

(f) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Safety Management Group, FAA, may approve AMOCs for this AD. Send your proposal to: Matt Fuller, Senior Aviation Safety Engineer, Safety Management Group, Rotorcraft Directorate, FAA, 2601 Meacham Blvd., Fort Worth, Texas 76137; telephone (817) 222-5110; email 9-ASW-FTW-AMOC-Requests@faa.gov.

(2) For operations conducted under a 14 CFR part 119 operating certificate or under 14 CFR part 91, subpart K, we suggest that you notify your principal inspector, or lacking a principal inspector, the manager of the local flight standards district office or certificate holding district office before operating any aircraft complying with this AD through an AMOC.

(g) Additional Information

The subject of this AD is addressed in European Aviation Safety Agency (EASA) AD No. 2015-0045, dated March 13, 2015, and corrected April 2, 2015, and in EASA AD No. 2016-0002, dated January 4, 2016. You may view the EASA ADs on the Internet at <http://www.regulations.gov> in the AD Docket.

(h) Subject

Joint Aircraft Service Component (JASC)
Code: 6200, Main Rotor System.

Issued in Fort Worth, Texas, on January 30, 2017.

Scott A. Horn,

*Acting Manager, Rotorcraft Directorate,
Aircraft Certification Service.*

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DEPARTMENT OF HEALTH AND HUMAN SERVICES**45 CFR Parts 147, 155, and 156**

[CMS-9929-P]

RIN 0938-AT14

Patient Protection and Affordable Care Act; Market Stabilization

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This rule proposes changes that would help stabilize the individual and small group markets. This proposed rule would amend standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period in the individual market for the 2018 plan year; standards related to network adequacy and essential community providers for qualified health plans; and the rules around actuarial value requirements.

DATES: To be assured consideration, comments must be received at one of

the addresses provided below, no later than 5 p.m. on March 7, 2017.

ADDRESSES: In commenting, please refer to file code CMS-9929-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9929-P, P.O. Box 8016, Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9929-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—
Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—
Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Jeff Wu, (301) 492-4305, Lindsey Murtagh, (301) 492-4106, or Michelle Koltov, (301) 492-4225, for general information.

Rachel Arguello, (301) 492-4263, for matters related to Exchange special enrollment periods and annual open enrollment periods.

Erika Melman, (301) 492-4348, for matters related to network adequacy, and essential community providers.

Allison Yadsko, (410) 786-1740, for matters related to actuarial value.

Jacob Ackerman, (301) 492-4179, for matters related to guaranteed availability.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received at <http://regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Executive Summary

Affordable Insurance Exchanges, or "Exchanges" (in this proposed rule, we also call an Exchange a Health Insurance MarketplaceSM,¹ or MarketplaceSM) are competitive marketplaces through which qualified individuals and qualified employers can purchase health insurance coverage. Many individuals who enroll in qualified health plans (QHPs) through individual market Exchanges are eligible to receive a premium tax credit to make health insurance premiums

¹ Health Insurance MarketplaceSM and MarketplaceSM are service marks of the U.S. Department of Health & Human Services.

more affordable, and receive reductions in cost-sharing payments to reduce out-of-pocket expenses for health care services.

The 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. Some issuers have had difficulty attracting and retaining the healthy consumers necessary to provide for a stable risk pool that will support stable rates. In particular, some issuers have cited special enrollment periods as a potential source of adverse selection that has contributed to this problem. Concerns over the risk pool have led some issuers to cease offering coverage on the Exchanges in particular states and counties, and other issuers have increased their rates.

A stabilized individual and small group insurance market will depend on greater choice to draw consumers to the market and vibrant competition to ensure consumers have access to competitively priced, affordable coverage. Higher rates, particularly for consumers who are not receiving advance payments of the premium tax credit (APTC), resulting from minimal choice and competition can cause healthier individuals to drop out of the market, further damaging the risk pool, and risking additional issuer attrition from the market. This proposed rule would take steps to provide needed flexibility to issuers to help attract healthy consumers to enroll in health insurance coverage, improving the risk pool and bringing stability and certainty to the individual and small group markets.

To improve the risk pool and promote stability in the individual insurance market, we propose taking several steps to increase the incentives for individuals to maintain enrollment in health coverage and decrease the incentives for individuals to enroll only after they discover they require services. First, we propose changing the dates for open enrollment in the individual market for the benefit year starting January 1, 2018, from a range of November 1, 2017, to January 31, 2018 (the previously established open enrollment period for 2018), to a range of November 1, to December 15. This change would require individuals to enroll in coverage prior to the beginning of the year, unless eligible for a special enrollment period, and is consistent with the open enrollment period established for the open enrollment periods for 2019 and beyond. We anticipate 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.

Second, in response to concerns from issuers about potential abuse of special enrollment periods in the individual market Exchanges resulting in individuals enrolling in coverage only after they realize they will need services, we propose increasing pre-enrollment verification of eligibility for all categories of individual market special enrollment periods for all States served by the *HealthCare.gov* platform from 50 to 100 percent of new consumers who seek to enroll in Exchange coverage. We also propose making several additional changes to our regulations regarding special enrollment periods that we believe could improve the risk pool, improve market stability, and promote continuous coverage.

