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CMS Finalizes Market Stabilization Rule

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Health Care

Last Thursday, the Centers for Medicare & Medicaid Services (CMS) finalized the Affordable Care Act (ACA) market stabilization rule, which it originally proposed in February, 82 Fed. Reg. 10,980 (Feb. 17, 2017). This final rule was published today in the Federal Register and will become effective on June 19, 2017. 82 Fed. Reg. 18,346.

The final rule includes several changes that will be welcome news for insurers, including a tightening of the regulations governing special enrollment periods. However, the final rule does not does address the most significant contributors to uncertainty in the individual market: whether the ACA will be repealed and/or replaced; whether the Trump Administration will make the cost sharing reduction payments that are currently subject to litigation pending before the U.S. Court of Appeals for the District of Columbia; and how (if at all) the Trump Administration will enforce the individual mandate.

Special Enrollment

Under CMS regulations implementing the ACA, health plans are required to provide special enrollment periods for individuals with certain life events that may require them to shop for new health insurance (e.g., loss of current health insurance, change in eligibility for premium tax credits or cost sharing subsidies). 45 C.F.R. § 147.104(b)(2); 45 C.F.R. § 155.420.

The final rule makes several changes to the policies and regulations governing special enrollment periods.

Expanding Pre-Enrollment Verification

Beginning in June 2017, for all States with a federally facilitated exchange or a state-based Exchange with a federal partnership (i.e., all States using Healthcare.gov), CMS will expand its pre-enrollment verification to cover all special enrollment qualifying events. That is, consumers who apply for a special enrollment period will be subject to a verification process.

In the preamble, CMS indicates that it is expanding its verification process in response to concern from the insurance industry that relying on self-attestation to access a special enrollment period can easily be abused and negatively impact the risk pool. For example, a healthy individual can simply wait until he or she needs medical care and then falsely attest to a qualifying event to get access to health insurance immediately.

CMS regulations provide that the effective date of coverage obtained through a special enrollment period is either the first day of the month following the enrollee's Qualified Health Plan (QHP) selection or the first day of the second month following that selection, depending on whether the enrollee signs up in the first half of a month or the second half. § 155.420(b)(1).

Enrollees going through the verification process will have coverage retroactive back to whichever of these two dates applies.

Under the new rule, enrollees facing these verifications can, at their option, request that the effective date of coverage and premium payment responsibilities be delayed by up to one month, if "enrollment is delayed until after the verification of the consumer's eligibility for a special enrollment period, and the assignment of a coverage effective date . . . would [otherwise] result in the consumer being required to pay 2 or more months of retroactive premium to effectuate coverage or avoid cancellation." *Id.* § 155.420(b)(5). CMS "interpret[s] 2 or more months of retroactive premium to mean that, at the time that the enrollment transaction is sent by the [federally facilitated Exchange] to the issuer, no less than 2 months has elapsed from the date that the consumer's coverage was originally scheduled to begin." 82 Fed. Reg. at 18,361. CMS "do[es] not anticipate that many consumers will be eligible to request a later effective date under this provision," as "[it] do[es] not expect the pre-enrollment verification processes to result in such delays." *Id.* But CMS "recognize[s] that there may be unforeseen challenges as we implement the verification process," and it "believe[s] the option to have a later effective date could help keep healthier individuals in the market, who otherwise might be deterred by the prospect of paying for 2 or more months of retroactive coverage that they did not use." *Id.*

Limiting Enrollees' Ability to Change Types of Coverage

CMS amends its regulations to limit enrollees' ability to use special enrollment periods to change their level of coverage, in part because of concerns from insurers about "existing Exchange enrollees . . . utilizing special enrollment periods to change plan metal levels based on health needs that emerge during the benefit year," which "is having a negative impact on the risk pool." *Id.* at 18,358.

