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# **State Health Reform Assistance Network**

## Charting the Road to Coverage

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# Marketplace Stabilization Rule Webinar

*State Health Reform Assistance Network*

**Manatt Health**  
**February 24, 2017**

# Agenda

- **Overview**
- **Enrollment Periods**
- **Actuarial Value**
- **Network Adequacy**
- **Discussion/Q&A**
- **Next Steps**

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# *Overview*

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# Overview of Proposed Rule

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CMS released proposed rule on February 15 with comments due by March 7



Rule designed to stabilize Marketplaces for 2018 while repeal and replace is pending



Rule is response to insurer concerns about adverse selection and unbalanced risk pool



CMS acknowledges that changes could have unintended consequences and seeks comment as to market impact



Rule does not address all stabilization issues

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# Topics Covered in Stabilization Rule

## Rule cover three topics

- 1 New limits on annual open enrollment and special enrollment periods (SEPs)
- 2 Relaxed actuarial value standards
- 3 Relaxed network adequacy standards and more state flexibility

### Changes impact states in different ways

- 39 Healthcare.gov states vs. 12 state Marketplaces
  - Active vs. passive Healthcare.gov states

# Changes in Plan Year 2018 Schedule

Milestone	Original Date	Proposed Date
Initial QHP submission deadline	May 3	June 21
Rate filing justifications due (states without effective rate review program)	May 3	June 1
CMS sends first correction notices	June 13	August 2
Rate filing justifications due (states with effective rate review program)	July 17	July 17
CMS & states post rate changes	August 1	August 1
Final issuer changes to QHP application	August 21	August 16
CMS sends final correction notices	September 11	September 15
States send CMS final plan recommendations	September 15	September 27
Issuers send signed agreements to CMS	September 15	September 27
Open enrollment begins	November 1	November 1

Sources: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Revised-Key-Dates-for-Calendar-Year-2017-2-17-17.pdf>  
<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Key-Dates-for-Calendar-Year-2017-12-16-16.pdf>