Third, we propose revising our interpretation of the guaranteed availability requirement to allow issuers to apply a premium payment to an individual's past debt owed for coverage from the same issuer enrolled in within the prior 12 months. We believe 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 health care services. We also believe this proposal is important as a means of encouraging individuals to maintain continuous coverage throughout the year and prevent gaming.

Fourth, we propose to increase the de minimis variation in the actuarial values (AVs) used to determine metal levels of coverage for the 2018 plan year. This proposed change is intended 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. We are not proposing a modification for the de minimis range for the silver plan variations.

We believe these changes are critical to improving the risk pool, and would together promote a more competitive market with increased choice for consumers.

The proposed amendments in this rule are also intended to affirm the traditional role of States in overseeing their health insurance markets while reducing the regulatory burden of participating in Exchanges for issuers. The first of these proposals relates to

network adequacy review for QHPs. The modified approach would not only lessen the regulatory burden on issuers, but also would recognize the primary role of States in regulating this area. The second change would allow issuers to use a write-in process to identify essential community providers (ECPs) who are not on the HHS list of available ECPs for the 2018 plan year; and lower the ECP standard to 20 percent (rather than 30 percent), which we believe would make it easier for a QHP issuer to build networks that comply with the ECP standard.

Robust issuer participation in the individual and small group markets is critical for ensuring consumers have access to affordable coverage, and have real choice in coverage. Continued uncertainty around the future of the markets and concerns regarding the risk pools are two of the primary reasons issuer participation in some areas around the country has been limited. The proposed changes in this rule are intended to promote issuer participation in these markets and to address concerns raised by issuers, States, and consumers. We believe such changes would result in broader choices and more affordable coverage.

II. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this proposed rule, we refer to the two statutes collectively as the “Affordable Care Act.”

The Affordable Care Act reorganizes, amends, and adds to the provisions of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 2702 of the PHS Act, as added by the Affordable Care Act, requires health insurance issuers that offer non-grandfathered health insurance coverage in the group or individual market in a State to offer coverage to and accept every employer and individual in the State that applies for such coverage unless an exception applies.

Section 2703 of the PHS Act, as added by the Affordable Care Act, and former section 2712 and section 2742 of the PHS Act, as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), require health insurance issuers that

offer health insurance coverage in the group or individual market to renew or continue in force such coverage at the option of the plan sponsor or individual, unless an exception applies.

Section 1302(d) of the Affordable Care Act describes the various levels of coverage based on actuarial value. Consistent with section 1302(d)(2)(A) of the Affordable Care Act, AV is calculated based on the provision of essential health benefits (EHB) to a standard population. Section 1302(d)(3) of the Affordable Care Act directs the Secretary to develop guidelines that allow for de minimis variation in AV calculations. Section 2707(a) of the PHS Act directs health insurance issuers that offer non-grandfathered health insurance coverage in the individual or small group market to ensure that such coverage includes essential health benefits.

Section 1311(c)(1)(B) of the Affordable Care Act requires the Secretary to establish minimum criteria for provider network adequacy that a health plan must meet to be certified as a QHP.

Section 1311(c)(6)(B) of the Affordable Care Act states that the Secretary is to set annual open enrollment periods for Exchanges for calendar years after the initial enrollment period.

Section 1311(c)(6)(C) of the Affordable Care Act states that the Secretary is to provide for special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 (the Code) and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act (the Act) for the Exchanges.

Section 1321(a) of the Affordable Care Act provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the Affordable Care Act.

1. Market Rules

A proposed rule relating to the 2014 health insurance market rules was published in the November 26, 2012 **Federal Register** (77 FR 70584). A final rule implementing the health insurance market rules was published in the February 27, 2013 **Federal Register** (78 FR 13406) (2014 Market Rules).

A proposed rule relating to Exchanges and Insurance Market Standards for 2015 and Beyond was published in the March 21, 2014 **Federal Register** (79 FR 15808) (2015 Market Standards Proposed Rule). A final rule implementing the Exchange and

Insurance Market Standards for 2015 and Beyond was published in the May 27, 2014 **Federal Register** (79 FR 30240) (2015 Market Standards Rule).

2. Exchanges

We published a request for comment relating to Exchanges in the August 3, 2010 **Federal Register** (75 FR 45584). We issued initial guidance to States on Exchanges on November 18, 2010.² We proposed a rule in the July 15, 2011 **Federal Register** (76 FR 41865) to implement components of the Exchanges, and a rule in the August 17, 2011 **Federal Register** (76 FR 51201) regarding Exchange functions in the individual market, eligibility determinations, and Exchange standards for employers. A final rule implementing components of the Exchanges and setting forth standards for eligibility for Exchanges was published in the March 27, 2012 **Federal Register** (77 FR 18309) (Exchange Establishment Rule).

In the March 8, 2016 **Federal Register** (81 FR 12203), we published the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 (2017 Payment Notice), and established additional Exchange standards, including requirements for network adequacy and essential community providers; and established the timing of annual open enrollment periods.

