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

February 22, 2017
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary .................................................................</td>
</tr>
<tr>
<td>Detailed Overview .................................................................</td>
</tr>
<tr>
<td>Guaranteed Availability of Coverage .......................................</td>
</tr>
<tr>
<td>Open Enrollment ..........................................................................</td>
</tr>
<tr>
<td>Special Enrollment Periods ......................................................</td>
</tr>
<tr>
<td>Updates to Certification Process .............................................</td>
</tr>
<tr>
<td>Actuarial Value ..........................................................................</td>
</tr>
<tr>
<td>Network Adequacy ........................................................................</td>
</tr>
<tr>
<td>Essential Community Providers ...............................................</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

On February 15, 2017, the Centers for Medicare and Medicaid Services (CMS) released the proposed Patient Protection and Affordable Care Act; Market Stabilization Rule. The proposed rule represents the first regulatory changes related to the Affordable Care Act introduced by the new administration following its executive order announcing an intent to increase flexibility. The rule proposes changes aimed at stabilizing the individual and small group markets. The proposals include tightening enrollment standards and providing increased flexibility related to standards for Qualified Health Plans (QHPs), as outlined in detail below.

In addition to the proposed changes outlined below, CMS announced in the preamble that it is “actively exploring” and seeking input regarding additional policies to promote continuous coverage in the individual market. This may include expanding lookback periods for special enrollment periods that require prior coverage or imposing waiting periods or late enrollment penalties for those without continuous coverage.

Shortly after issuing the regulations, CMS released an Addendum to the 2018 Letter to Issuers in the Federally-facilitated Marketplaces and a Draft Bulletin which, together, make changes to the timelines for QHP certification and the rate review process for 2018 coverage, as outlined below. 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 proposed rule changes. These dates were also included in a revised list of key dates for 2017.

Comments on the regulations and the rate review bulletin are due on March 7th at 5pm. As you will see below, CMS has requested feedback on specific questions in addition to general comments.

PCG subject matter experts have created a comprehensive summary to assist regulators as they seek to understand what the proposed 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

In light of guaranteed availability requirements, carriers are currently prohibited from requiring 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. Instead, carriers must effectuate coverage if the first month’s premium payment is made even if there is outstanding debt owed.1 The proposed rules would eliminate this prohibition, applying the same rule that currently applies for coverage within the same product. Carriers would be permitted to apply initial premium payments to outstanding debts for prior coverage under a different product from the same issuer within the prior 12 months. The carrier would 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 proposed for both the individual and group markets, though CMS explained in the preamble that it cannot be effectuated in the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). State laws prohibiting this change would not be preempted, though – in the preamble – CMS has encouraged states to take the same approach.

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1 Carriers can pursue collections for the amounts owed.
The rules require that carriers apply such requirements uniformly and in compliance with non-discrimination requirements. This policy could not be applied when an individual is changing carriers or applied to any person that is not contractually responsible for premium payments.

CMS is specifically seeking comments regarding:

- Whether carriers should be allowed to consider a percentage less than the full amount due to be sufficient to effectuate coverage going forward;
- Whether there should be notice requirements; and
- How these requirements should be operationalized outside of Marketplaces.

**Open Enrollment**

CMS is proposing to make the open enrollment period for the individual market shorter for the 2018 plan year. For 2018 coverage, open enrollment would still begin on November 1, 2017 but would 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, would be for the entire year.

CMS is seeking comment on:

- The capacity of State-based Marketplaces (SBMs) to shift to the shorter open enrollment period for 2018;
- The impact of the shorter timeline on carriers’ ability to enroll healthy consumers; and
- Challenges agents, brokers, navigators and assisters may have in providing assistance in a shorter time period.

**Special Enrollment Periods**

**Pre-Enrollment Eligibility Verification**

The proposed regulations would expand upon the pilot announced by the previous administration for verifying eligibility for all individual market special enrollment periods (SEPs). The pre-enrollment verification would take the place of self-attestations of SEP eligibility and would be required prior to enrollment being effectuated. The regulations propose expanding the pilot to all SEPs within the Federally-facilitated Marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs). SBMs would be encouraged but not required to implement pre-enrollment verification of SEP eligibility.

This process would be introduced in the expanded manner at the same time the pilot was slated to begin (June 2017) and seeks to ensure individuals do not have incentives to delay enrollment.

Effective dates of coverage would continue to be determined by the date of plan selection, though enrollment would be pended until SEP eligibility is verified, with it then being retroactive. Individuals would 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. Enrollees would be given 30 days to provide required documentation and electronic data matches would be sought when applicable.

CMS has stated in the preamble that it would monitor implementation to ensure that healthier individuals are not deterred from enrollment due to this process, undermining the risk pool.

CMS is specifically seeking comments on:

- The impact of this change on consumers;
• The proposed verification method;
• Whether a small percentage of SEP enrollments should remain outside of this process to allow for the comparative study that had been planned for as part of the pilot;
• What strategies CMS should undertake to ensure individuals complete the verification process; and
• Whether SBMs should be required to verify SEP eligibility and, if so, how soon.

Limitations on Coverage Changes

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

• Enrollees would 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 would make the family eligible for cost-sharing reductions and the family is not currently enrolled in a Silver plan);
• Enrollees who are eligible for a SEP due to becoming newly eligible for cost-sharing reductions would be limited to enrollment in the Silver coverage level (CMS is seeking comment on whether this should also apply to those becoming newly eligible for advance-payment tax credits); and
• Enrollees who are eligible for most other SEPs\(^2\) would only be able change enrollment within the same QHP or another within the same coverage level.