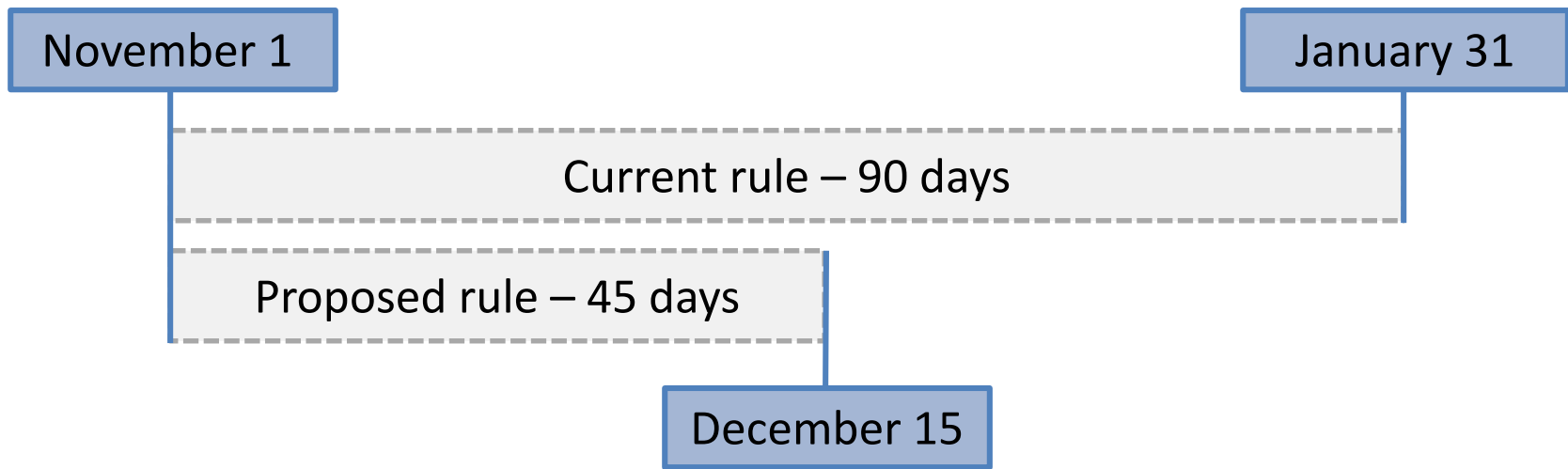


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# *Enrollment Periods*

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# Shorter Open Enrollment Period (OEP) for 2018



CMS already intended to switch to a 45-day open enrollment for 2019. Proposal would accelerate the change by one year.

# Background on Special Enrollment Periods

- Special enrollment periods (SEPs) allow enrollment outside of OEP due to loss of coverage, qualifying life events, exceptional circumstances, or other reasons
- CMS has broad flexibility to define SEPs and impose restrictions on them that would not be allowed for the annual OEP
- SEP restrictions in rule apply only to 39 states using Healthcare.gov
- 12 state Marketplaces may maintain their own SEP policies

## Facts & Figures

### **2015: 1.6 million enrolled through SEPs**

- 60% - loss of coverage
- 18% - needed Medicaid determination before enrollment
- 9% - tax season SEP

Source: <http://www.gao.gov/products/GAO-17-78>

# New Restrictions on Special Enrollment Periods

- 1 Some SEPs eliminated**
  - No more SEPs for consumers who have to adjust their tax credits; those affected by SSI errors; those not informed about COBRA; or non-citizens with errors in determination of eligibility or processing delays
  
- 2 Exceptional circumstances limited**
  - Going forward, CMS will only use exceptional circumstances SEPs where situation is “truly exceptional” and consumers are verifiably, directly impacted
  
- 3 100% verification of SEP eligibility for HealthCare.gov users**
  - Applies to all SEPs
  - Enrollments will be pending until verification complete
  - Will use automated electronic verification where possible
  - CMS “recommends” 12 state Marketplaces follow suit; seeks comment if they should be required

# New Restrictions on Special Enrollment Periods (cont'd)

- 4 No buy-up to higher level of coverage in most SEPs**
  - Current enrollees with SEP can enroll in new coverage, but could no longer move to higher metal level
  - Does not apply in group market
  - Exceptions (i.e., silver-level enrollment when newly eligible for cost sharing reductions)
  
- 5 Maximum delayed enrollment of one month**
  - Consumers can still request future enrollment date if enrollment delayed to avoid retroactive premiums
  - But delays would be limited to one month

# New Restrictions on Special Enrollment Periods (cont'd)

## 6 New leeway for issuers to prevent non-payment of premium

- Insurer can apply new enrollee's premium payments to past due non-payments without violating guaranteed availability (if same insurer)
- Insurer can reject enrollment where consumer previously terminated for nonpayment and past due amounts not repaid

## 7 Evidence of prior coverage required for certain SEPs

- Marriage only triggers SEP if one spouse had at least one day of prior coverage
- Consumers with permanent moves must give evidence, not an attestation, of at least one day of prior coverage

# CMS Seeks Comment on Continuous Coverage

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- CMS is considering whether continuous coverage requirements would discourage adverse selection and encourage continuous enrollment in the individual market
  - CMS seems to recognize limits on administrative action by proposing no specific changes beyond minimal prior coverage requirements for a few SEPs
    - Establishing a HIPAA-like policy (18 months of creditable coverage with pre-existing condition waiting periods) would require statutory change
  - CMS is seeking comment on the merits of the continuous coverage approach and how it could be implemented
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# Discussion Questions

