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ALERTS

Compensation And Benefits Law Alert - Proposed Rule Seeks Market Stabilization For Exchanges

February 28, 2017 | Atlanta | Chicago | Columbus | Dallas | Delaware | Elkhart | Fort Wayne | Grand Rapids | Indianapolis | Los Angeles | Minneapolis | New York | South Bend

Acknowledging the need for swift action to aid the health insurance exchanges, comments on the proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) are due by March 7. The proposed rule is intended to "stabilize the individual and small group markets" for health insurance coverage. Affordable insurance exchanges established under the Patient Protection and Affordable Care Act (PPACA) are competitive marketplaces through which individuals and employers purchase health insurance coverage.

Premium tax credits and reductions in cost-sharing payments are often available to individuals who enroll in qualified health plans (QHPs) through the exchanges, reducing the out-of-pocket cost of the coverage for individuals. Recently, there has been an exit of issuers from the exchanges due to concerns over the risk pool in the individual and small group health insurance markets. Some issuers who remain in the exchanges have raised premiums in certain areas of the country.

The proposed rule is designed to prevent individuals from taking certain actions during open enrollment and special enrollment periods which have resulted in the escalation of premiums, ultimately improving the risk pool for the individual and small group markets. The proposed rule also revises the standards related to network adequacy and essential community providers for QHPs, as well as the rules regarding actuarial value requirements for plan metal levels. This client alert addresses the highlights of the proposed rule.

Open Enrollment Dates for 2018

Under the proposed rule, the open enrollment period for the benefit year beginning Jan. 1, 2018, would be shortened from 90 days to 45 days. The open enrollment period would be changed from Nov. 1, 2017-Jan. 31, 2018, to Nov. 1, 2017-Dec. 15, 2017. This change would require individuals to enroll in health insurance coverage before the beginning of the benefit year, unless a special enrollment period is available. This shortened open enrollment period would improve the risk pool for the exchanges because it would reduce opportunity for individuals to enroll after the benefit year has commenced and they discover a health problem. It would also encourage healthy individuals to join for an entire benefit year. This is consistent with the open enrollment periods for benefit years beginning Jan. 1, 2019, and beyond.

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Special Enrollment Requirements

Special enrollment periods are intended to provide continuous health insurance coverage by allowing new coverage elections to be made by individuals who may lose coverage or have a gap in coverage for themselves or their dependents due to a qualifying life event. The proposed rule addresses issues in the current procedures for special enrollment for qualifying life events, which have led to potential abuse of the special enrollment periods (i.e., individuals waiting until they are sick to enroll), ultimately resulting in higher premium rates and reduced availability of health insurance coverage. CMS previously addressed these concerns by adding warnings on the HealthCare.gov website regarding the abuse of special enrollment periods, announcing random audits of special enrollments related to loss of minimum essential coverage and permanent move special enrollment periods and creating the Special Enrollment Confirmation Process, under which individuals enrolling through common special enrollment periods were asked to provide documentation related to eligibility.

The proposed rule:

- Takes steps to tighten the eligibility confirmation process for special enrollment periods. Pre-enrollment verification of all special enrollment periods would begin in June, 2017. Individuals would go through the special enrollment process when a qualifying life event occurs and enrollment would be "pended" until the special enrollment verification is completed. Automated electronic means would be used to confirm the occurrence of a qualifying life event when possible (e.g., confirmation of a birth through electronic verification). Additionally, individuals would be given 30 days to provide the required documentation for verification.
- Permits an individual enrolling through the individual market to elect to start coverage one month later than the effective date would have been if the verification process for the special enrollment period is prolonged and results in the individual being required to pay two or more months of retroactive premiums to effectuate the coverage.
- Limits existing exchange enrollees in the individual market to making enrollment changes in the same QHP or to another QHP within the same plan metal level during a special enrollment period. This change is intended to prevent individuals from using a special enrollment period as a way to simply switch coverage levels or plans during a benefit year. An exception may apply with respect to silver level coverage.
- Provides that when a special enrollment period occurs due to loss of minimum essential coverage an issuer may reject an enrollee who has a record of termination of coverage due to non-payment of premiums if the enrollee tries to renew his coverage within 60 days of being terminated, unless the enrollee satisfies the premium obligations under the prior coverage. To implement this provision, exchanges would store data from issuers regarding past premium payment history of individuals.
- States that when an individual is newly enrolling in a QHP in the individual market through an exchange during a special enrollment period due to marriage, at least one spouse must have had minimum essential coverage for at least one day during the 60

days preceding the date of marriage (unless they lived outside of the U.S. or a U.S. territory).
- Expands verification requirements related to a special enrollment period for a permanent move and the use of the “exceptional circumstances” special enrollment period would be subject to stricter scrutiny.

