Issue Brief

FEDERAL ISSUE BRIEF • April 14, 2017

CMS Issues Final Rule Regarding the ACA; Market Stabilization

The Centers for Medicare & Medicaid Services has issued a final rule that is intended to help stabilize the individual and small group insurance markets and affirm the traditional role of state regulators. The final rule (1) amends standards relating to special enrollment periods, (2) guaranteed availability, and the timing of the annual open enrollment period for the 2018 plan year; (3) standards related to network adequacy and essential community providers for qualified health plans; (4) and the rules around actuarial value requirements.

The 139-page document is scheduled for publication in the *Federal Register* on April 18. A copy is currently available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-07712.pdf. This link will be change upon publication.

CMS published the "Patient Protection and Affordable Care Act; Market Stabilization" proposed rule in the February 17, 2017 *Federal Register*.

COMMENT

This is a fairly well written regulation. It provides clear understandings of the actions being taken by the agency with clear and concise issues raised by commentators and the rationales for the final actions being made.

While this rule is aimed at the insurance marketplace, it will impact providers by moving those individuals who are no longer able to acquire coverage and thus become uninsured.

SUMMARY

According to CMS, "Affordable Health Benefit Exchanges, or 'Exchanges' are competitive marketplaces through which qualified individuals and qualified employers can purchase health insurance coverage. Many individuals who enroll in qualified health plans through individual market Exchanges are eligible to receive advance payments of the premium tax credit to reduce their costs for health insurance premiums, and receive reductions in cost-sharing payments to reduce out-of-pocket expenses for healthcare services."

CMS notes that "this final rule takes steps to provide needed flexibility to issuers to help attract healthy consumers to enroll in health insurance coverage, improve the risk pool and bring stability and certainty to the individual and small group markets, while increasing the options for patients and providers."

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A. PART 147 – HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

1. Guaranteed availability of coverage (§147.104)

The guaranteed availability provisions at Section 2702 of the Public Health Service Act and §147.104 require health insurance issuers offering non-grandfathered coverage in the individual or group market to offer coverage to and accept every individual and employer in the State that applies for such coverage, unless an exception applies. Individuals and employers typically are required to pay the first month's premium (sometimes referred to as a binder payment) before coverage is effectuated.

CMS proposed to modify its interpretation of the guaranteed availability rules with respect to non-payment of premiums.

CMS is finalizing its proposal as follows. "To the extent permitted by applicable State law, an issuer may attribute to any past-due premium amounts owed to that issuer the initial premium payment made in accordance with the terms of the health insurance policy to effectuate coverage. If the issuer is a member of a controlled group, the issuer may attribute any past-due premium amounts owed to any other issuer that is a member of such controlled group, for coverage in the 12-month period preceding the effective date of the new coverage when determining whether an individual or employer has made an initial premium payment to effectuate new coverage. Consistent with the scope of the guaranteed availability provision and subject to applicable State law, 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 the effectuation of new coverage on payment of past-due premiums or permit any issuer to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premiums.

(Note: There is no Number 2 to this section.)

B. PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

1. Enrollment of qualified individuals into QHPs (§155.400)

CMS is finalizing an amendment to §155.400 to address binder payment requirements that apply when a consumer whose enrollment was delayed due to an eligibility verification opts to delay the coverage start date under §155.420(b)(5).

2. Initial and annual open enrollment periods (§155.410)

After consideration of the comments received, CMS is finalizing an open enrollment period for the 2018 benefit year that begins on November 1, 2017, and runs through December 15, 2017.

3. Special enrollment periods (§155.420)

Section 1311(c)(6) of the PPACA establishes enrollment periods, including special enrollment periods, for qualified individuals for enrollment in QHPs through an Exchange. Section 1311(c)(6)(C) states that the Secretary is to provide for special enrollment periods specified in section 9801 of the Code and

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other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act. Section 2702(b)(3) of the PHS Act also directs the Secretary to provide for market-wide special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974.

a. Pre-Enrollment Verification of Special Enrollment Period Eligibility
In an effort to curb abuses of special enrollment periods, in 2016 CMS added warnings on HealthCare.gov regarding inappropriate use of special enrollment periods. CMS also eliminated several special enrollment periods and tightened certain eligibility rules. Also in 2016, CMS announced retrospective audits of a random sampling of enrollments through loss of minimum essential coverage and permanent move special enrollment periods. CMS proposed to increase the scope of pre-enrollment verification of special enrollment periods to all applicable special enrollment periods in order to ensure complete verification of eligibility.