Regardless these changes CMS is also specifically seeking comment on:

• Whether SBMs should be required to implement such limitations, and, if so, how soon;
• How these policies should be operationalized off-Marketplace; and
• Alternative strategies (including pre-enrollment verifications).

Eligibility for SEPs

Finally, CMS is proposing the following additional policy changes to SEPs for the individual market:

• If a SEP for loss of minimum essential coverage (MEC) was due to non-payment, a FFM or SBM-FP carrier would be allowed to reject an enrollment unless the outstanding premiums are paid; Marketplaces would 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 would 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;
• Individuals that qualify for a SEP based on a permanent move would 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; and
• CMS would 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.

\(^2\) 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. CMS has requested comments on whether other SEPs should be excluded.
Updates to Certification Process

CMS issued separate guidance to update the QHP certification timeline and the rate review submission deadlines to give additional time for carriers to develop - and states to review - form and rate filings for the 2018 plan year that reflect the changes in the Proposed Market Stabilization Rule.

Key Dates for QHP Certification

On February 17, 2017, the CMS released an addendum to the 2018 Letter to Issuers in the Federally-facilitated Marketplaces announcing a new timeline for the QHP certification process:

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<th>Activity</th>
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| **Initial application submission / transfer deadline to CMS**            | **May 3, 2017** (submissions can begin April 5th)  
**June 21, 2017** (submissions can begin May 10th) |
| Initial CMS review                                                      | May 4th through June 5th  
June 22nd through July 25th |
| First correction notices                                               | June 12th through June 13th  
August 1st through August 2nd |
| Service Area petition deadline                                         | August 3rd  
August 4th |
| **Final submission / transfer deadline**                                | **August 21st**  
August 16th |
| CMS review of revised submissions                                       | June 28th through July 28th  
August 17th through September 11th |
| CMS sends Final Correction Notice to issuers, with Agreements for signature and plan lists for confirmation | September 11th  
September 14th through September 15th |
| **State deadlines for final plan recommendations from plan management partnership states** | **September 15th**  
September 27th |
| Issuers send signed agreements, confirmed plan lists, and final Plan Crosswalks to CMS | September 12th through September 15th  
September 16th through September 27th |
| CMS validation notices                                                 | September 21st through September 22nd  
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 12th through October 13th  
September 15th through October 7th |
| **Open enrollment**                                                     | **November 1, 2017 through January 31, 2018**  
November 1, 2017 through December 15, 2017 |
Rate Review Timeline

Also on February 17th, CMS released a Draft Bulletin with updates to the deadlines for the rate review process:

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<tr>
<td>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)³</td>
<td>May 3rd</td>
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<td>June 1st</td>
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<tr>
<td>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)</td>
<td>July 17th (or earlier as set by the state)</td>
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<td>Deadline for Effective Rate Review Program (ERRP) states to post online (or link to⁴) proposed rate increases subject to state review</td>
<td>August 1st</td>
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<tr>
<td>Deadline for all risk pools with QHPs to be in “final” status in the Unified Rate Review System</td>
<td>August 21st</td>
</tr>
<tr>
<td>Deadline for all rate filings that only have non-QHPs to be in “final” status</td>
<td>August 16th</td>
</tr>
<tr>
<td>Deadline for CMS and states to post or link to information about all final rate increases</td>
<td>November 1st</td>
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Actuarial Value

CMS has proposed to amend 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 would be implemented starting with the 2018 AV Calculator, subject to the exceptions outlined below. CMS is seeking input on whether it should delay the change until the 2019 plan year, given the lead time issuers need to design plans.

CMS is not proposing to modify the de minimis range for the Silver plan cost-sharing variations (plans with an AV of 73, 87 and 94 percent). However, CMS is considering whether carriers must be required to reduce cost-sharing for individuals between 250% and 400% of the Federal poverty level given the enhanced de minimis variations.

CMS is proposing to maintain the de minimis range for the “expanded” Bronze plans that meet specified requirements related to coverage of services prior to the deductible, but to change the permissible variation to +5 / −4 percentage points (from +5 / −2 percentage points) to align with the changes to the permissible de minimis variation more broadly.

CMS is seeking comment on these proposals, including regarding:

- The permissible de minimis values for metal levels, including Silver plan cost-sharing variations; and
- Whether the permissible percentage point variations should differ when increasing or decreasing AV.

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³ Applies to on- and off-Marketplace plans of issuers seeking to offer QHPs; does not apply to SADPs.
⁴ [https://ratereview.healthcare.gov](https://ratereview.healthcare.gov)
Network Adequacy

CMS has stated in the preamble that, beginning in the 2018 plan year, it intends to rely on state regulators to ensure network adequacy within FFMs in addition to SBMs, no longer applying minimum Federal time and distance criteria. The only exception to this approach would 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 would 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 would 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

In conducting reviews of carriers’ inclusion of Essential Community Providers (ECPs) in provider networks, CMS proposes the following changes to the approach previously finalized in the 2018 Payment Notice and outlined in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces:

- Starting in 2018, carriers would 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 with 2017 coverage) would be reinstated for 2018, as long as the ECPs that are written-in apply for ECP status.