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ACA Market Stabilization Proposed Rule

OVERVIEW

On February 15th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule aimed at strengthening the financial stability and predictability of enrollee costs for insurers selling coverage through the Affordable Care Act (ACA) marketplaces. The proposed rule makes a number of changes that apply to all ACA-compliant individual market plans, not only to plans sold on the marketplaces.

Because New York operates its own state marketplace and doesn't rely on HealthCare.gov for eligibility and enrollment, some provisions of this proposed rule will only be implemented at state option and expense.

CMS proposes the following modifications to the ACA's individual markets and marketplaces:

- **Open Enrollment:** Reduce the planned 2018 open enrollment period in every state, from 90- to 45-days, to run from November 1 to December 15, 2017;
- **Special Enrollment Eligibility Verification:** Require pre-enrollment verification before a special enrollment can take place through HealthCare.gov, and encouraging state marketplaces to adopt a similar approach;
- **Special Enrollment Period Limits:** Further limit the ability of users of HealthCare.gov to enroll mid-year or move from one metal tier to another mid-year (CMS seeks comment on whether and when those same changes should take place in state marketplaces);
- **Payment of Past Due Premiums:** Allow insurers to require enrollees to pay prior unpaid premiums before re-enrolling in coverage;
- **Plan Design Changes:** Increase insurers' flexibility to offer lower-value (and lower-cost) plans while complying with ACA standards, by reducing the minimum actuarial value used to determine level of coverage;
- **Network Adequacy:** Remove federal review of network adequacy for insurers' products in states that have authority and ability to conduct such a review; and
- **Certification Deadlines:** Revising the 2018 plan certification timelines and federal rate review requirements so insurers have time to adjust to the proposed rule.

Comments on the proposed rule must be received by 5:00 pm on March 7, 2017.

OPEN ENROLLMENT DATE CHANGE

CMS proposes that open enrollment in every state run from November 1 through December 15, 2017, instead of from November 1, 2017 to January 31, 2018 as allowed under current regulations. CMS states this change could increase the number of insured individuals who begin coverage in January. It is also expected to lower total marketplace enrollment.

SPECIAL ENROLLMENT PERIOD (SEP) POLICY CHANGES

CMS proposes a number of changes to individual market SEPs in all states, and some changes impacting only individual market enrollments taking place through the Federally Facilitated Marketplace (FFM), also known as HealthCare.gov. SEP changes would not apply to the ACA-compliant small group market.

Pre-Enrollment Verification

CMS proposes that the FFM verify the eligibility of any consumer seeking to enroll in or change plans in the individual market using any SEP. In states that use HealthCare.gov, verification will be performed before that consumer's plan selection is sent to their insurer, beginning in June 2017. Where possible, CMS would verify eligibility for SEPs electronically (e.g. in the case of a birth). However, CMS indicates that most verifications will take place manually and consumers will be required to submit documentation proving they qualify for coverage.

CMS encourages state marketplaces to also implement pre-enrollment verification and seeks comment on whether they should be required to conduct pre-enrollment verification with sufficient time to implement the process. CMS also seeks comment on how long such a transition period should be allowed if state marketplaces are required to implement pre-enrollment verification.

Mid-year Change To Metal Tiers

CMS proposes to limit current enrollees' ability to use SEPs to change the metal plan levels mid-year. Most SEPs could only be used to change to another QHP within the same metal tier. This limitation does not extend to the following circumstances:

- An erroneous enrollment or non-enrollment due to error, misrepresentation, misconduct or inaction of the exchange or an associated entity;
- Special enrollment periods for American Indians and/or their dependents enrolling at the same time on the same exchange application;
- Circumstances that are "truly exceptional" as evaluated by HHS, further explained below; and,
- Special enrollment available to victims of domestic violence, abuse or spousal abandonment and/or dependents of such a victim applying on the same application and enrolling at the same time;
- An enrollee gains a dependent and in doing so newly qualifies for cost sharing reductions at the silver level; and
- An enrollee gains a dependent who cannot be enrolled in the same plan level as the enrollee.

As an example, enrollees gaining a dependent would be able to add the dependent to their current plan, or if the plan's rules didn't allow the addition, to enroll the dependent in another plan at the same metal level. If no other plans are available at the same metal level, the dependent could be added to a QHP in an adjacent metal level (i.e. from silver to gold). Under the proposal, if adding the dependent to the household size made the tax household eligible for cost sharing reductions, the enrollee and the dependent could both transition to a silver level plan, even if that change is otherwise prohibited under the proposal.

Under the proposal, state marketplaces would have to implement these changes. CMS seeks comment on the following questions:

- Whether other SEPs should also be exempt from the new limitations;
- An appropriate transitional period for state-based marketplaces to implement these changes;
- Whether the changes should be optional for state marketplaces; and,
- How to operationalize these changes outside the marketplaces.

Exceptional Circumstances SEPs

CMS would limit exceptional circumstances SEPs on HealthCare.gov to "truly exceptional" situations, and require consumers to submit documentation proving they actually qualify. Additional information would be provided to consumers via guidance.

Limitations on Re-enrollment after Nonpayment

CMS is looking to limit the ability of consumers to newly enroll or re-enroll in marketplace coverage through SEPs if they were disenrolled from other coverage for non-payment of premiums unless they repay past premiums owed, and seeks comments on how to operationalize such a requirement.

Prior Coverage Requirements to Enroll Due to Marriage

CMS proposes to limit the ability of couples enrolling through an SEP due to marriage. Under the proposed rule, CMS would require at least one of the newly married individuals seeking coverage to have been enrolled in minimum essential coverage or been outside the United States (or in a U.S. Territory) during at least one of the prior 60 days.

FELXIBILITY IN PLAN DESIGN

De Minimis Variation in Plan Value

CMS proposes to allow a de minimis variation in the actuarial value (AV) of plans of -4 or +5 percentage points for bronze plans, provided the plan either covers and pays for at least one major service (other than preventive services) before the deductible, or qualifies as a high deductible health plan. CMS proposes a -4 to +2 percent AV variation for silver, gold, and platinum plans (other than cost sharing reduction silver plans). Cost sharing reduction silver variant plans would continue to be held to a de minimis flexibility of no more than plus or minus 2 percent.

Network Adequacy

CMS intends to defer to states to ensure network adequacy requirements are met, provided the state has legal authority to do so, and regardless of whether the state operates its own exchange. In states without legal authority, HHS would rely instead on an insurer's accreditation in either the commercial or Medicaid markets from an HHS-recognized accrediting agency, which in 2018 would include: the National Committee for Quality Assurance, URAC, and the Accreditation Association for Ambulatory Health Care.

Essential Community Providers (ECPs)

CMS proposes to reduce the required number of ECPs for each QHP's network from 30% to 20% of available ECPs in each plan's service area.