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HHS Makes Its First Move to Stabilize the Individual Health Insurance Market

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Wednesday, the Trump Administration released its first proposed regulation seeking to stabilize the individual insurance market – in particular, the Affordable Care Act (ACA) insurance exchange market (or marketplace). Amidst efforts to repeal, replace and repair the ACA, the health care industry has warned of a collapsing marketplace that has limited consumer access and choice. In response to these concerns, the Centers for Medicare & Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS), proposed a much-anticipated regulation that addresses some of the policies that have contributed to an unbalanced risk pool, resulting in rising premiums and the departure of insurers from the marketplace. Stakeholders will have until March 7, 2017, to comment on the proposed regulation, which is less than the typical 30-60 day comment period.

Proposed Marketplace Changes for 2018

CMS proposes a number of changes to improve the stability of the marketplace for 2018. CMS believes these changes would grant insurers the flexibility needed to attract more healthy consumers to the marketplace, thereby strengthening the current risk pool. Specifically, CMS proposes changes to special enrollment periods, the annual enrollment period, guaranteed availability, network adequacy rules, the inclusion of essential community providers and actuarial value requirements.

Notably, the proposed regulation does not include expected changes to the age ratio (or age band) for setting premium rates. The 3:1 age band, which is set forth in the ACA, has been the subject of intense partisan debate as to whether changing the age band to 5:1 would lower premiums enough to incentivize young and healthy individuals to join the marketplace. An earlier leaked draft of the proposed rule indicated that CMS might propose to change the age band from 3:1 to 3.49:1.

Guaranteed Availability of Coverage

The ACA currently requires non-grandfathered plans to offer coverage to all individuals who apply unless an exception applies. CMS has interpreted this requirement to mean that consumers can purchase coverage for a new plan year with an issuer without having to pay past due premiums for a previous plan year to that same issuer. In response to comments on the potential to "game" this policy, CMS proposes that an issuer does not violate the guaranteed availability requirements if the same issuer refuses to provide new coverage until the individual pays any outstanding premium debt from the prior 12 months of coverage. CMS notes that this policy does not preclude an individual from seeking coverage from another issuer. CMS encourages states to adopt a similar policy.

Open Enrollment Period

CMS proposes to shorten the 2018 open enrollment period from November 1, 2017 – January 31, 2018, to November 1, 2017 – December 15, 2017.

Special Enrollment Periods

The ACA established special enrollment periods to maintain continuous coverage for individuals who might either lose coverage or experience circumstances that might require a change in coverage. For example, special enrollment periods allow individuals to seek new coverage or make changes to existing coverage for

circumstances, including the birth of a child or marriage. Special enrollment periods, however, have also enabled consumers to enter and exit the marketplace with only a simple self-attestation to determine eligibility.

While CMS attempted to curb these abuses in 2016, CMS is proposing additional changes to ensure special enrollment periods are used as intended. Specifically, beginning in June 2017, CMS proposes to conduct pre-enrollment verification of eligibility for all categories of special enrollment periods for all new consumers in all states served by the healthcare.gov platform. Once consumers apply for a plan, their enrollment would be "pending" until the eligibility is verified and the enrollment information is provided to the issuer. CMS is encouraging state-based exchanges to also conduct the same type of pre-enrollment verification.

CMS is also considering a number of other proposals, including the following:

- If a consumer is currently enrolled in a plan and has a change in circumstance, the current coverage would remain in effect until the consumer submits information to verify the change in circumstance.
- Limiting the ability of existing marketplace enrollees to change plan metal levels during a coverage year.
- If an enrollee qualifies for a special enrollment period due to gaining a new dependent, the dependent would be added to the enrollee's qualified health plan (QHP). If not allowed by the QHP, the dependent could enroll in another QHP within the same level of coverage.
- Allowing consumers to delay coverage by one month if the verification process results in a delay in enrollment that would result in two or more months of retroactive premium payments to effectuate coverage or avoid termination for non-payment.

Finally, CMS proposes changes to strengthen and streamline requirements for many of the existing special enrollment periods. For example, to align with the proposed changes regarding guaranteed availability, CMS proposes to allow issuers to deny coverage under a special enrollment period for loss of minimum essential coverage if the issuer has a record of termination due to an individual's non-payment of premiums.

Continuous Coverage

CMS notes the importance of adopting policies that promote continuous coverage to stabilize the market. In addition to proposals relating to guaranteed availability, annual open enrollment and special enrollment periods that encourage individuals to maintain coverage throughout the year, CMS is exploring other proposals to promote continuous coverage. For example, CMS is considering whether to extend the "look back" period for prior coverage for 6 to 12 months for the special enrollment periods that require prior coverage.

Levels of Coverage

The ACA authorizes the HHS Secretary to establish guidelines for a "de minimis variation" in the actuarial variations used to determine the level of coverage of a plan to account for differences in actuarial estimates. The current de minimis variation is +2/-2 percentage points with the exception of certain expanded bronze plans that have a variation of +5/-2 percent points. In an effort to provide added flexibility to plans, CMS proposes to change the de minimis variation to +2/-4 percentage points for all non-grandfathered individual and small group market plans required to comply with the ACA's actuarial value (AV) requirements. For the expanded bronze plans, CMS proposes to change the variation to +5/-4 percentage points. The new de minimis variation would apply with the 2018 AV calculator. CMS proposes not to make changes for the silver plan variations (i.e., plans with an AV of 73, 87 and 94 percent).

Network Adequacy

Under the HHS Secretary's authority, CMS established minimum network adequacy requirements for QHPs. In recognition of the customary role of states in regulating the insurance market, CMS proposes to defer to state reviews of network adequacy in states where the federal-facilitated exchange is operating. CMS proposes this

shift so long as states have a sufficient network adequacy review process that is at least equal to the current standard. For plan year 2018, in those states that do not have the authority or means to conduct such network adequacy reviews, CMS proposes to apply the standard used in 2014. That is, CMS would rely on an issuer's accreditation from an HHS-recognized accrediting entity.

Essential Community Providers

The ACA requires issuers to include in their network a sufficient number and geographic distribution of providers that serve predominantly low-income, medically underserved individuals, commonly referred to as essential community providers (ECPs). For the 2018 plan year, CMS proposes to return to the 2014 threshold, requiring an issuer contract with at least 20 percent of available ECPs in each plan's service area to be part of the plan's network. Of note, CMS increased this threshold to 30 percent in 2015.

Further, CMS proposes to change its guidance with respect to which providers issuers consider to be ECPs. For plan years 2017 and 2018, CMS proposes to return to its policy of allowing issuers to write-in ECPs not on the ECP list, which is maintained by CMS, to count toward the ECP standard. However, the written-in ECP would be required to submit an ECP petition to CMS by no later than the deadline for the issuer to submit changes to the QHP application.

If you have questions regarding the proposed regulation or need assistance in drafting comments to the proposed regulation, please contact Sheila Burke, chair of Baker Donelson's Government Relations and Public Policy Group.