PCG Memorandum on Final Rule: Patient Protection and Affordable Care Act; Market Stabilization

April 18, 2017

PCG Health

Public Focus. Proven Results.™

CONTENTS

Please Note: Red text indicates changes made by CMS from the proposed to final rules.

EXECUTIVE SUMMARY

On April 13, 2017, the Centers for Medicare and Medicaid Services (CMS) released the final Patient Protection and Affordable Care Act; Market Stabilization Rule. The final rule is aimed at stabilizing the individual and small group markets by tightening enrollment standards and providing increased flexibility related to standards for Qualified Health Plans (QHPs), as outlined in detail below. The final rule also seeks to provide greater deference to state regulation of health insurance.

After reviewing 4,005 comments, CMS finalized each of the changes it put forth in the proposed regulations, with some tweaks outlined below, including:

- Altering the administration's interpretation of guaranteed availability as it applies to outstanding premium payments;
- Shortening the open enrollment period;
- Enhancing pre-verification of eligibility for special enrollment periods and otherwise limiting special enrollment periods;
- Increasing the de minimis variation allowed to the actuarial values for coverage levels;
- Deferring to states regarding network adequacy; and
- Decreasing the essential community provider standard to 20% and reinstating write-ins.

CMS reiterated in the preamble of the final rule that it is exploring policies to promote continuous coverage. It outlined comments received, noting that the majority of commenters opposed additional continuous coverage requirements such as longer lookback periods for special enrollment period prior coverage requirements, waiting periods, late enrollment penalties, and lookbacks to avoid pre-existing condition exclusions. CMS is not taking regulatory action at this time but stated that it will continue to explore these options.

At the same time as issuing the final regulations, CMS released guidance that finalizes the timelines for QHP certification and the rate review process for 2018 coverage, as outlined below, as well as an updated AV Calculator for 2018. The new timeline is compressed, eliminating some of the back-and-forth between CMS and states. A later start to the process gives insurers more time to decide if they will seek to participate on Marketplaces and to make modifications to comply with the final rule changes. CMS also issued a FAQ on Compliance Standards for Issuers in the FFM and QHP Certification Guidance.

PCG subject matter experts have created a comprehensive summary to assist regulators as they seek to understand what the rule changes and updated timelines mean for the coverage and markets in their states. Please contact us for more information about any of the provisions outlined below.

DETAILED OVERVIEW

Guaranteed Availability of Coverage

The regulations finalize the proposal to change the administration's interpretation of guaranteed availability requirements, allowing carriers to require enrollees to pay outstanding debts owed to the carrier for previous coverage under a *different* product – in addition to the first month's premium - in order to effectuate new coverage to the extent permitted under state law. Carriers will no longer be required to effectuate coverage if the first month's premium payment is made even if there is outstanding debt owed. Instead, carriers will be permitted to apply initial premium payments to outstanding debts for prior coverage under a different product from the same issuer (or an issuer within the same controlled group) within the prior 12 months prior to applying it to effectuate new coverage, just as they currently can do for renewals of coverage. The carrier will be able to require all amounts due for premiums within the prior 12 months to be paid prior to effectuating new coverage or could choose to accept a portion of the payment as sufficient. This policy seeks to encourage continuous coverage.

This change is being implemented in both the individual and group markets, both within and outside of the Exchanges, though CMS confirmed in the final preamble that it cannot be effectuated in the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). State laws prohibiting this change will not be preempted, though – in the preamble – CMS has encouraged states to take the same approach while allowing them to do so on a more limited basis.

This policy cannot be applied when an individual is changing carriers outside of the controlled group or applied to any person that is not contractually responsible for premium payments.

The rules require that carriers apply such requirements uniformly and in compliance with non-discrimination requirements. Within those parameters, carriers may implement (and states may require) hardship waivers and an appeals process as long as they are unrelated to health status.

Carriers adopting this policy must provide notice in enrollment application materials and in any notice that is provided regarding non-payment of premiums. CMS clarified that carriers may begin to implement this policy for individuals for whom notice was provided prior to their failure to pay premiums. CMS also clarified that the carrier must pay all claims for services rendered during any month for which past due premiums are paid and that advance payment tax credits are not available for those outstanding months.

Open Enrollment

CMS has finalized the proposal to shorten the open enrollment period for the individual market starting with the 2018 plan year. For 2018 coverage, open enrollment will still begin on November 1, 2017, but will end prior to the new year, on December 15, 2017, rather than January 31, 2018. This is the open enrollment timeline that was previously announced for plan years beginning in 2019 and future years. As a result, all coverage, except that enrolled in via special enrollment periods, will be for the entire year.

In the preamble of the final rule, CMS noted that, under existing regulatory authority, State-based Marketplaces (SBMs) may choose to supplement the open enrollment period with a transitional special enrollment period to account for any operational challenges related to the transition to a shorter open enrollment period.

