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COMPLIANCE UPDATE, APRIL 21, 2017

HHS ISSUES FINAL RULE ON MARKET STABILIZATION

On April 13, 2017, the Department of Health and Human Services (HHS) released its final market stabilization rule, the first regulatory act of the Trump administration. The final version is largely unchanged from the proposed rule released on February 10, 2017. Unless otherwise specified, the rule is effective 60 days after publication and will apply to plan years beginning on or after January 1, 2018. The final rule is generally applicable to issuers of individual, small group and Marketplace coverage.

HHS received over 4,000 comments on the proposed rule, all in the course of a 20-day comment period, a much shorter period of time than the 30 to 60 days common for proposed rules. HHS noted, however, in response to complaints over the length of the timeframe that the period was shorter than normal, but that it was sufficient for compliance with the Administrative Procedures Act and was necessary to finalize the rule in time for insurers to incorporate the changes into their plans for 2018.

In the press release accompanying the final rule, Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma emphasized that the regulations are not an endorsement of the ACA. "While these steps will help stabilize the individual and small group markets, they are not a long-term cure for the problems that the Affordable Care Act has created in our healthcare system," she said.

Under President Trump's Reducing Regulation and Controlling Regulatory Costs Executive Order of January 30, executive agencies are required to identify two regulations to be repealed for each new "significant regulatory action that imposes costs." HHS concluded that the market stabilization rule is not such a regulation, and so did not identify rules for repeal.

GUARANTEED AVAILABILITY

The first issue addressed by the final rule is guaranteed availability. The ACA provides that if consumers who are receiving advance premium tax credits fall behind on their premium payments, their coverage cannot be terminated until the end of a three-month grace period. Previous HHS regulations laid out specific rules for applying this provision. During the first month the insurer must pay provider claims, but after the first month the insurer pends claims instead of paying them. If the consumer catches up on premium payments during the three-month period, the insurer must reinstate coverage and pay the pended claims. If the consumer fails to catch up, the insurer may terminate coverage as of the end of the first month and not pay subsequent claims.

Under the final rule, an insurer would not violate the federal guaranteed availability requirement if a consumer is required to repay past-due premiums from the previous 12 months before being granted new coverage if they sign up with the same insurer. The rule change will not limit the ability of individuals or employers to enroll in coverage with a different insurer. The final rule goes beyond the proposed rule in that it also permits insurers that are members of the same controlled group as the insurer owed the premium to deny coverage. A different insurer other than the insurer owed the premium or a member of the same controlled group, however, may not deny coverage for premiums owed. The rule applies inside and outside the exchange and to the individual market and the small and large group markets. Due to operational constraints, the rule won't apply to the Small Business Health Options Program (SHOP).

OPEN ENROLLMENT FOR 2018

The final rule reduces the open enrollment period for 2018 to 45 days, running from November 1 to December 15, 2017. HHS had earlier

proposed that the open enrollment period for 2018 would run from November 1, 2017 to January 31, 2018, and that beginning with 2019, the open enrollment period would run from November 1 to December 15. The final rule moves this change up a year to the 2018 open enrollment period.

SPECIAL ENROLLMENT PERIODS

The final rule tightens up special enrollment periods (SEPs) for exchange coverage in several ways:

Pre-Enrollment Verification. Under the new rule, 100 percent of SEP applications would undergo preapproval verification, beginning June 2017. This requirement will be for all applicable SEP categories for all new applicants in federally facilitated exchanges. Consumers must provide documentation proving they qualify for special enrollment before getting coverage. Consumers will be given 30 days to either upload or mail documentary verification. Once approved, coverage will be retroactive to the date of plan selection. If verification takes two or more months, an enrollee may choose not to pay for coverage for the first month.

Metal-Level Coverage Upgrades. The final rule limits the ability of existing exchange enrollees to upgrade from one metal level to another during the coverage year by using an SEP. Under the final rule, if the enrollee and the new dependent wish to be in the same qualified health plan (QHP), the enrollee will have to add the new dependent to the enrollee's QHP, or, if that was not possible, to another QHP in the same metal level (or in an adjacent metal level, if no QHP in the same metal level is available). The dependent may also enroll in a separate QHP at any metal level (an alternative worth considering, for example, for babies with high medical needs).

SEP Coverage Effective Dates. The final rule changes current regulations with respect to coverage effective dates where coverage is delayed due to eligibility verification. Under prior rules, an enrollee whose coverage was delayed because of verification issues such that the enrollee would have to pay for two or more months of retroactive coverage could choose a later effective date. Under the new rule, the enrollee who would have to pay two or more months of retroactive payment for coverage may delay coverage one month from the date when it otherwise would have been effective. To avoid cancellation of coverage, the enrollee must make a binder payment covering all months of retroactive coverage (except for the one month that coverage can be delayed, where applicable) and for the first month of prospective coverage.

Restrictions On Other SEPs. HHS is imposing limits of eligibility for additional SEPs. It will:

1. Allow insurers to reject SEP applicants claiming loss of minimum essential coverage where the applicant lost coverage for non-payment of premiums unless the applicant pays premiums due for previous coverage;
2. Require, for special enrollments resulting from marriage, at least one spouse to have had health coverage for at least one day in the two months before their marriage; and
3. Significantly limit the use of the exceptional circumstances SEP. Exceptional circumstances will have to be "truly exceptional" and verified by supporting documentation where practicable.

ACTUARIAL VALUE

The ACA allows de minimis variation in AV across metal levels. De minimis has been previously defined as +/- 2 percent. The final rule changes this to allow a variation from -4 to +2 percentage points (except for bronze plans, which can vary -4 to +5 percentage points) beginning with the 2018 plan year. Thus, a silver plan can have an AV ranging from 66 percent to 72 percent. This will allow insurers to market plans with higher cost sharing but lower premiums.

if a low AV plan becomes the second-lowest cost silver plan (the amount of advanced tax credits is tied to the premium for the second-least expensive silver plan in an individual's local market), premium tax credits will be reduced. Consumers who qualify for premium tax credits would have to choose between paying more out-of-pocket for premiums or for cost-sharing.

NETWORK ADEQUACY

Under the ACA, HHS must require health plans as a condition of QHP certification to "ensure a sufficient choice of providers" and to provide information on the availability of network and out-of-network providers. Since 2017, CMS has applied quantitative standards similar to those applied to Medicare Advantage plans to ensure the availability of adequate network providers.

Under the final rule, HHS will, beginning with the 2018 plan year, rely on state regulators to ensure network adequacy as long as the state has authority to ensure reasonable access to providers and the means to assess network adequacy. In states where the state lacks authority or means to ensure network adequacy, HHS will rely on an insurer's accreditation (commercial or Medicaid) from an HHS-recognized accreditation body.

ADDITIONAL GUIDANCE

HHS released two additional pieces of guidance on April 13. One of them establishes a good faith compliance policy for 2018. HHS will not impose civil money penalties against or decertify QHPs that act in good faith and make reasonable efforts to address regulatory concerns.

The second announces that in keeping with Executive Order 13765 on the Affordable Care Act, 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 will rely, starting with plan year 2018, on state reviews of QHP certification standards for states with federally facilitated exchanges, including states with FFEs that perform plan management functions in partnership with CMS.

Under the final market stabilization rule, for states with a network adequacy review process (regardless of whether the state otherwise performs plan management functions), CMS will no longer conduct network adequacy review, and will defer to state processes.

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