In the September 6, 2016 **Federal Register** (81 FR 61456), we published the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 proposed rule (proposed 2018 Payment Notice). In the December 22, 2016 **Federal Register** (81 FR 94058), we published the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 final rule (2018 Payment Notice) and established additional Exchange standards, including requirements for network adequacy and essential community providers.

3. Special Enrollment Periods

In the July 15, 2011 **Federal Register** (76 FR 41865), we published a proposed rule establishing special enrollment periods for the Exchange. We implemented these special enrollment periods in the Exchange Establishment Rule (77 FR 18309). In the January 22, 2013 **Federal Register** (78 FR 4594), we published a proposed rule amending certain special enrollment periods,

including the special enrollment periods described in § 155.420(d)(3) and (7). We finalized these rules in the July 15, 2013 **Federal Register** (78 FR 42321).

In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed to add a special enrollment period when the Exchange determines that a consumer has been incorrectly or inappropriately enrolled in coverage due to misconduct on the part of a non-Exchange entity. We finalized this proposal in the October 30, 2013 **Federal Register** (78 FR 65095). In the March 21, 2014 **Federal Register** (79 FR 15808), we proposed to amend various special enrollment periods. In particular, we proposed to clarify that later coverage effective dates for birth, adoption, placement for adoption, or placement for foster care would be effective the first of the month. The rule also proposed to clarify that earlier effective dates would be allowed if all issuers in an Exchange agree to effectuate coverage only on the first day of the specified month. Finally, this rule proposed adding that consumers may report a move in advance of the date of the move and established a special enrollment period for individuals losing medically needy coverage under the Medicaid program even if the medically needy coverage is not recognized as minimum essential coverage (individuals losing medically needy coverage that is recognized as minimum essential coverage already were eligible for a special enrollment period under the regulation). We finalized these provisions in the May 27, 2014 **Federal Register** (79 FR 30348). In the October 1, 2014 **Federal Register** (79 FR 59137), we published a correcting amendment related to codifying the coverage effective dates for plan selections made during a special enrollment period and clarifying a consumer's ability to select a plan 60 days before and after a loss of coverage.

In the November 26, 2014 **Federal Register** (79 FR 70673), we proposed to amend effective dates for special enrollment periods, the availability and length of special enrollment periods, the specific types of special enrollment periods, and the option for consumers to choose a coverage effective date of the first of the month following the birth, adoption, placement for adoption, or placement in foster care. We finalized these provisions in the February 27, 2015 **Federal Register** (80 FR 10866). In the July 7, 2015 **Federal Register** (80 FR 38653), we issued a correcting amendment to include those who become newly eligible for a QHP due to a release from incarceration. In the

² Initial Guidance to States on Exchanges (November 10, 2010). Available at https://www.cms.gov/CCIIO/Resources/Files/guidance_to_states_on_exchanges.html.

December 2, 2015 **Federal Register** (80 FR 75487) (proposed 2017 Payment Notice), we sought comment and data related to existing special enrollment periods, including data relating to the potential abuse of special enrollment periods. In the 2017 Payment Notice, we stated that in order to review the integrity of special enrollment periods, the Federally-facilitated Exchange (FFE) will conduct an assessment by collecting and reviewing documents from consumers to confirm their eligibility for the special enrollment periods under which they enrolled.

In an interim final rule with comment published in the May 11, 2016 **Federal Register** (81 FR 29146) we amended the parameters of certain special enrollment periods.

In the 2018 Payment Notice we established additional Exchange standards, including requirements for certain special enrollments.

4. Actuarial Value

On February 25, 2013, we established the requirements relating to EHBs and AVs in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, which was published in the **Federal Register** (78 FR 12833) (EHB Rule), implementing section 1302 of the Affordable Care Act and 2707 of the PHS Act. In the 2018 Payment Notice published in the December 22, 2016 **Federal Register** (81 FR 94058), we finalized a provision that allow an expanded de minimis range for certain bronze plans.

B. Stakeholder Consultation and Input

HHS has consulted with stakeholders on policies related to the operation of Exchanges. We have held a number of listening sessions with consumers, providers, employers, health plans, the actuarial community, and State representatives to gather public input, with a particular focus on risks to the individual and small group markets. We consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners, regular contact with States through the Exchange Establishment grant and Exchange Blueprint approval processes, and meetings with Tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties.

III. Provisions of the Proposed Rule

A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Guaranteed Availability of Coverage (§ 147.104)

The guaranteed availability provisions at section 2702 of the PHS Act and § 147.104 require health insurance issuers offering non-grandfathered coverage in the individual or group market to offer coverage to and accept every individual and employer in the State that applies for such coverage unless an exception applies. Individuals and employers typically are required to pay the first month's premium to have coverage effectuated.

We have previously interpreted the guaranteed availability requirement to mean that an issuer may not apply any premium payment made for 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.³ Under that interpretation, any coverage under a different product would fall under the guaranteed availability requirements and the consumer must be allowed to purchase coverage without having to pay past due premiums. However, under our previous interpretation, should the individual seek to renew prior coverage with the same issuer in the same product, the issuer could attribute the enrollee's forthcoming premium payments to prior non-payments.

