enrollment period not extending into the new year, and it is less operationally burdensome for issuers. CMS also mentioned that shifting to the shorter open enrollment period may improve the risk pool by preventing individuals who learn that they need coverage in late December and January from enrolling in a plan.

2. **Increasing pre-enrollment verification of eligibility for all categories of special enrollment periods from 50 to 100 percent of new consumers seeking to enroll**

The ACA and its implementing regulations[3] provided for special enrollment periods ("SEPs") to enable individuals who lose coverage due to certain unexpected events (e.g., marriage, job loss, etc.) occurring outside the open enrollment period to enroll in a new plan and maintain continuous coverage. Issuers complained that individuals who were previously uninsured (and thus not eligible for the SEPs) were using the SEPs to enroll in coverage for which they were not eligible due to only having to self-attest to their eligibility with no supporting documentation, resulting in a sicker risk pool and undermining the incentive for individuals to enroll during the annual open enrollment period.

CMS had previously indicated that, in the second half of 2017, it would pilot a program to sample 50 percent of new consumers trying to enroll via certain SEPs. Under the Market Stabilization Proposed Rule, CMS is now proposing to expand the pre-enrollment eligibility verification to all SEPs for 100 percent of new enrollees seeking coverage via either federally facilitated exchanges or state-based exchanges on the federal platform. The agency is encouraging state-based exchanges to adopt a similar approach. Individuals undergoing the verification process will be required to mail or electronically upload specific documentation demonstrating that they are eligible for the SEP.

CMS also proposes to strengthen and streamline the requirements of several existing SEPs, including:

[3] *See* 45 C.F.R. § 155.420. Also note that several special enrollment periods have been created via CMS guidance.

- **Loss of Minimum Essential Coverage SEP:** Issuers can reject enrollees using this SEP if the loss of minimum essential coverage was due to nonpayment of premiums. CMS also proposed better tracking of individuals who lost coverage for nonpayment of premiums to help prevent them from using this SEP to gain coverage.

- **Marriage SEP:** At least one spouse must demonstrate continuous minimum essential coverage for at least one day in the 60 days preceding the marriage, or that both spouses have moved from outside the United States or lived in a U.S. territory.

- **Permanent Move SEP:** Individuals must now demonstrate continuous minimum essential coverage for at least one day in the 60 days preceding the move, unless moving from outside the United States or a U.S. territory. They will be required to show documentation for previous and new addresses.

- **Exceptional Circumstances SEP:** This SEP is designed as a catch-all for events not considered a life event, such as an enrollment or systems error. CMS proposes to significantly restrict the use of this SEP and will apply a more rigorous test to determine if a circumstance is truly exceptional.

3. Allowing 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

The ACA requires issuers to offer coverage to anyone who applies during the open enrollment period or a SEP, if the individual qualifies. This requirement, known as the "guaranteed availability," has been one of concern for issuers based on CMS's position that issuers could not deny coverage to anyone based on prior nonpayment of premiums so long as the individual or employer was not reenrolling in the same plan in which they had been enrolled in the previous coverage year.

Under the Market Stabilization Proposed Rule, CMS has altered its previous position. The agency now proposes to allow issuers to require an individual or employer that was terminated for nonpayment of premiums to pay off any outstanding debt before resuming coverage with the issuer without being considered in violation of guaranteed availability requirements. Moreover, issuers would be allowed to attribute premium payments from a reenrolling individual or employer to any outstanding debt associated with nonpayment of premiums, even if the individual or employer reenrolls in a different plan offered by that issuer, as long as the debt in question was accrued during the previous 12 months of coverage. This new premium payment policy must be applied uniformly by issuers and in compliance with applicable nondiscrimination requirements. It is important to note that some state laws may not permit issuers to prohibit further coverage until all past due premiums are paid, but CMS has encouraged states to adopt its approach.

4. **Increasing the de minimis variation in the actuarial values used to determine metal levels of coverage for the 2018 plan year**

A plan's actuarial value ("AV") represents the share of the health care expenses that an issuer will cover (based on the health care needs of a standard population). For a plan that has an AV of 70 percent, the plan will pay 70 percent of the enrollees' health care expenses, with the enrollees covering the remaining 30 percent through some combination of deductibles, copays, and coinsurance. Plans offered on the exchanges are required by the ACA to have a specific AV that corresponds with the metal level of each plan (e.g., bronze plans are required to have an AV of 60 percent while a platinum plan must have an AV of 90 percent). The ACA permits a de minimis variation in AV from year to year, which is currently +/- 2 percent for 2017. Under the Market Stabilization Proposed Rule, CMS would change the de minimis variation in AV from +2 to -4 percent for all metal levels, except bronze (which is permitted to vary from +5 to -4 percent). By changing the de minimis variation in AV, CMS hopes to encourage issuers to design new plans for future years that will result in more competition. In addition, these changes will allow issuers to keep their plan cost sharing the same from year to year, and may also put downward pressure on premiums.

5. **Allowing states to police plan network adequacy and require fewer essential community providers**

Issuers are required to maintain a network that is sufficient in number and the types of providers included, and CMS currently assesses network adequacy using the same standards used to ensure that Medicare Advantage plans have an adequate provider network. In the Market Stabilization Proposed Rule, CMS has proposed deferring to the states when it comes to assessing network adequacy so long as a state has the authority to ensure reasonable access to providers and the means to assess issuer network adequacy. If a state doesn't meet these requirements, then CMS will rely on an issuer's accreditation (Medicaid or commercial) from a recognized accrediting entity.

CMS has also proposed allowing issuers to include fewer essential community providers ("ECPs") in their plan networks. ECPs are providers that serve predominately low income and medically underserved individuals. Issuers are currently required to contract with 30 percent of ECPs in a plan's area, but CMS has proposed requiring issuers to contract with only 20 percent of ECPs in a plan's area.

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All stakeholders are encouraged to closely review the Market Stabilization Proposed Rule and provide CMS with comments no later than **5 p.m. (EST) on March 7, 2017**.

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This Client Alert was authored by **Helaine I. Fingold** *and* **M. Brian Hall, IV.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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