Summary of the CMS Final Market Stabilization Regulation by Timothy Jost. Excerpted from this blog: http://healthaffairs.org/blog/2017/04/14/examining-the-final-market-stabilization-rule-whats-there-whats-not-and-how-might-it-work/

Guaranteed Availability

The first issue addressed in the final rule preface 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. The insurer receives advance premium tax credits (APTC) for the three months. The insurer can keep the first month's APTC, but must refund the payments received for the second and third month if the consumer fails to catch up during that time.

One of the most important of the ACA's insurance reforms is "guaranteed availability." Insurers must offer coverage to any consumer who applies during open enrollment or during a special enrollment period for which the consumer qualifies. HHS has previously interpreted this to mean that individuals cannot be denied coverage simply because they owe a debt to an insurer for a previous year's coverage as long as the consumer is not reenrolling in the same product from which the consumer was terminated for nonpayment. If the consumer were reenrolling in the same product, the ACA's "guaranteed renewability" requirement would apply instead, which does permit insurers to refuse to renew coverage if premiums are owed. Under the prior interpretation, the insurer could, of course, pursue collection efforts for past-due premiums, but could not condition coverage for a new coverage period under a different product on payment of the amount due.

Insurers have complained that this arrangement has encouraged gaming and undermined the risk pool. They claim that some consumers stop paying their premiums late in the year, catching up if they incur health care costs, but leaving the premiums unpaid if they remain healthy, starting all over again the next year with a clean slate.

In fact, low-income individuals, who are often living on the margins, do often fall behind on their exchange premiums. A McKinsey study cited by HHS found that about 21 percent of consumers of individual market plans stopped premium payments at some point in 2015 and 87 percent of them repurchased plans in 2016. Many consumers terminate coverage during one year and return the next, perhaps because they got employer coverage or Medicaid in the interim, perhaps because their ability to pay fluctuates.

HHS estimates that one in ten enrollees in the federally facilitated exchange (FFE) had coverage terminated for non-payment of premiums during 2016, and that 16 percent of those reenrolled with the same insurer for 2017. The rule preface provides no evidence, however, that enrollees are in fact currently intentionally gaming the current rules to avoid paying premiums.

A New Approach

Under the new HHS interpretation, an insurer would not violate the federal guaranteed availability requirement if it attributed payments from a consumer or employer reenrolling with the insurer to outstanding debt for coverage under any of its products during the previous 12 months. The insurer could also refuse to effectuate further coverage until outstanding premiums were paid. This interpretation applies during open and special enrollment periods.

The approach goes beyond that found in 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.

This interpretation applies inside and outside the exchange and to individuals in the individual market and employers in the small group and large group markets—although not in the federally facilitated SHOP exchange, which does not have the technical capacity to apply it.

Insurers could be prohibited from denying coverage for premiums owed under state law, but HHS encourages the states to follow the federal approach. States or insurers may also recognize exceptions from the requirement for hardships. States may also permit or require insurers to accept payments in installments.

Individuals terminated for nonpayment after the grace period expired would normally owe the premium for the first month of the grace period minus the amount of APTC the plan received, as coverage should be terminated retroactively to the end of the first month. But there will almost certainly be mistakes and disputes as to the amounts owed. HHS does not create any appeal procedures to address mistakes and disputes, but does recognize that states may do so.

Insurers do not have to apply this policy if they choose not to, and may accept installment payments or set a threshold of payments they will accept. They must, however, apply whatever payment policy they adopt uniformly and in a nondiscriminatory manner to all individuals and employers (and if they adopt a threshold premium payment policy, they must apply it to all premiums throughout the year).

The change will not limit the ability of individuals or employers to enroll in coverage with a different insurer (if more than one insurer is available in the market) without catching up on premiums owed, nor will it affect the ability of an individual not contractually responsible for payment of a premium to purchase coverage. An employee will not be barred from coverage, for example, just because its employer owes money to an insurer. Because of operational constraints the policy will not apply in the federally facilitated SHOP program.

Insurers must clearly describe their policy (and the policies of other insurer members of the same control group) on the consequences of nonpayment of premiums on future enrollment in any enrollment application materials or any premium nonpayment notice. This requirement will become effective with respect to notices provided 60 days after the publication of the final rule. No separate notice document is required, however, setting out an insurer's policy.

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. During the first year of the ACA exchanges, open enrollment ran for six months from October 1, 2013 to March 31, 2014. In the second year open enrollment ran from November 15 to February 15, and during the third and fourth years from November 1 to January 31.

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.

The arguments for this change are that it will allow insurers to collect a full year's premium for 2018 from all regular enrollees, encourage continuity of full-year coverage, and reduce opportunities for adverse selection by individuals who learn that they have health problems during December or January. Many commenters, however, contended that shortening the open enrollment period will reduce enrollment—particularly for young and healthy people who wait until the end of the open enrollment period to enroll; overload navigators, assisters, agents, and brokers, even exchange technology; and come at a time of year when individuals are distracted by winter holidays and financially strained.