HHS has received comments from stakeholders expressing concerns about the potential for individuals with histories of non-payment to take advantage of guaranteed availability by declining to make premium payments for coverage at the end of a benefit year, for example.⁴ In the preamble to the 2014 Market Rules, HHS encouraged States to consider approaches to discourage gaming and adverse selection while upholding consumers' guaranteed availability rights and indicated that we intended to address this issue in future guidance.

To address the concern about potential gaming, we propose to modify our interpretation of the guaranteed availability rules with respect to non-payment of premiums. Under this proposal, an issuer would not be

considered to violate the guaranteed availability requirements if the issuer attributes a premium payment for coverage under the same or a different product to the outstanding debt associated with non-payment of premiums for coverage from the same issuer enrolled in within the prior 12 months and refuses to effectuate new coverage for failure to pay premiums. Assuming State law does not prohibit such action, this would permit an issuer to require a policyholder whose coverage is terminated for non-payment of premium in the individual or group market to pay all past due premium owed to that issuer after the applicable due date for coverage enrolled in the prior 12 months in order to resume coverage from that issuer. The issuer would be required to apply its premium payment policy uniformly to all employers or individuals regardless of health status, and consistent with applicable non-discrimination requirements.⁵ This proposal would not prevent the individual or employer from enrolling in coverage with a different issuer, or affect the ability of any individual other than the person contractually responsible for the payment of premium to purchase coverage, whether from the same or different issuer. We encourage States to adopt a similar approach, with respect to any State laws that might otherwise prohibit this practice.

Because of rules regarding grace periods and termination of coverage, individuals with past due premium would generally owe no more than 3 months of premiums.⁶ Furthermore, for

⁵ We remind issuers that they may also have obligations under other applicable Federal laws prohibiting discrimination, and issuers are responsible for ensuring compliance with all applicable laws and regulations. For example, issuers that receive Federal financial assistance are subject to Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and section 1557 of the Affordable Care Act, and as a result, have separate responsibilities not to discriminate on the basis of race, color, national origin, sex, age, and disability, in providing access to their services. In addition, § 156.200(e) requires QHP issuers to not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. There may also be separate, independent non-discrimination obligations under State law.

⁶ Section 156.270(d) requires issuers to observe a 3 consecutive month grace period before terminating coverage for those enrollees who are eligible for and have elected to receive APTC and who upon failing to timely pay their premiums are receiving APTC. Section 155.430(d)(4) requires that when coverage is terminated following this grace period, the last day of enrollment in a QHP through the Exchange is the last day of the first month of the grace period. Therefore, individuals whose coverage is terminated at the conclusion of a grace period would owe at most 1 month of premiums. Individuals who attempt to enroll in new coverage

³ Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program Enrollment Manual, Section 6.3 Terminations for Non-Payment of Premiums, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_FFMSHOP_Manual_080916.pdf.

⁴ 78 FR 13416 (Feb. 27, 2013).

individuals on whose behalf the issuer received APTC, their past premium owed would be net of any APTC paid on their behalf to the issuer.

We note that due to operational constraints, the Federally-facilitated Small Business Health Options Program will be unable to offer issuers this flexibility at this time.

We seek comment on this proposal, including whether issuers that choose to adopt this type of premium payment policy should be permitted to implement it with a premium payment threshold policy, under which the issuer can consider an individual to have paid all amounts due, if the individual pays an amount sufficient to maintain a percentage of total premium paid out of the total premium owed equal to or greater than a level prescribed by the issuer. We also seek comment on whether issuers should be required to provide notice to individuals regarding whether they have adopted a premium payment policy permitted under this proposal.

In addition, we propose to amend paragraph (b)(2)(i) to conform with proposed changes to special enrollment periods discussed in greater detail in section III.B.2. of this proposed rule. Because the proposed changes to § 155.420(a)(4) through (5) are being proposed for special enrollment periods in the individual market, both inside and outside of an Exchange, we propose to amend § 147.104(b)(2)(i) to specify that these paragraphs apply to special enrollment periods throughout the individual market. We seek comment on how these changes would be operationalized outside of the Exchanges.

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Initial and Annual Open Enrollment Periods (§ 155.410)

We propose to amend paragraph (e) of § 155.410, which provides the dates for the annual Exchange open enrollment period in which qualified individuals and enrollees may apply for or change coverage in a QHP. In prior rulemaking, we established that the open enrollment period for the benefit year beginning on January 1, 2018 would begin on November 1, 2017 and extend through January 31, 2018; and that the open enrollment period for benefit years beginning on January 1, 2019 and beyond would begin on November 1 and

extend through December 15 of the calendar year preceding the benefit year.⁷ We noted at the time that we believe that, as the Exchanges continue, a month-and-a-half open enrollment period provides sufficient time for consumers to enroll in or change QHPs for the upcoming plan year. We also noted that this timeframe would achieve our goals of shifting to an earlier end date for open enrollment so that all consumers who enroll during this time will receive a full year of coverage, which will simplify operational processes for issuers and the Exchanges. We also believe that this shorter open enrollment period may have a positive impact on the risk pool because it will reduce opportunities for adverse selection by those who learn they will need services in late December or January. While we originally included a longer transition period before moving to this shorter open enrollment period, we believe that the market and issuers are ready for this adjustment sooner. Therefore, we propose to amend § 155.410(e) to change the open enrollment period for plan year 2018 so that it begins on November 1, 2017, and ends on December 15, 2017. All consumers who select plans on or before December 15, 2017 would receive an enrollment effective date of January 1, 2018, as already required by § 155.410(f)(2)(i). We believe that this open enrollment period would align better with many open enrollment periods for employer-based coverage, as well as the open enrollment period for Medicare. We would intend to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame.