CMS will also consider moving the open enrollment period earlier in the fall in subsequent years.

Special Enrollment Periods

Pre-Enrollment Eligibility Verification

As proposed, the final regulations expand upon the pilot announced by the previous administration for verifying eligibility for all individual market special enrollment periods (SEPs). The pre-enrollment verification will take the place of self-attestations of SEP eligibility and will be required prior to enrollment being effectuated. The regulations expand the pilot to all applicable SEPs within the Federally-facilitated Marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs) (rather than 50% of such enrollments). SBMs may choose whether and how to implement such a process, including deferring to carriers to do so. CMS encourages them to implement a pre-verification process as soon as possible.

This process will be introduced in the expanded manner at the same time the pilot was slated to begin (June 2017) but phased in, starting first with the SEPs of highest volume and most concern (such as loss of minimum essential coverage, permanent move, Medicaid / CHIP denial, marriage, and adoption). CMS will monitor the effectiveness of the process and adjust it as necessary to ensure accuracy of determinations. This process seeks to ensure individuals do not have incentives to delay enrollment.

Effective dates of coverage will continue to be determined by the date of plan selection, though enrollment will be pended until SEP eligibility is verified, with it then being retroactive. Individuals will be allowed to request that

enrollment be delayed one month if the SEP verification process is delayed to the extent that they would otherwise be required to pay two months or more worth of retroactive premium payments to effectuate coverage.[1]

Enrollees will be given 30 days to provide required documentation and electronic data matches will be sought when applicable. CMS will exercise reasonable flexibility regarding required documentation, including allowing individuals to send in details about their qualifying event with an explanation of why they cannot submit required documentation. CMS will decide, based on that letter, whether to forgo the documentation requirement.

Limitations on Coverage Changes

Pre-enrollment verification will only apply to new enrollments (and not plan changes during SEPs). However, CMS will limit the ability of existing enrollees to change metal levels during the coverage year via SEPs, as proposed. In the individual market:

- Enrollees will be allowed to add new dependents via a SEP but only into the enrollee's current QHP (unless the existing QHP does not allow dependent coverage or the addition of a new dependent will make the family eligible for cost-sharing reductions and the family is not currently enrolled in a Silver plan);[2]
- Enrollees who are eligible for a SEP due to becoming newly eligible for cost-sharing reductions will be limited to enrollment in the Silver coverage level; and
- Enrollees who are eligible for most other SEPs[3] will only be able change enrollment within the same QHP or another within the same coverage level or one metal level higher or lower if no QHP is available in the same coverage level.

These limitations will not apply outside of the Marketplace. In addition, members of Federally-recognized tribes and Alaska Natives are excluded.

Eligibility for SEPs

Finally, CMS finalized the following additional policy changes to SEPs:

- If a SEP for loss of minimum essential coverage (MEC) was due to non-payment, a FFM or SBM-FP carrier will be allowed to reject an enrollment unless the outstanding premiums are paid; Marketplaces will be allowed to gather and store information about terminations for non-payment and to prevent individuals from qualifying for a SEP for loss of MEC if the termination was due to premium non-payment;
- In order for individuals to qualify for a SEP based on marriage, at least one of the spouses will have to provide evidence that he or she was enrolled in MEC within the 60 days prior to the marriage or lived outside of the United States during that time (this does not apply to Native Americans or Alaska Natives or within the group market);
- Individuals that qualify for a SEP based on a permanent move will have to provide evidence that they were enrolled in MEC within the prior 60 days or that they lived outside of the United States during that time (this does not apply to Native Americans or Alaska Natives); and
- CMS will limit use of the "exceptional circumstances" SEP under 45 CFR 155.420(d)(9), requiring greater documentation (subject to future guidance) and eliminating those related to early year challenges in the Marketplaces.

---

[1] Individuals that qualify for SEPs based on adoption, foster care, or through child support or other court order are still entitled to previously provided alternative coverage effective dates.
[2] New dependents can enroll separately into any plan on the Marketplace.
[3] This rule does not apply to the following SEPs: (1) SEP based on unintentional, inadvertent or erroneous enrollment / non-enrollment that was due to error, misrepresentation, misconduct or inaction of the Marketplace, CMS, or an enrollment entity (45 CFR 155.420(d)(4)); (2) SEPs based on exceptional circumstances (45 CFR 155.420(d)(9)); (3) SEPs based on domestic abuse or spousal abandonment (45 CFR 155.420(d)(10)); and (4) SEPs for Indians and their dependents.

Regarding prior coverage requirements, CMS expects State-based Marketplaces to implement these requirements as soon as feasible and has excluded members of Federally-recognized tribes and Alaska Natives.