Nevertheless, HHS finalized the abbreviated, end of the year enrollment period. The open enrolment period applies to all exchanges, but HHS recognizes that state-based exchanges have discretion as to special enrollment periods and "may elect to supplement the open enrollment period, as a transitional measure, to account for those operational difficulties." HHS does commit itself to engage in outreach to ensure awareness of the reduced open enrollment period.

Special Enrollment Periods

The lengthiest and most detailed provisions of the rule deal with special enrollment periods (SEPs). To encourage continuous coverage and discourage consumers from waiting until they become sick before enrolling, the ACA requires consumers to enroll during an annual open enrollment period. However, recognizing that consumers often experience changes that cannot be anticipated during the open enrollment period—such as the loss of employer coverage or the birth of a child—the ACA, like other insurance programs, recognizes special enrollment periods (SEPs) for life changes. Situations that qualify for SEPs are generally defined by regulation, although some have been established by guidance.

Insurers have long complained that consumers have been enrolling through special enrollment periods who in fact do not qualify, and that this has both increased claims and decreased revenue for insurers. Insurers have in response increased their premiums, discouraging enrollment by healthy enrollees.

HHS took a number of steps during 2016 to address insurer complaints, including eliminating some minor SEPs, redefining the SEP for consumers who experience a move to only apply to those who were covered before the move, requiring documentation for some SEPs, and revising the risk adjustment formula to recognize higher plan costs for partial year enrollees. At the end of 2016, the Obama administration announced that, beginning in the summer of 2017, it would initiate a pilot program requiring verification for 50 percent of enrollees using some SEPS before enrollment.

Pre-Enrollment Verification

The final rule tightens up SEPs, contending that this is necessary both to encourage consumers to maintain continuous coverage and to discourage adverse selection and inappropriate use of SEPs. The rule takes a four-pronged approach to this end. First, HHS will begin to require pre-enrollment verification of eligibility as of June 2017 for all applicable SEP categories for all new applicants in states served by the HealthCare.gov platform. Implementation will be phased in, beginning with the categories with the highest volume and of most concern. Consumers will be able to submit an application and select a plan, but the application will then be pended until eligibility is verified. HHS estimates that about 650,000 individuals will be subjected to increased verification procedures.

Consumers will be given 30 days to either upload or mail documentary verification. HealthCare.gov will use automated electronic means where possible to verify eligibility, for example for the birth of a child or where the loss of Medicaid coverage. 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. State-based exchanges that do not already verify SEP eligibility are encouraged to do so.

Many commenters expressed skepticism whether verification of SEP eligibility will in fact stabilize the risk pool. They cited evidence that the real problem with the risk pool is that too few rather than too many eligible individuals are enrolling through SEPs. Only a tiny fraction of individuals who lose employer coverage—most of whom would be expected to be relatively healthy—enroll in exchange coverage through SEPs. It would seem that additional paperwork burdens could be more likely to discourage young people than sick people who really need coverage. Commenters also expressed concern that many applicants will have a difficult time documenting eligibility, particularly immigrants, low-income workers, people with limited English proficiency, and residents of rural areas.

HHS recognizes these concerns and says that it will conduct trainings to ensure stakeholders understand verification requirements; expedite review to minimize delay; and exercise reasonable flexibility where consumers offer an explanation as to why documentation is not available. It also will not require state-based exchanges that do not use HealthCare.gov to conduct pre-enrollment verification. But in the end, HHS is accepting insurer assertions that SEPS are being gamed and that tighter controls are needed. It estimates that SEP verification and the other changes it is proposing will

reduce exchange premiums by 1.5 percent by decreasing the number of SEP enrollees, who tend to cost more than enrollees who enroll during open enrollment.

Metal-Level Coverage Upgrades

Second, HHS is limiting the ability of existing exchange enrollees to upgrade from one metal level to another during the coverage year by using an SEP. When an individual enrolled in coverage marries or has a child, for example, the enrollee and new spouse or child qualify for an SEP. Under the final rule, if the enrollee and the new dependent wish to be in the same 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 that HHS suggests may be worth considering for babies with high medical needs. If an enrollee is not enrolled in a silver-level plan, however, and adding the dependent would make the unit eligible for cost-sharing reductions, the enrollee may move to a silver-level plan.

Enrollees will also be prohibited from changing metal levels for most other SEPs, including the permanent move SEP and the SEP for loss of minimum essential coverage. The upgrade prohibition does not apply to some SEPs, however, where the qualifying event may have prevented the applicant from applying for the applicant's preferred plan to begin with (such as an error or misconduct by the exchange) and it does not apply to Indians who qualify for an SEP. This rule change does not apply to the individual market outside the exchange or to the group market, including the SHOP exchanges.