We seek comment on this proposal, in particular on the capacity of State-based Exchanges to shift to the shorter open enrollment period for the 2018 plan year, on the effect of the shorter enrollment period on issuers' ability to enroll healthy consumers, and any difficulties agents, brokers, navigators and assisters may have in serving consumers seeking to enroll during this shorter time period.

2. Special Enrollment Periods (§ 155.420)

Section 1311(c)(6) of the Affordable Care Act establishes enrollment periods, including special enrollment periods for qualified individuals, for enrollment in QHPs through an Exchange. Section 1311(c)(6)(C) of the Affordable Care Act states that the Secretary is to provide for special enrollment periods specified in

section 9801 of the Code and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Act. Section 2702(b)(3) of the PHS Act also directs the Secretary to provide for market-wide special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974.

Special enrollment periods are a longstanding feature of employer-sponsored coverage. They exist to ensure that people who lose health coverage during the year (for example, through non-voluntary loss of minimum essential coverage provided through an employer), or who experience other qualifying events such as marriage or the birth or adoption of a child, have the opportunity to enroll in new coverage or make changes to their existing coverage. While the annual open enrollment period allows previously uninsured individuals to enroll in new coverage, special enrollment periods are intended, in part, to promote continuous enrollment in health coverage during the plan year by allowing those who were previously enrolled in coverage to obtain new coverage without a lapse or gap in coverage.

Our past practice, in many cases, was to permit individuals seeking coverage through the Exchanges to self-attest to their eligibility for most special enrollment periods and to enroll in coverage without further verification of their eligibility or without submitting proof of prior coverage. This practice had the virtue of minimizing barriers for consumers to obtain coverage, which can, in particular, deter enrollment by healthy individuals. However, as the Government Accountability Office noted in a November 2016 report, relying on self-attestation without verifying documents submitted to support a special enrollment period triggering event could allow applicants to obtain subsidized coverage they would otherwise not qualify for.⁸ In addition, allowing previously uninsured individuals who elected not to enroll in coverage during the annual open enrollment period to instead enroll in coverage through a special enrollment period that they would not otherwise qualify for during the coverage year, undermines the incentive for enrolling in a full year of coverage through the annual open enrollment period and increases the risk of adverse selection from individuals who wait to enroll until they are sick. Such behaviors can

while in a grace period (and whose coverage has not yet been terminated) could owe up to 3 months of premium, net of any APTC paid on their behalf to the issuer.

⁷ 81 FR 12203, 12273.

⁸ November 2016, *Results of Enrollment Testing for the 2016 Special Enrollment Period*, GAO-17-78, U.S. Government Accountability Office.

create a sicker risk pool, leading to higher rates and less availability of coverage.

In an effort to curb abuses of special enrollment periods, in 2016 we added warnings on *HealthCare.gov* regarding inappropriate use of special enrollment periods. We also eliminated several special enrollment periods and tightened certain eligibility rules.⁹ Also in 2016, we announced retrospective audits of a random sampling of enrollments through loss of minimum essential coverage and permanent move special enrollment periods, two commonly used special enrollment periods. Additionally, we created The Special Enrollment Confirmation Process under which consumers enrolling through common special enrollment periods were directed to provide documentation to confirm their eligibility.¹⁰ Finally, we proposed to implement (beginning in June 2017) a pilot program for conducting pre-enrollment verification of eligibility for certain special enrollment periods.¹¹

As discussed in the 2018 Payment Notice, the impact of special enrollment period verification on risk pools may be complex. Some commenters suggested that additional steps to determine special enrollment period eligibility worsen the problem by creating new barriers to enrollment, with healthier, less motivated individuals, the most likely to be deterred. The pilot was initially planned to sample 50 percent of consumers who were attempting to newly enroll in Exchange coverage through certain special enrollment periods in order to provide a statistically sound method to compare the claims experience in the second half of 2017 between individuals subject to pre-enrollment verification with those who were not.

However, based on strong issuer feedback and the potential to help to stabilize the market for 2018 coverage, we propose to increase the scope of pre-enrollment verification of special enrollment periods to all applicable special enrollment periods, as outlined below, in order to ensure complete verification of eligibility. We would begin to implement this expanded pre-enrollment verification starting in June 2017. We have consistently heard from

issuers and other stakeholders that pre-enrollment verification of special enrollment periods is critical to promote continuous coverage, protect the risk pool, and stabilize rates. We agree that policies and practices that allow individuals to remain uninsured and wait to sign up for coverage through a special enrollment period only after becoming sick can contribute to market destabilization and reduced issuer participation, which can reduce the availability of coverage for individuals.