Updates to Certification Process

CMS in conjunction with the final market stabilization rule issued separate guidance to update the QHP certification timeline and the rate review submission deadlines: Key Dates for Calendar Year 2017 and Rate Review Timeline Bulletin.

Key Dates for QHP Certification

Below are the finalized dates for the Plan Year 2018 certification period, as well as the truncated open enrollment period:

Activity	Date
Initial application submission / transfer deadline to CMS	**June 21, 2017** (submissions can begin May 10th)
Initial CMS review	June 22nd through July 25th
First correction notices	August 1st through August 2nd
Service Area petition deadline	August 4th
Final submission / transfer deadline	**August 16th**
CMS review of revised submissions	August 17th through September 11th
CMS sends Final Correction Notice to issuers, with Agreements for signature and plan lists for confirmation	September 14th through September 15th
State deadlines for final plan recommendations from plan management partnership states	**September 27th**
Issuers send signed agreements, confirmed plan lists, and final Plan Crosswalks to CMS	September 16th through September 27th
CMS validation notices	October 11th through October 12th
Limited data correction window: Outreach to issuers with CMS or state identified data errors; issuers submit corrections; CMS reviews and finalizes data for Open Enrollment	September 15th through October 7th
Open enrollment	**November 1, 2017 through December 15, 2017**

Rate Review Timeline

Below are the final dates for rate review for single risk pool coverage:

Activity	Date
Deadline for issuers to submit rate filing justifications for single risk pool coverage (QHPs and non-QHPs) for states without an Effective Rate Review Program (ERRP)[4]	June 1st
Deadline for issuers to submit Uniform Rate Review rate filing justifications for single risk pool coverage (QHPs and non-QHPs) for states with an Effective Rate Review Program (ERRP)	July 17th (or earlier as set by the state)
Deadline for Effective Rate Review Program (ERRP) states to post online (or link to[5]) proposed rate increases subject to state review	August 1tst
Deadline for all risk pools with QHPs to be in "final" status in the Unified Rate Review System	August 16th
Deadline for all rate filings that only have non-QHPs to be in "final" status	October 6th
Deadline for CMS and states to post or link to information about all final rate increases	November 1st

Actuarial Value

CMS has amended the definition of "de minimis" as it applies to permissible variations from the actuarial value (AV) ranges for plan metal levels 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. This change will be implemented starting with the 2018 AV Calculator, subject to the exceptions outlined below.

CMS did not modify the de minimis range for the Silver plan cost-sharing variations (plans with an AV of 73, 87 and 94 percent).

CMS finalized that the de minimis range for the "expanded" Bronze plans that meet specified requirements related to coverage of services prior to the deductible will have a permissible variation to −4 / +5 percentage points (from −2 / +5 percentage points) to align with the changes to the permissible de minimis variation more broadly. CMS noted that they recognize that the difference between the Bronze and Silver plans under this de minimis range is only one percent and, as such, CMS will monitor the effect of this in 2018 and may consider further changes to the de minimis ranges in the future.

CMS acknowledged that states may apply stricter AV standards and noted that, given the maximum out-of-pocket (MOOP) amounts under the ACA, Bronze plans will likely not be able to have an AV below 58.54 percent. CMS is also monitoring Silver plan designs and whether this change will necessitate implementation of the requirement that QHPs reduce MOOPs for individuals with incomes between 250% and 400% of the Federal Poverty Level because of the new minimum AV for Silver plans.

Network Adequacy

CMS finalized the changes to network adequacy as proposed. Beginning in the 2018 plan year, CMS will rely on state regulators to ensure network adequacy within FFMs in addition to SBMs, no longer applying minimum

[4] Applies to on- and off-Marketplace plans of issuers seeking to offer QHPs; does not apply to SADPs.
[5] https://ratereview.healthcare.gov

Federal time and distance criteria. CMS will continue to coordinate with states to monitor network adequacy, for example through complaint tracking.

The only exception to this approach will be if the state does not have a sufficient network adequacy review process. If a FFM state does not have adequate authority or means to conduct a "sufficient" network adequacy review, CMS will rely on an insurer's (commercial or Medicaid) accreditation from a CMS-recognized accreditation body. Similar to 2014, non-accredited insurers and standalone dental plans will be required to submit a network adequacy access plan that is consistent with the National Association of Insurance Commissioner's network adequacy model act.

Essential Community Providers

CMS finalized the following changes to the reviews of carriers' inclusion of Essential Community Providers (ECPs) in provider networks[6]:

- Starting in 2018, carriers will only be required to include 20 percent of available ECPs within their provider networks rather than the current requirement of 30 percent.
- The ability of issuers to write-in ECPs (a process terminated by the previous administration starting for 2017 coverage) will be reinstated for 2018, as long as the ECPs that are written-in apply for ECP status.

[6] CMS previously finalized these changes in the 2018 Payment Notice and outlined in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces.

www.publicconsultinggroup.com