Interpretation of Guaranteed Availability Requirement

Under PPACA, health insurers offering non-grandfathered coverage in the individual or group markets must offer coverage to and accept every individual and employer in the state that applies for coverage unless an exception applies. Payment of the first month’s premium is required to effectuate the coverage. Currently, an issuer cannot apply any premium payment made for enrollment in coverage in a different product to any outstanding debt owed from any previous coverage and then refuse to effectuate the enrollment based on failure to pay premiums.

Under the proposed rule, if a policyholder seeks to renew coverage with the same issuer under the same or a different product, any premium payments made may be applied toward the outstanding debt associated with non-payment of premiums for coverage from the same issuer during the prior 12-month period. The issuer may refuse to effectuate new coverage for failure to pay premiums, assuming state law does not prohibit this action. An issuer could require a policyholder whose coverage terminated for non-payment of premiums to pay all past due premiums for the prior 12 months to resume coverage from that issuer (i.e., likely no more than three months of premiums due to the rules regarding grace periods and coverage termination). Issuers who apply such a policy would be required to apply it uniformly, regardless of health status and consistent with nondiscrimination requirements. This revised interpretation would not impact the ability of an individual or employer to enroll in coverage with a different issuer and would not impact any individual other than the individual contractually responsible for the past due premiums to enroll in coverage with the same issuer or a different issuer. Like the other proposed changes, this proposed change reduces the opportunity for policyholders to seek coverage and pay premiums only when health issues have arisen.

Network Adequacy

QHP issuers must maintain a network that is sufficient in number and type of providers. CMS reviews QHPs for compliance with this requirement in federally facilitated exchange states. Under the proposed rule, states would conduct the reviews to ensure network adequacy where a federally facilitated exchange is operating, if the state has a review process in place. If the state does not have a review process in place, CMS has proposed to permit reliance on an issuer’s accreditation from an HHS-recognized accrediting agency. This proposed change recognizes the traditional role of the states in the development and oversight of insurance markets.

Essential Community Providers

Essential community providers (ECPs) are providers that predominantly serve low-income and medically underserved individuals. QHPs must include a sufficient number and geographic distribution of ECPs. Currently, QHPs are required to include at least 30 percent ECPs as

participating practitioners. Under the proposed rule, to permit more flexibility in plan design, this percentage is reduced to 20 percent. The proposed rule also permits the write-in process for ECPs who are not on the ECP list issued by the Department of Health and Human Services (HHS), provided that a timely ECP petition is submitted to HHS.

Actuarial Values for Plan Metal Levels

Issuers are required to offer QHPs with certain levels of coverage (metal levels) in accordance with the PPACA. The metal levels are based on actuarial values for plan coverage, with a bronze plan requiring an actuarial value of 60%, a silver plan requiring an actuarial value of 70%, a gold plan requiring an actuarial value of 80% and a platinum plan requiring an actuarial value of 90%. Currently, a variation of +/-2 percentage points is permitted for variation in the actuarial value at a given metal level. To allow more flexibility in plan design, under the proposed rule, the permitted variation in the actuarial value would be -4/+2 percentage points. This proposed change would not apply to silver plan variations.

CMS Comment Request

CMS has requested comments regarding certain aspects of the proposed rule, including:

- With regard to the change in open enrollment dates, whether state-based exchanges can facilitate the change in time for the 2018 open enrollment period and whether agents and brokers can process enrollment during the shortened period
- With regard to the changes applicable to special enrollment periods, the anticipated impact of the proposed verification process on consumers and whether state-based exchanges should also be required to participate in the verification process. Additionally, comments are requested on the ability of existing exchange enrollees to change plan metal levels mid-year
- With regard to interpretation of the guaranteed availability requirement, whether a premium payment “threshold” should apply to the reinstatement policy, so that policyholders can effectuate coverage once that threshold amount has been paid

CMS has requested comments on certain PPACA issues not addressed in the proposed rule which may be considered for purposes of future guidance, including:

- Whether the look-back period for a special enrollment period that requires evidence of prior coverage should be 6-12 months
- Whether in the individual market, there should be requirements for maintaining continuous, creditable coverage without a 63-day break to avoid pre-existing condition exclusions and the imposition of permitted waiting periods

All comments must be received by CMS by March 7. The comment time frame is much shorter than is typical for CMS proposed rules, consistent with the goal of implementing changes quickly.

A draft of proposed legislation, which would repeal and replace certain provisions of the PPACA, was leaked. While the draft could change prior

to being finalized, it is consistent with aspects of the proposed rule, including the importance of stabilizing premiums and encouraging healthy individuals to obtain coverage. Also, consistent with the CMS comment request, the draft legislation emphasizes the need for individuals to maintain continuous creditable coverage.

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