Therefore, this rule proposes that HHS conduct pre-enrollment verification of eligibility for Exchange coverage for all categories of special enrollment periods for all new consumers in all States served by the *HealthCare.gov* platform, which includes Federally-facilitated Exchanges and State-based Exchanges on the Federal platform (SBE-FPs).

Under pre-enrollment verification, HHS would verify eligibility for certain special enrollment period categories for all new consumers who seek to enroll in Exchange coverage through a special enrollment period. Consumers would be able to submit their applications and select a plan and, as is the current practice for most special enrollment periods, the start date of that coverage would be determined by the date of plan selection. However, the consumers' enrollment would be "pending" until verification of special enrollment period eligibility is completed. In this context, "pending" means holding the information regarding plan selection and coverage date at the FFE or SBE-FP until special enrollment period eligibility is confirmed, before releasing the enrollment information to the relevant issuer. Consumers would be given 30 days to provide documentation, and would be able to upload documents into their account on *HealthCare.gov* or send their documents in the mail. Where applicable, we intend to make every effort to verify an individual's eligibility for the applicable special enrollment period through automated electronic means instead of through documentation. For example, verifying a birth by confirming the baby's existence through existing electronic verifications or verifying electronically that a consumer was denied Medicaid or CHIP coverage, where such information is available. Otherwise, we will seek documentation from the individual applying for the special enrollment period. We note that even though we do not currently perform verification for all consumers new to the Exchange, we already require all consumers to provide documentation if they are applying for a special

enrollment period based on certain triggering events. Under this proposal, we anticipate approximately the same amount of documentation and therefore would not anticipate an increased burden on consumers. We seek comment on the impact on consumers. We seek comment on our proposed method for pre-enrollment verification and whether we should retain a small percentage of enrollees outside the pre-enrollment verification process to conduct the study discussed above. If we do not, HHS would continue to monitor other indicators of risk where available in lieu of the statistical comparison. Recognizing that pre-enrollment verification could have the unintended consequence of deterring healthier individuals from purchasing Exchange coverage, we also seek comment on what strategies HHS should take to increase the chances that these individuals complete the verification process.

We also recommend that State-based Exchanges that do not currently conduct pre-enrollment verification of special enrollment period eligibility consider following this approach as well, and request comment on whether State-based Exchanges should also be required to conduct pre-enrollment verification, with an appropriate amount of time to implement such a process, and how long that transition period should be.

As noted above, the pre-enrollment verification of special enrollment period eligibility is intended to address concerns about potential adverse selection. However, we have heard concerns that existing Exchange enrollees are utilizing special enrollment periods to change plan metal levels based on ongoing health needs during the coverage year, and that this is having a negative impact on the risk pool. We have concerns about applying the approach of pending a plan selection until pre-enrollment verification is conducted while the consumer would still have an active policy because we believe the potential overlap of current, active policies and pending plan selections will create significant confusion for consumers and create burden on issuers to manage the potential operational issues. For example, if a consumer who is currently enrolled is seeking to add a new spouse under the marriage special enrollment period, the current coverage would remain in force until the consumer submits documentation to verify the marriage. At that time the pending plan selection would be released, potentially with a retroactive coverage effective date based on the date of the plan

⁹ February 25, 2016, Fact Sheet: Special Enrollment Confirmation Process. Available online at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html>.

¹⁰ *Ibid.*

¹¹ December 14, 2016, Fact Sheet: Pre-Enrollment Verification for Special Enrollment Periods, available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Pre-Enrollment-SEP-fact-sheet-FINAL.PDF>.

selection with both individuals; and the current coverage with the single enrollee would be retroactively terminated to when the new policy begins. If the new plan selection is with a new issuer, any claims incurred during that time period would need to be reconciled across the issuers.

As an alternative, we are proposing new paragraph (a)(4) to limit the ability of existing Exchange enrollees to change plan metal levels during the coverage year. The proposed changes in paragraph (a)(4) would apply in the individual market outside the Exchanges, but would not apply in the group market. We are proposing changes to § 147.104(b)(2)(i) and § 155.725(j)(2)(i) to specify this. We are also proposing to amend the introductory language in paragraph (d) of this section and to add a new paragraph (a)(3) to conform with this proposed change. For special enrollment periods administered on the Exchange, the Exchange would limit the plan selection choices. We request comment on all aspects of this proposal, including whether it would be preferable to address adverse selection concerns for existing enrollees by applying the approach of pending plan selections until pre-enrollment verification is completed based on document reviews instead of the current plan and metal level restrictions. We also request comment on any alternative strategies for addressing potential adverse selection issues for existing enrollees who are eligible for a special enrollment period.

We understand that State-based Exchanges may not be able to implement these changes starting in 2017, and seek comment on an appropriate transitional period for State-based Exchanges, or whether these changes should be optional for State-based Exchanges.

