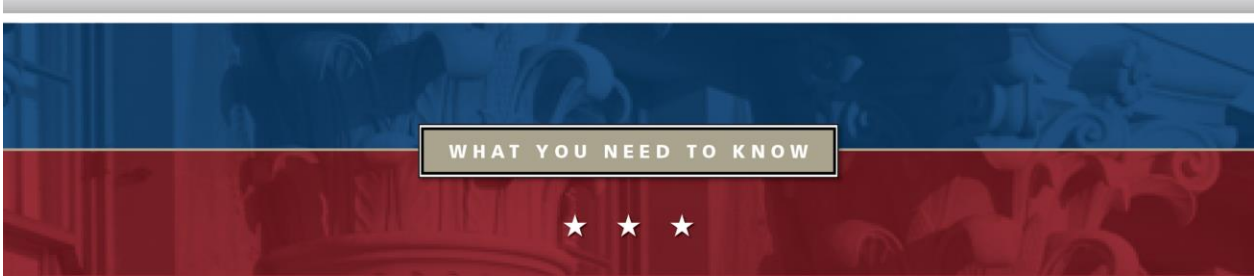

ACA Market Stabilization Final Rule

On April 18, 2017, the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) issued its final rule regarding Patient Protection and Affordable Care Act (ACA) market stabilization.

The rule amends standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period in the individual market for the 2018 plan year, standards related to network adequacy and essential community providers for qualified health plans, and the rules around actuarial value requirements.

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.

The regulations are effective on June 17, 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 final rule and as permitted by state law, an issuer may apply the initial premium payment to any past-due premium amounts owed to that issuer. If the issuer is part of a controlled group, the issuer may apply the initial premium payment to any past-due premium amounts owed to any other issuer that is a member of that controlled group, for coverage in the 12-month period preceding the effective date of the new coverage.

Practically speaking, when an individual or employer makes payment in the amount required to trigger coverage and the issuer lawfully credits all or part of that amount to past-due premiums, the issuer will determine that the consumer made insufficient initial payment for new coverage.

This policy applies both inside and outside of the Exchanges in the individual, small group, and large group markets, and during applicable open enrollment or special enrollment periods.

This policy does not permit a different issuer (other than one in the same controlled group as the issuer to which past-due premiums are owed) to condition new coverage on payment of past-due premiums or permit any issuer to condition new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premiums.

Issuers adopting this premium payment policy, as well as any issuers that do not adopt the policy but are within an adopting issuer's controlled group, must clearly describe the consequences of non-payment on future enrollment in all paper and electronic forms of their enrollment application materials and any notice that is provided regarding premium non-payment.

Annual Open Enrollment Periods

Currently, annual Exchange open enrollment for plan year 2018 begins on November 1, 2017, and ends on January 31, 2018. Under the final rule, the open enrollment period will shorten; it will begin on November 1, 2017, and end on December 15, 2017. This open enrollment period will be consistent with the month-and-a-half open enrollment period beginning with and after the open enrollment for the 2019 benefit year.

Special Enrollment Periods

Starting in June 2017, all new consumers who seek to enroll in Exchange coverage through applicable special enrollment periods will be subject to pre-enrollment eligibility verification. This will include all states served by HealthCare.gov. This pre-enrollment verification will apply to the individual market only, not to special enrollment periods under the Small Business Health Options Program (SHOP).

New dependents can enroll in a new qualified health plan (QHP) at any metal level if they enroll in a separate QHP from other existing enrollees; however, if the new dependent is enrolling in the same QHP as those who are already QHP enrollees, then the dependent and existing QHP enrollees are restricted from changing plans or metal levels. This does not apply to the small group market or SHOP.

Consumers who were terminated from coverage due to premium nonpayment will not be allowed to enroll in coverage mid-year through a special enrollment period due to loss of minimum essential coverage.