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- 1 Will proposed changes limit enrollment by healthy consumers?
  - 2 Should there be a control group that is not subject to verification to conduct a study on its effectiveness?
  - 3 Should all SEPs be subject to same verification procedures?
  - 4 Should state Marketplaces follow CMS lead with more stringent verification?
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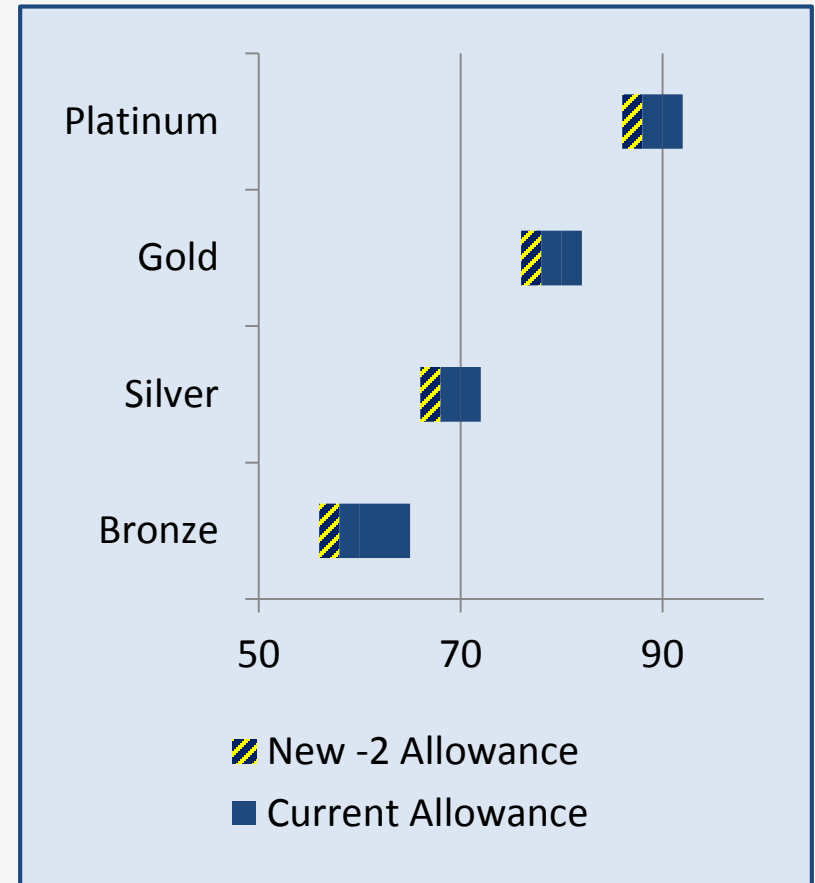
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# *Actuarial Value*

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# Rule Allows Lower Actuarial Values at Each Metal Level

- CMS currently allows deviation from defined actuarial values of metal level plans by +/- 2%, or -2 / +5 for some bronze plans
- New proposal widens the allowable variation by additional -2 points at bottom end of range for each level
- Silver plan variations remain at +/- 1% (73, 87 and 94% AVs)
- At new tolerances, line blurred between the highest-value bronze plans (65%) and the lowest-value silver plans (66%)
- CMS hopes to prevent need for annual plan redesign and allow for stability in cost sharing from year to year



# Impact of Change: Could be Higher Cost Sharing, Lower Premiums or Lower Tax Credits

## How the Proposed Rule Could Affect Coverage Affordability

Illustrative Example: Family of Four with Income of \$65,000\*

	Annual Gross Premium	Premium Tax Credit	Net Premium	Per-person Deductible	Change for Family
<b>Current Rules</b>					
<b>68% actuarial value silver plan (benchmark)</b>	\$13,080	\$7,416	\$5,664	\$1,900	N/A
<b>Proposed Rule</b>					
<b>66% actuarial value silver plan (new benchmark)</b>	\$12,753	\$7,089	\$5,664	\$2,450	Deductible ↑ \$550/person
<b>68% actuarial value silver plan (old benchmark)</b>	\$13,080	\$7,089	\$5,991	\$1,900	Premium ↑ \$327/year