The final rule requires individuals to submit supporting documentation for special enrollment periods and ensures that only those who are eligible are able to enroll. As proposed, CMS will implement pre-enrollment verification of eligibility for special enrollment periods beginning in June 2017. "Stakeholders will receive additional updates from CMS in the coming months."

b. Special Enrollment Period Limitations for Existing Enrollees
CMS says it has heard concerns that existing Exchange enrollees are utilizing special enrollment periods to change plan "metal levels" based on health needs that emerge during the benefit year, and that this is having a negative impact on the risk pool. CMS proposed to limit the ability of existing Exchange enrollees to change plan metal levels during the benefit year.

Under new paragraph (a)(4)(i) of §155.420, CMS proposed to require that, if an enrollee qualifies for a special enrollment period due to gaining a dependent the Exchange may allow him or her to add the new dependent to his or her current QHP. Alternatively, if the QHP's business rules do not allow the new dependent to enroll (for example, because the QHP is only available as self-only coverage), the Exchange may allow the enrollee and his or her new dependent to enroll in another QHP within the same level of coverage (or an "adjacent" level of coverage, if no such plans are available), as defined in §156.140(b).

CMS is finalizing these provisions largely as proposed.

c. Special Enrollment Period Coverage Effective Dates
CMS proposed allowing consumers to start their coverage no more than 1 month later than their effective date would ordinarily have been, if the special enrollment period verification process delays their enrollment such that they would be required to pay 2 or more months of retroactive premium to effectuate coverage or avoid cancellation. CMS is adopting its proposal.

d. Tightening Other Special Enrollment Periods
CMS proposed that consumers who were terminated from coverage due to nonpayment of premium from enrolling in coverage midyear through a special enrollment period due to loss of minimum essential coverage.

CMS says it believes that it is important for consumers to maintain continuous coverage both as protection against

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unforeseen health needs and to create stability in the individual market, and therefore is finalizing provisions as basically proposed.

CMS is adopting its proposal to add new paragraph (d)(2)(i)(A) to require that, if consumers are newly enrolling in QHP coverage through the Exchange through the special enrollment period for marriage, at least one spouse must demonstrate having had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.

CMS is adopting, as proposed, the verification requirements related to the special enrollment period for a permanent move. This special enrollment period is only available to a qualified individual or enrollee who has gained access to new QHPs as a result of a permanent move and had coverage for 1 or more days in the 60 days preceding the move, unless he or she is moving to the U.S. from a foreign country or a U.S. territory.

C. PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

1. Levels of coverage (actuarial value) (§156.140)

CMS proposed to amend the definition of de minimis included in §156.140(c), 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. As proposed, for example, a silver plan could have an AV between 66 and 72 percent.

CMS is finalizing the policy as proposed and is adding regulation text to reflect that the policy applies to plan years beginning on or after January 1, 2018.

2. Network adequacy (§156.230)

For the 2018 plan year, CMS proposed, and is adopting, to defer to the States' reviews in States with the authority that is at least equal to the "reasonable access standard" identified in §156.230 and means to assess issuer network adequacy.

3. Essential community providers (§156.235)

Essential community providers (ECPs) include providers that serve predominantly low income and medically underserved individuals, and specifically include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Act. Section 156.235 establishes requirements for inclusion of ECPs in QHP provider networks and provides an alternate standard for issuers that provide a majority of covered services through employed physicians or a single contracted medical group.

CMS is finalizing its proposal to decrease the ECP threshold requirement from 30 to 20 percent for plan year 2018 in an effort to reduce the regulatory burden on issuers and stabilize the Exchanges. The final rule provides that this threshold will be applicable for the 2018 plan year.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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