For consumers who are newly enrolling in QHP coverage through the Exchange through the special enrollment period for marriage, at least one spouse must have had minimum essential coverage for one or more days during the 60 days preceding the marriage date, or both spouses must have lived in a foreign country or a U.S. territory for one or more days during the 60 days preceding the marriage date. This applies to the individual market only. This does not apply to the small group market or SHOP.

For consumers who are newly enrolling in QHP coverage through the Exchange through the special enrollment period for a permanent move, the consumer will need to provide documentation of the move and evidence of prior coverage for one or more days in the 60 days preceding the move, unless the consumer is moving to the U.S. from a foreign country or a U.S. territory. This applies to the individual market. The requirement to show prior coverage for the permanent move special enrollment period is applicable to the SHOP. Further, CMS intends to release guidance on documentation that will be acceptable for this special enrollment period.

For the remainder of 2017 and for future plan years, CMS will significantly limit the use of the exceptional circumstances special enrollment period by using a more rigorous test that will require consumers to provide supporting documentation. CMS intends to provide guidance on situations that will meet the more rigorous test and on documentation that consumers will be required to provide. This applies to the individual market only.

A consumer may request and the Exchange must provide for a coverage effective date that is no more than one month later than the consumer's effective date would ordinarily have been, if the special enrollment period verification process delays the enrollment so that the consumer would be required to pay two or more months of retroactive premium to effectuate coverage or avoid cancellation. This applies to the individual market and SHOP.

The final rule indicates that the following special enrollment periods are no longer available:

- Consumers who enrolled with an advance premium tax credit (APTC) that is too large because of a redundant or duplicate policy
- Consumers who were affected by a temporary error in the treatment of Social Security Income for tax dependents
- Lawfully present non-citizens that were affected by a temporary error in the determination of their APTC eligibility
- Lawfully present non-citizens with incomes below 100 percent of federal poverty level (FPL) who experienced certain processing delays
- Consumers who were eligible for or enrolled in COBRA and were not sufficiently informed about their coverage options

Continuous Coverage

CMS solicited and received comments on policies that would promote continuous coverage; however, CMS did not take any action in this final rule regarding such policies.

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 QHPs, 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 *de minimis* variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

The final rule amends 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 (other than bronze plans meeting certain conditions) that are required to comply with AV. For example, a silver plan could have an AV between 66 and 72 percent. For bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan, the allowable variation in AV will be -4/+5 percentage points. This applies to plans beginning on or after January 1, 2018. CMS' revised 2018 AV Calculator (scroll to Plan Management, Guidance) reflects the amended AV *de minimis* range.

Network Adequacy

CMS will rely on state reviews for network adequacy in states where a federally facilitated exchange (FFE) is operating as long as the state has a sufficient network adequacy review process. In states that do not have the authority and means to conduct sufficient network adequacy reviews, CMS will rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity. CMS will use the following three accrediting entities for 2018 plan year network adequacy reviews: the National Committee for Quality Assurance, URAC, and the Accreditation Association for Ambulatory Health (these accrediting entities were previously recognized by HHS for QHP accreditation).

Unaccredited issuers are required to submit an access plan as part of the QHP application; the access plan must demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act.

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.

CMS will 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. Also, CMS will continue to allow an issuer's ECP write-ins to count toward the satisfaction of the ECP standard, if the written-in provider has submitted an ECP petition to HHS no later than the issuer submission deadline for QHP application changes.

Conclusion

The final rule adopts almost all the proposed rule's provisions. The primary changes from the proposed rule to the final rule are: clarifications to the scope of the guaranteed availability policy regarding unpaid premiums, changes to special enrollment period provisions, updates to the definitions and general standards for eligibility determinations, and clarification regarding states' roles.

CMS acknowledges that these provisions' net effect on enrollment, premiums and total premium tax credit payments is uncertain. However, CMS determined that these regulations are urgently needed to stabilize markets, incentivize issuers to enter or remain in the market, and ensure premium stability and consumer choice.

4/17/2017