SBEs are encouraged to implement the changes as quickly as possible. HHS believes that they will prevent gaming by enrollees trying to upgrade their coverage mid-year and are a preferable alternative to requiring verification for SEPS that result in changed coverage.

SEP Coverage Effective Dates

Third, 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 will only be able to 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

Fourth, HHS is imposing limits of eligibility for additional SEPs. It will 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. HHS is considering collecting and storing information on terminations for non-payment to ensure that consumers who lose coverage for non-payment do not

subsequently gain coverage through an SEP for loss of minimum essential coverage, but for the time being HHS leaves it to insurers to identify consumers in this situation.

The rule limits the marriage SEP so that it only is available if at least one partner had minimum essential coverage or lived in a foreign country outside the United States or in a United States territory for one or more days during the previous 60 days. HHS acknowledges that this provision could be problematic when individuals who live in a state that did not expand Medicaid marry and each has an income below 100 percent of the federal poverty level, but the two spouses together have a combined income that qualifies them for APTC. HHS notes, however, that these individuals would qualify for a separate SEP that applies in states that did not expand Medicaid to people whose income increases, making them eligible for APTC. The new rule applies only in the individual and not in the group market and not to the SHOP exchange.

Consumers claiming eligibility under the permanent move SEP will also have to show coverage for one or more days during the previous 60 days or a move from outside the U.S. or from a U.S. Territory. The applicant will have to submit documentation of both the previous and new addresses and of previous coverage.

Both the rules requiring prior coverage for the marriage SEP and permanent move SEP do not apply to Indians. State-based exchanges not using HealthCare.gov are encouraged to implement the changes as soon as possible

Finally, HHS will significantly limit the use of the exceptional circumstances SEP. Exceptional circumstances will have to be "truly exceptional" and verified by supporting documentation where practicable. HHS will provide further guidance on when the more rigorous test applies. HHS intends to apply it consistently but flexibly. HHS is also formalizing previous guidance eliminating several SEPs based on temporary errors, processing delays, or misinformation listed in the preface. State-based exchanges are requested to apply similar standards.

Continuous Coverage

The NPRM preface asked for comments on establishing continuous coverage requirements to discourage adverse selection and encourage continuous coverage. It suggested that these could take the form of requiring 6 to 12 months of prior coverage (subject perhaps to a short gap of up to 60 days) where an SEP requires evidence of prior coverage or imposing a 90-day waiting period or late enrollment penalty where an applicant cannot establish prior coverage but is otherwise qualified for a special enrollment period.

Continuous coverage requirements have been endorsed by some congressional Republicans and are supported by insurers. The American Health Care Act includes a penalty to be enforced against individuals who seek to enroll in coverage but have not maintained continuous coverage. A majority of commenters on the proposed rule opposed continuous coverage requirements, contending that they would discourage healthy people from enrolling, thus worsening the risk pool and disproportionately penalize vulnerable populations. A number of commenters also argued that continuous coverage requirements would violate the ACA's guaranteed availability requirement.

HHS has decided not to take action on a continuous coverage requirement at this point, but it will continue to explore possibilities.

Actuarial Value

The ACA requires insurers in the individual and small group market to issue plans that fit into one of four metal levels—platinum, gold, silver, or bronze—based on actuarial value (AV). Actuarial value refers to the percentage of the total cost of health care expenses of a standard population borne by the plan rather than the enrollee. The AVs of these metal categories are 90, 80, 70, and 60 percent. Silver plans with AVs of 73, 87, and 94 percent must also be made available to low-income individuals that qualify for cost-sharing reductions. Finally, the ACA permits plans to sell catastrophic policies under certain circumstances.

The ACA allows de minimis variation in AV, recognizing that it is difficult to hit an exact AV and allowing plans to market a greater variety of products. De minimis variation also allows insurers to retain the same plan design from year to year while staying at the same metal level as costs change. De minimis has been previously defined as +/- 2 percent. As of 2017, bronze plans are also allowed to have actuarial values as high as 65 percent if they offer at least one major service before the deductible or qualify for a health savings account.

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. States can apply stricter standards. HHS acknowledges that the ACA's out-of-pocket limit will probably not allow a bronze plans with an actuarial value below 58.54 percent.

The changes in the definition of de minimis will not be applied to the 73, 87, and 94 percent silver plan cost-sharing variations, which may only vary by +/- 1 percent. HHS considered whether they might also require the implementation of an until-now ignored ACA provision that requires QHPs to reduce out-of-pocket limits for consumers with incomes not exceeding 400 percent of the federal poverty level as long as this does not increase the AV of plans covering consumers with incomes between 250 and 400 percent of the federal poverty level to above 70 percent. HHS acknowledges that this requirement may apply to 66 percent actuarial value plans, but is for the time being monitoring silver plan designs to see if this requirement should be applied.