Under the new rule, for individuals for whom a special enrollment period is triggered because the enrollee gains a new dependent, the Exchange must allow the dependent to enroll in the enrollee's current QHP. § 155.420(a)(4)(i). The Exchange need only allow the enrollee and his or her dependent to choose an alternative plan if the enrollee's existing QHP's "[b]usiness rules do not allow the dependent to enroll," *id.*

For most other enrollees and their eligible dependents for whom special enrollment is triggered,[1] the new rules provides that the Exchange must allow "changes to his or her enrollment in the same QHP or change to another QHP within the same level of coverage (or one metal level higher) . . . or, at the option of the enrollee or dependent, enroll in any separate QHP." § 155.420(a)(4)(iii). In the preamble, CMS describes this provision as follows: "the Exchange generally need only allow the enrollee and his or her dependents to make changes to their enrollment in the same QHP or to change to another QHP within the same level of coverage, as defined in §156.140(b), if other QHPs at that metal level are available." 82 Fed. Reg. at 18,359. However, the actual text of the rule is not clear, as it states these enrollees and dependents

[1] This applies to enrollees whose special enrollment was triggered by one of the following qualifying events: loss of coverage under § 155.420(d)(1); loss of dependent under § 155.420(a)(2)(ii); new eligibility for a QHP under § 155.420(a)(3); QHP materially violates the contract with the enrollee under § 155.420(d)(5); new eligibility for tax credit under § 155.420(d)(6)(iii)-(iv); and move creates access to new QHPs under § 155.420(d)(7). § 155.420(a)(4)(iii).

"must" be permitted to enroll "in the same QHP or change to another QHP within the same level of coverage (or one metal level higher) . . . or, at the option of the enrollee or dependent, enroll in any separate QHP." § 155.420(a)(4)(iii) (emphasis added).

The final rule also includes an exception to all these limitations on changing coverage through a special enrollment period: if the enrollee and his or her dependent become eligible for cost-sharing subsidies, they must be permitted to switch to silver-level QHP to access those cost-sharing subsidies, § 155.420(a)(4)(ii).

These limits on changing coverage apply only in the individual market; they do not apply in the group market. § 147.104(b)(2)(i); 45 C.F.R. § 155.725(j)(7).

Changes to Avenues for Special Enrollment

The final rule narrows several avenues for special enrollment:

- As mentioned above, a special enrollment is triggered if "[t]he qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order." The final rule provides that people seeking special enrollment through this avenue because of a marriage may only do so if at least one of the two spouses had insurance for at least one day in the previous 60 days. § 155.420(d)(2)(i)(A).
- Several special enrollment periods require an individual to demonstrate that he or she had prior coverage within 60 days of the qualifying event. The final rule requires that, to make this showing, an individual must establish that he or she: had such coverage on at least one day of the previous 60 days; lived in a foreign country or United States territory for at least one day in the previous 60 days; or is an "Indian as defined by section 4 of the Indian Health Care Improvement Act. " *Id.* § 155.420(a)(5).
- CMS announces its "interpretation" that the guaranteed availability rule does not prohibit an issuer from requiring an individual who owes it past-due premiums to pay those premiums in full before enrolling in a new plan, without running afoul of the guaranteed availability requirement. 82 Fed. Reg. at 18,346. CMS acknowledges that there may be state laws that prevent an insurer from taking these steps, and it "encourages" (but does not require) States to follow CMS's lead in allowing this practice.

  Insurers that choose to deny enrollment for outstanding premium debts must do so in a uniform and non-discriminatory way. Since guaranteed availability applies to both QHPs and individual market plans sold outside of the Exchange, this interpretation is relevant for both types of individual market plans.

Initial Open Enrollment Period

Under current CMS rules, the initial enrollment period for QHPs for benefit years 2016, 2017 and 2018 runs from November 1 of the calendar year preceding the benefit year through January 31 of the benefit year. For example, for the 2017 benefit year, the initial enrollment period ran from November 15, 2016 through January 31, 2017. Starting with the 2019 benefit year, the initial enrollment period will be shortened, such that it runs for only approximately six weeks: November 1 to December 15 of the calendar year preceding the benefit year.

CMS's final rule moves up the shortened initial enrollment period to start with benefit year 2018 instead of 2019. 45 C.F.R. § 155.410(e)(1)(iv). That is, for the 2018 benefit year, initial enrollment will run only from November 1 through December 15, 2017. That six-week enrollment period will apply to all future benefit years as well.

