Market Stabilization Regulation – Summary and Analysis

PROVISION	DRAFT	FINAL	ANALYSIS
Re-Enrolling Members With Unpaid Premiums From Prior Year (Guaranteed Availability)	Per the ACA and subsequent CMS regulation, non-grandfathered individual and small group market issuers are required to enroll eligible members without first requiring them to pay unpaid premiums from a previous enrollment. CMS proposed to let issuers refuse new coverage to these enrollees until they pay outstanding prior premium debts from a plan sold by the same issuer. This proposal did not preclude an enrollee from seeking coverage from another issuer.	This provision is largely finalized as proposed and clarifies that the rule also applies to large group market issuers. Extends the policy to an issuer that is within the same "controlled group" as the previous issuer. Issuers are expected to update applicable enrollee materials regarding the consequences of non-payment of premiums.	The rule change is intended to promote continuous coverage. Operational limitations and state laws may cause the regulation to not apply uniformly across all states and markets. In addition, the policy change may have less impact in service areas with two or more unaffiliated issuers.
Open Enrollment Period	CMS proposed to shorten the 2018 open enrollment period to November 1, 2017 – December 15, 2017. In previous years, the enrollment period extended through the end of January.	This provision is finalized as proposed.	The primary impact of a shorter enrollment season will likely be to suppress enrollment. Issuers will benefit somewhat from effectuating all of their open enrollments in January instead of having new enrollments staggered throughout the longer enrollment season.
Practices that Incent Continuous Coverage	In the proposed rule, CMS suggested that it would explore proposals that promote continuous coverage, including extending the "look back" period for prior coverage for 6 to 12 months for SEPs that require prior coverage.	In the final rule, CMS reiterates that it continues to "actively" explore additional policies to encourage consumers in the individual market to maintain continuous coverage as a stabilization tool. However, it opted not to introduce new requirements beyond those proposed in the draft regulation.	CMS may continue to implement modest changes to stabilize the individual market through practices that promote continuous coverage, and may propose more dramatic changes in the future.
Actuarial Value De Minimus Variation	The ACA establishes metal levels for ACA market plans based upon their level of generosity (actuarial value). CMS permits "de minimis variation" in the actuarial values of +2/-2 percentage points. Per the draft regulation, for 2018, CMS proposed to change the de minimis variation to +2/-4 percentage points for individual and small group market plans required to comply with the actuarial value (AV) requirements.	This provision is finalized as proposed and CMS has updated its Actuarial Value Calculator, a tool used by issuers estimate the AV of each product, accordingly.	This provision allows issuers to develop plans with higher cost sharing but lower premiums, and thereby furthers an Administration goal of bringing products into the market with lower premiums, in hopes of making the market more attractive to healthier people who have not purchased ACA-compliant coverage to date.

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Special Enrollment Periods (SEPs)—Prospective Verification	Effective June 1, CMS proposed to conduct prospective verification of SEP eligibility for all new exchange enrollees in the roughly 40 state exchanges that are federally-facilitated or state-based but dependent upon the federal platform (federally-run exchanges). SEP enrollments would be placed in "pending" status until CMS verifies eligibility.	This provision is largely finalized as proposed. CMS will phase in prospective verification for all new applicants to the federally-run exchanges starting in June 2017, prioritizing the categories with the highest volume and of most concern, such as loss of minimum essential coverage. CMS will give applicants 30 days to submit documentation to allow CMS to verify eligibility.	Along with other policies finalized in the rule, these new SEP provisions are expected to temper premium increases for 2018. Both the agency's operational execution of SEP changes and the effects on the risk pool should be closely monitored to assess whether the policies will have their intended effects on decreasing "gaming" and encouraging enrollment in a full 12 months of coverage.
Other SEP Changes	CMS proposed several other SEP changes to tighten program requirements: 1) Enrollees who qualify for a change-in-circumstance SEP would remain in the same QHP until the consumer submits information to verify the change in circumstance. 2) Existing exchange enrollees that qualify for a mid-year SEP would be unable to change plan metal levels. 3) Enrollees who qualify for an SEP due to birth or adoption would be added to the existing enrollee's plan and would be required to stay within the same metal level. 4) Issuers would be permitted to deny coverage under an SEP for loss of minimum essential coverage if the issuer can demonstrate prior termination of the enrollee due to non-payment of premiums.	These provisions are largely finalized as proposed, with a few modifications, including: 1) Certain exceptions will apply to exchange enrollees qualifying for an SEP mid-year who can no longer switch metal levels under the rule (for example, for low-income enrollees who become newly eligible for cost-sharing reductions). 2) Due to operational concerns, issuers processing mid-year SEP enrollments outside the exchanges will not be required to limit plan switches to selections within the same metal level. 3) In federally-run exchanges, issuers in the same "controlled group" as the issuer with a record of an SEP applicant's failure to pay past-due premiums may refuse to effectuate new enrollment for that applicant, unless he or she pays in full.	
Network Adequacy	For the federally-run exchanges, CMS established quantitative network adequacy standards for certain types of providers. For the 2018 plan year, CMS proposed to defer to state reviews of network adequacy. CMS proposed to rely on an issuer's accreditation status in the event that a state does not conduct network adequacy reviews.	This provision is finalized as proposed. The regulation is silent on whether it will continue complementary consumer- facing requirements: machine readable directories, a network provider finding tool, and network breadth rating pilot.	This provision returns CMS oversight of the federally-run exchanges to the state-centric approach used in 2014. Since that time, some states have made their network adequacy reviews more rigorous.
Essential Community Providers	The ACA requires issuers to include a sufficient number of safety net providers (Essential Community Providers, or ECPs) in their provider networks for exchange plans. For the 2018 plan year, CMS proposed to require an issuer contract with at least 20 percent of available ECPs. This would lower the 30 percent standard used in recent years. CMS also proposed to allow issuers to write-in ECPs, a practice that was not permitted for plan year 2017.	This provision is finalized as proposed. Issuers that do not meet the 20 percent standard can offer a narrative explanation and still be judged as compliant on a case-by-case basis. State run exchanges can maintain higher thresholds.	The relaxation of ECP standards permits issuers to save money by further narrowing their networks and focusing more on providers of their choice. For Medicaid beneficiaries that transition into the exchange plans, the relaxed ECP standard raises the chances of that consumer needing to change providers.