Under new paragraph (a)(4)(i), we propose to require that if an enrollee qualifies for a special enrollment period due to gaining a dependent in paragraph (d)(2)(i) of this section, the Exchange may allow him or her to add the new dependent to his or her current QHP (subject to the ability to enroll in silver level coverage in certain circumstances as discussed in the next paragraph). Alternatively, if the QHP's business rules do not allow the new dependent to enroll, the Exchange may allow the enrollee and his or her new dependent to enroll in another QHP within the same level of coverage (or an "adjacent" level of coverage, if no such plans are available), as defined in § 156.140(b). This ensures that enrollees who qualify for the special enrollment period due to

gaining a dependent are using this special enrollment period for its primary purpose of enrolling the new dependent in coverage. If finalized, we intend to implement this policy for the FFEs and SBE-FPs as soon as practicable. We seek comment on this proposal.

New paragraph (a)(4)(ii) proposes to require that if an enrollee or his or her dependent is not enrolled in a silver level QHP and becomes newly eligible for cost-sharing reductions and qualifies for the special enrollment periods in paragraph (d)(6)(i) and (ii) of this section, the Exchange may allow the enrollee and dependent to enroll in only a QHP at the silver level, as specified in § 156.140(b)(2). We seek comment on this proposal, including with respect to whether individuals newly eligible for APTC in this circumstance should also be able to enroll in a silver level QHP, or QHPs of other metal levels.

New paragraph (a)(4)(iii) proposes that, for an enrollee who qualifies for the remaining special enrollment periods specified in paragraph (d), the Exchange must only allow the enrollee and his or her dependents to make changes to their enrollment in the same QHP or to change to another QHP within the same level of coverage, as defined in § 156.140(b), if other QHPs at that metal level are available. This restriction would extend to enrollees who are on an application where a new applicant is enrolling in coverage through a special enrollment period. This proposal ensures that enrollees who qualify for a special enrollment period or are on an application where an applicant qualifies for a special enrollment period to newly enroll in coverage are not using this special enrollment period to simply switch levels of coverage during the coverage year. This policy would apply to most Exchange enrollees who qualify for a special enrollment period during the coverage year, further protecting the Exchanges from adverse selection. Affected special enrollment periods include special enrollment periods for enrollees who lost minimum essential coverage through the Exchange during the coverage year in accordance with paragraph (d)(1); demonstrated to the Exchange that the QHP into which they have enrolled has violated a material provision of its contract in accordance with paragraph (d)(5); gained access to a new QHP due to a permanent move in accordance with paragraph (d)(7); or were affected by a material plan or benefit display errors in accordance with paragraph (d)(12). Enrollees who qualify for the special enrollment periods in paragraphs (d)(4), (d)(9), and

(d)(10) would be excluded from this new requirement because the qualifying events that enabled them to qualify for these special enrollment periods may have also resulted in an inability to enroll in their desired plan during the annual open enrollment period. In addition, we propose to exclude the special enrollment period in paragraph (d)(8) for Indians and their dependents. We seek comment on this proposal, and whether other special enrollment periods should be excluded. We also seek comment on the appropriate transitional period to enable State-based Exchanges to build these capacities, or whether the proposals in new paragraph (a)(4) should be at the option of the Exchanges. We also seek comment on how this proposal would be operationalized in the off-Exchange individual market.

In the 2018 Notice of Payment and Benefit Parameters, HHS finalized paragraph (b)(5) to allow consumers to request a later coverage effective date than originally assigned if his or her enrollment was delayed due to an eligibility verification and the consumer would be required to pay 2 or more months of retroactive premium in order to effectuate coverage or avoid termination of coverage due to nonpayment of premiums. When finalizing this amendment, we did not place a limit on how much later the coverage effective date could be. After further consideration and concerns raised by stakeholders regarding potential adverse selection impacts, we propose modifying that requirement and instead allowing consumers to start their coverage 1 month later than their effective date would ordinarily have been, if the special enrollment period verification process results in a delay in their enrollment such that they would be required to pay 2 or more months of retroactive premium to effectuate coverage or avoid termination for nonpayment. Therefore, a consumer who was originally scheduled to begin coverage on March 1, may elect to have coverage start on April 1, if he or she owes retroactive premiums for March, April, and May due to delays in document verification. We note that we do not anticipate that many consumers would be eligible to request a later effective date under this paragraph, as we do not expect the pre-enrollment verification processes to result in such significant delays. However, we recognize that there may be unforeseen challenges as we implement the verification process, and believe it is important to offer this flexibility in the event of such delays. We believe the

option to have a later effective date could help keep healthier individuals in the market, who otherwise might be deterred by the prospect of paying for 2 or more months of retroactive coverage that they did not use. We seek comment on this proposal, and the appropriate coverage effective date for these consumers.

As part of our enhanced verification efforts for special enrollment periods, we are proposing to take additional steps 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.

