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Centers for Medicare & Medicaid Services Releases "Market Stabilization" Proposed Rule; Comments Due March 7

On Feb. 15, the Centers for Medicare & Medicaid Services (CMS) released a new proposed rule titled "Patient Protection and Affordable Care Act; Market Stabilization." This proposed rule would alter a number of existing regulations affecting the individual and small group health insurance markets, including plans offered within and outside of the exchanges created under the Patient Protection and Affordable Care Act (ACA). Specifically, the proposed rule would amend standards relating to annual open enrollment periods, special enrollment periods and guaranteed availability in the individual market for the 2018 plan year; modify regulatory standards related to network adequacy and essential community providers for qualified health plans (QHPs) offered through the exchanges; and revise the rules for permissible *de minimis* variations in actuarial value requirements.

The proposed rule states that "[t]he health and competitiveness of the Exchanges, as well as the individual and small group markets in general, have recently been threatened by issuer exit and increasing rates in many geographic areas" and notes that some insurers have left the marketplace and others have raised rates. Department of Health and Human Services (HHS) Secretary Tom Price said in a statement that "Obamacare has failed" and that the proposed rule would "provide some immediate relief to the American people" through market stabilization. A number of Democrats in Congress have criticized the proposed rule, stating that it prioritizes health insurers above patients and consumers.

Below, we provide an overview of certain key provisions in the proposed rule:

- **Open Enrollment Timing.** The proposal would change the annual open enrollment period for 2018 and subsequent years to six weeks (Nov. 1 to Dec. 15 of the calendar year preceding the benefit year), instead of the time frame under current regulations of approximately 3 months (which extends through Jan. 31 of the benefit year). The proposed rule states that this change "could improve the risk pool because it would reduce opportunities for adverse selection by those who learn they will need services in late December and January; and will encourage healthier individuals who might have previously enrolled in partial year coverage after December 15th to instead enroll in coverage for the full year."

- **Special Enrollment Periods.** For individuals eligible for a special enrollment period due to marriage, birth or other qualifying event, the proposed rule would increase the percentage of new enrollees subject to the pre-enrollment eligibility verification to 100 percent (instead of 50 percent under current regulations). This requires documentation for qualifying for a special enrollment period instead of relying on an attestation. The proposal would also work "to strengthen and streamline the parameters of several existing special enrollment periods and ensure consumers are adhering to existing and new eligibility parameters to further promote continuity of coverage and market stability."
- **Guaranteed Availability.** In general, the ACA's guaranteed availability provision requires plans offering coverage to accept all applications in case an exception applies. CMS previously interpreted this provision to prohibit plans from using premium payments to cover past debts and then failing to enroll the individual because premiums were not paid. CMS proposes to change this interpretation to permit health plan issuers to apply a premium payment to the person's debt if such debt occurred within the last year. CMS states that the agency "believe[s] this proposal would have a positive impact on the risk pool by removing economic incentives individuals may have had to pay premiums only when they were in need of healthcare services." CMS seeks comment on the potential impact of the proposed change.
- **Network Adequacy.** The proposal would permit states or accrediting agencies to determine whether exchange insurers are offering adequate networks of doctors and hospitals. States would be able to determine network adequacy and would only be required to ensure that the plan is at least equal to the "reasonable access standard," as defined in the regulations. If a state does not have a process in place to conduct the review, CMS would rely on three specified accreditation entities to conduct network adequacy reviews. Unaccredited issuers would be required to submit an access plan to CMS as part of their QHP applications.
- **Essential Community Providers.** CMS' proposal would permit issuers to "write in" essential community providers (ECPs) not listed on HHS's list of such providers. The proposed rule also would modify the ECP standard to return to the 20 percent minimum percentage that previously applied but recently had been changed to 30 percent. Under this standard, CMS would consider the issuer to have satisfied the regulatory standard if the issuer contracts with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network.
- **Actuarial Value.** CMS also proposes to permit greater variation in the actuarial values, or coverage levels, used to determine whether a plan is considered a bronze, gold or platinum plan, beginning in 2018. The metal designations established coverage levels for four types of plans: bronze, silver, gold and platinum. The ACA gives the HHS Secretary authority to establish *de minimis* variation levels in a plan's actuarial value for purposes of qualifying for a particular metal level. Under the proposed rule, CMS would expand the *de minimis* ranges that exist under current regulations. CMS states that this proposed change seeks "to allow issuers greater flexibility in designing new plans and to provide additional options for issuers to keep cost sharing the same from year to year."

Comments to the proposed rule are due on March 7.

If you have any questions regarding this Sidley Update, please contact the Sidley lawyer with whom you usually work or

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