CMS cited several reasons for this change. CMS would like to "shift[] to an earlier open enrollment end date, so that all consumers who enroll during this time will receive a full year of coverage, which will increase access for patients and simplify operational processes for issuers and the Exchanges." 82 Fed. Reg. at 18,353. In addition, CMS believes that a shorter open enrollment period "may have a positive impact on the risk pool because it will reduce opportunities for adverse selection by those who learn that they will need healthcare services in late December or January." *Id.* at 18,353-54.

Network Adequacy

In the final rulemaking, CMS announces that, starting in benefit year 2018, it will "rely on State reviews for network adequacy in States in which an [federally facilitated Exchange] is operating, provided the State has a sufficient network adequacy review process" and "defer to the States' reviews in States with the authority that is at least equal to the 'reasonable access standard' identified in [45 C.F.R.] § 156.230 and means to assess issuer network adequacy." 82 Fed. Reg. at 18,371-72.

For "States that do not have the authority and means to conduct sufficient network adequacy reviews," CMS will "apply a standard similar to the one used in the 2014 plan year," *i.e.*, "rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity." *Id.* at 18,372.

Essential Community Providers

Current CMS regulations impose standards for including Essential Community Providers in plans' networks. 45 C.F.R. § 156.235.

In the final rulemaking, CMS announces that it is finalizing two changes to how it evaluates compliance with the Essential Community Provider requirement for benefit year 2018. First, it is lowering the "minimum percentage" that plans must cover from 30 percent to 20 percent. 82 Fed. Reg. at 18373-74. The "minimum percentage" is the percentage of Essential Community Providers in the service area that the plan must include in its network. Second, it is modifying previous guidance to allow insurers to get approval from CMS, through a "write-in process," to count providers that are not listed on the Essential Community Provider list maintained by CMS. *Id.*

Actuarial Value

In calculating the actuarial value of a plan, CMS permits a "de minimis variation," *i.e.*, the allowable variation in the actuarial value "that does not result in a material difference in the true dollar value of the health plan." Under current regulations, this *de minimis* variation is +/- 2 percentage points, except for bronze plans, which are subject to a *de minimis* variation of −2 percentage points and +5 percentage points. 45 C.F.R. § 156.140(c).

CMS changes the *de minimis* variation to -4 percentage points and +2 percentage points for all non-bronze plans, and -4 percentage points and +5 percentage points for bronze plans that meet certain criteria. 45 C.F.R. § 156.140(c). CMS explains that this change was made to provide additional flexibility "to help issuers design new plans for future plan years," and to help "plans to keep their cost sharing the same from year to year."

Good Faith Compliance

For calendar years 2014 and 2015, 45 C.F.R. § 156.800(c) established a good faith safe harbor such that CMS would not impose penalties if the QHP issuer made good faith efforts to comply with applicable federally facilitated Exchange standards. This safe harbor was eliminated for benefit year 2016.

In a letter issued on the same day as the final rule, CMS announced that it was re-instating this good faith policy for the 2018 benefit year to "encourage the participation of issuers" and "to stabilize the markets while reducing regulatory burdens."

Reliance on State Regulators for Reviews of QHP Certification Standards

In another letter released last Thursday, CMS announced that, even in States with federally facilitated Exchanges, it will rely more heavily "on state reviews of QHP certification standards." More specifically, for states that perform States performing plan management functions, "CMS is legally obligated to make final certification determinations, but state certification decisions will be given great weight." And CMS will rely on state review for licensure, good standing and network adequacy. For States that do not perform plan management functions, "CMS will continue to review QHP data for these states, but will rely on state review for licensure, good standing, and network adequacy."

CMS explained that this additional deference to state regulators is "[i]n keeping with Executive Order 13765, which directs agencies to exercise all authority and discretion available to them to provide greater flexibility to states and cooperate with them in implementing healthcare programs." CMS "believe[s] these changes will help streamline the QHP certification process and avoid duplicative federal and state efforts."

It is unclear how this guidance will be implemented in States that do not have an interest in conducting, or the capacity to conduct, the state reviews on which CMS plans to rely.

If you have any questions concerning the material discussed in this client alert, please contact the following members of our Health Care practice:

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