Lower-premium, higher-cost-sharing plans could be attractive to healthy, higher-income consumers. But if a low AV plan became the second-lowest cost silver plan, premium tax credits would 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. The Center on Budget and Policy Priorities estimates that the proposed rule could require a family of four with an income of $65,000 to either pay $327 more a year in premiums for a plan with a 68 percent AV (the current minimum AV silver plan) or face a $550 increase in their deductible if they purchase a 66 percent AV plan (the new minimum A silver plan). Some consumers now use their APTC to buy bronze plans for a $0 or nominal premium. If the benchmark plan premium, and thus premium tax credits, are reduced, consumers may have to get lower-AV bronze plans to take full advantage of this.

On the other hand, as noted, consumers with incomes not exceeding 250 percent of the federal poverty level, who qualify for cost sharing reductions, will still be entitled to higher actuarial value plans meeting the 73, 87, or 94 percent AV requirements, even if they enrolled in a 66 percent AV plan. HHS estimates that the broader de minimis variation will reduce APTC by about $381 million a year but increase CSR payments by $200 to $400 million. (HHS apparently assumes that it will continue to pay CSRs, contrary to a threat from President Trump on April 12, 2017, that he might stop paying them. Together with the rule, HHS released a revised AV calculator and methodology. The only significant change in the calculator and methodology from those published earlier is the de minimis variation change.

Network Adequacy

One of the most common criticisms of the ACA is that health plans available through the exchanges tend to offer narrow provider networks. Although narrow networks can reduce the cost of health insurance, and generally seem to provide adequate care, they can result in inadequate coverage for some conditions and interfere with continuity of care for some consumers. They can also result in confusion if provider directories are inadequate or outdated and in burdensome balance billing if consumers receive services unwittingly from out-of-network providers.

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. HHS has taken a number of steps toward this end. Under prior rules, QHP insurers must make network provider directories accessible and keep them up to date. CMS is piloting an approach that will classify networks by breadth and make the information available to consumers.

Since 2017, CMS has applied quantitative standards similar to those applied to Medicare Advantage plans to ensure the availability of adequate network providers. HHS rules also impose continuity of care requirements on insurers, requiring them to continue coverage of treatment by providers who are terminated from a network for 30 days and to provide 90 days of coverage for a terminated provider if a patient is in active treatment at the time of termination. Finally, 2018 rules will offer some protection from surprise balance bills.

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. Non-accredited insurers and standalone dental plans will be required to submit a network adequacy access plan demonstrating the insurer's maintenance of an adequate network consistent with the National Association of Insurance Commissioner's model act. This approach applies to both the federally facilitated and state-based exchanges.

States have traditionally regulated provider networks, but they have often only regulated certain types of plans, and many states do not apply quantitative standards. Although the NAIC adopted a network adequacy model act in late 2015, few states have taken steps since then to tighten up network requirements. Moreover, accreditation is not an adequate substitute for governmental oversight. Accreditation network adequacy

standards are not publicly available but are reportedly procedural rather than quantitative in nature. Accreditation agencies cannot resolve consumer grievances and cannot take action against an insurer with an inadequate network other than to downgrade accreditation. It is ironic that with all the complaints one hears from consumers and politicians about the inadequacy of network coverage, that this would be an issue where HHS would decide to withdraw from its regulatory role.

Essential Community Providers

The ACA requires QHP insurers to "include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals." Essential Community Providers (ECPs) are community health centers, family planning clinics, safety-net hospitals (including children's hospitals), Ryan-White AIDS providers, Indian Health Services Centers, and other providers that serve predominantly low-income, medically underserved communities.

Under prior requirements, QHPs had to include within their network at least 30 percent of ECPs in their area and make a good faith offer to contract with any Indian health facility and with at least one of six categories of ECPs in their service area. Insurers that could not achieve the 30 percent standard could offer a narrative explanation as to why they are unable to do so. Until 2017, QHP insures could write in additional ECP providers in addition to the list provided by the federal government, but beginning with 2017, ECPs have been required to apply themselves to be recognized as ECPs.

Under the final rule, HHS will require plans to include only 20 percent of ECPs within their network rather than 30 percent. HHS claims that this will reduce the regulatory burden on issuers while preserving adequate access to care provided by ECPs. It notes, however, that in 2017, only 6 percent of insurers had to submit narrative explanations, seemingly not a heavy burden. Insurers will also be allowed to write-in ECPs again for 2018, as long as the ECPs that are written in apply for ECP status. And insurers who cannot even meet the 20 percent standard can still offer a narrative explanation. States that are not served by HealthCare.gov can require higher standards. HHS notes that the continuity of care requirements described above will apply to recipients of care from an ECP if it is terminated by an insurer.