Source: <http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for>

# Discussion Questions

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- 1 Will lower AV values be a net plus because of reduced premiums?
  - 2 Will lower AV values be a net minus because of higher cost sharing and the potential for a lower-priced benchmark plan?
  - 3 Should the changes proposed for in 2018 AV calculator be delayed until 2019?
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# ***Network Adequacy***

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# Network Adequacy Developments Over Time

2014

- Qualitative approach
- Defer to state, accept plan accreditation or require access plan
- Contract with at least 10% of available ECPs, 20% for safe harbor

2015-2017

- CMS review, ramped up each year, judges “reasonable access”
- In 2017 proposed quantitative review drawn from Medicare Advantage (MA), but did not finalize approach
- Contract with 30% of available ECPs with exceptions

2018

- Before Marketplace Stabilization rule proposed, CMS previously decided to use time and distance standards for all states

# New Proposed Network Adequacy Standards for 2018

## Proposed for 2018 – Three Steps, No Quantitative Standard

Under each, issuers need only 20% of identified Essential Community Providers

1. Rely on State Reviews	2. Rely on Accreditation	3. Use NAIC Model Act
Defer to state-established standards where state is applying standard at least equal to “reasonable access” and has means to evaluate adequacy	Absent acceptable state review, CMS will rely on accreditation as proxy for adequacy	CMS will require a network access plan consistent with NAIC Model Act from unaccredited plans in states with no acceptable review process

### CMS Access Requirement:

Issuer “[m]aintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay”

45 C.F.R. § 156.230(a)(2)

# Discussion Questions

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- 1 What are the pros and cons of a qualitative federal standard vs. federal time and distance standards?
  - 2 Will the states have resources to enforce stricter state standards if they so choose?
  - 3 What are the trade-offs between a 20% and a 30% standard for essential community providers?
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# Discussion/Q&A



# Next Steps

**Comments due by March 7<sup>th</sup>**

**RWJ Assistance**

# Thank You!

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# *Appendix*

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# Other Specific CMS Requests for Comment

## 1 Repayment of Premium

- Can issuers implement a premium payment threshold policy, under which the issuer can consider an individual to have paid all amounts due, if the individual pays some of the premium?
- Should issuers be required to provide notice to individuals regarding whether they have adopted a premium payment policy permitted under this proposal?
- How can premium repayment requirements be implemented off-exchange?

## 2 Open Enrollment

- Can state-based Exchanges shift to the shorter open enrollment period for the 2018 plan year?
- What will the effect of the shorter enrollment period be on issuers' ability to enroll healthy consumers?
- Will agents, brokers, navigators and assisters have difficulties in serving consumers seeking to enroll during this shorter time period?

# CMS Requests for Comment (cont'd)

3

## SEPs – Verification

- Should CMS retain a small percentage of enrollees outside the pre-enrollment verification process to conduct a study on its effectiveness?
- What strategies should CMS take to increase the chances that individuals complete the verification process and are not deterred from enrollment?
- Should state-based exchanges be required to implement pre-enrollment verification? How long a transition period should they be allowed?

# CMS Requests for Comment (cont'd)

4

## SEPs – Buy Ups

- Should current enrollees be permitted to buy up to higher level plans, but be subject to verification requirements?
- Are there any alternative strategies for addressing potential adverse selection issues for existing enrollees who are eligible for a special enrollment period?
- Should this change be voluntary for state based exchanges? If mandatory, what transition period is needed?
- Should current enrollees newly eligible for advance payment of tax credits be able to enroll in a silver QHP, or any level?
- For what SEPs should CMS allow changes in metal levels?

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## AV

- Is making the AV change effective for the 2019 plan year preferable, given the lead time issuers require to design plans?
- What is the appropriate de minimis value for metal level plans and silver plan variations, and should those values differ when increasing or decreasing AV?