First, in order to ensure that a special enrollment period for loss of minimum essential coverage in paragraph (d)(1) is not granted in cases where an individual was terminated for non-payment of premium, as described in paragraph (e)(1), FFE (and SBE-FPs) will permit the issuer to reject an enrollment for which the issuer has a record of termination due to non-payment of premiums unless the individual fulfills obligations for premiums due for previous coverage, consistent with the guaranteed availability approach discussed in the preamble for § 147.104. We believe that verifying that consumers are not attempting to enroll in coverage through the special enrollment period for loss of minimum essential coverage when the reason for their loss of coverage is due to non-payment of premiums is an important measure to prevent instances of gaming related to individuals only paying premiums and maintaining coverage for months in which they seek services. We seek comment on this proposal.

Further, HHS intends to explore options for verifying that a consumer was not terminated due to non-payment of premiums for coverage within the FFEs as a precursor for being eligible for the loss of minimum essential coverage special enrollment period. HHS proposes to allow Exchanges to collect and store information from issuers about whether consumers have been terminated from Exchange coverage due to nonpayment of premiums so that the Exchange may automatically prevent these consumers from qualifying for the special enrollment period due to a loss of minimum essential coverage if the consumer attempts to renew his or her Exchange coverage within 60 days of being terminated. We note that, if the consumer attempts to renew his or her Exchange coverage more than 60 days after being terminated, the consumer

would not be eligible for a special enrollment period due to loss of minimum essential coverage. We seek comment on this proposal.

Second, in response to concerns that consumers are opting not to enroll in QHP coverage during the annual open enrollment period and are instead newly enrolling in coverage during the coverage year through the special enrollment period for marriage, we are proposing to add new paragraph (d)(2)(i)(A) to require that, if consumers are newly enrolling in QHP coverage through the Exchange through the special enrollment period for marriage, at least one spouse must demonstrate having had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage. However, we recognize that individuals who were previously living abroad or in a U.S. territory may not have had access to coverage that is considered minimum essential coverage in accordance with 26 CFR 1.5000A-1(b) prior to moving to the U.S. Therefore, we propose that, when consumers are newly enrolling in coverage during the coverage year through the special enrollment period for marriage, at least one spouse must either demonstrate that they had minimum essential coverage or that they lived outside of the U.S. or in a U.S. territory for 1 or more days during the 60 days preceding the date of the marriage. This proposed change would only apply in the individual market. We seek comment on this proposal.

To streamline our regulations regarding special enrollment periods that require consumers to demonstrate prior coverage, we propose to add new paragraph (a)(5) to clarify that qualified individuals who are required to demonstrate prior coverage can either demonstrate that they had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of the qualifying event or that they lived outside of the U.S. or in a U.S. territory for 1 or more days during the 60 days preceding the date of the qualifying event. Paragraph (a)(5) would apply to paragraph (d)(2)(i)(A) for marriage (discussed above) and paragraph (d)(7)(i) for permanent move and this paragraph would replace current paragraph (d)(7)(ii). We seek comment on this proposal.

HHS acknowledges that this rule proposes changes for special enrollment periods in the individual market that differ from the rules regarding special enrollment periods in the group market. For example, this rule proposes changes that would require consumers to

demonstrate prior coverage to qualify for the special enrollment period for marriage in proposed paragraph (d)(2)(i)(A) and would generally limit plan selection to the same plan or level of coverage when an enrollee qualifies for a special enrollment period during the coverage year in proposed paragraph (a)(4). However, we believe that the differences in the markets—and the impacts of those differences on the risk pool—warrant an approach in the individual market that diverges from long-standing rules and norms in the group market. Employer-sponsored coverage is generally a more stable risk pool and less susceptible to gaming because the coverage is tied to employment and often substantially subsidized by the employer. Thus, we believe taking an approach in the individual market that imposes tighter restrictions on special enrollments and the ability to change plans for current enrollees better addresses the unique challenges faced in the individual market. We believe that this approach is consistent with the requirement in section 1311(c)(6)(C) of the Affordable Care Act directing the Secretary to require Exchanges to establish special enrollment periods as specified in section 9801 of the Code and under circumstances similar to such periods under Part D of title XVIII of the Act and the Secretary's authority under section 2702(b)(3) to promulgate regulations for the individual market with respect to special enrollment periods for qualifying events under section 603 of the Employee Retirement Income Security Act of 1974. We interpret section 1311 of the Affordable Care Act and section 2702 of the PHS Act to require the Secretary to implement special enrollment periods with the same triggering events as in the group market, but to provide the Secretary with flexibility in the specific parameters around how those special enrollment periods are implemented in the individual market, due to these unique dynamics of the individual market.

Third, we propose to expand the verification requirements related to the special enrollment period for a permanent move in paragraph (d)(7). This special enrollment period is only available to a qualified individual or enrollee who has gained access to new QHPs as a result of a permanent move *and* had coverage for 1 or more days in the 60 days preceding the move, unless he or she is moving to the U.S. from abroad or a U.S. territory. Currently, we require documentation to show a move occurred, and accept an attestation

regarding having had prior coverage or moving from abroad or a U.S. territory. To ensure that consumers meet all the requirements for this special enrollment period, we propose to require that new applicants applying for coverage through this special enrollment period submit acceptable documentation to the FFEs and SBE-FPs to prove both their previous and new addresses and evidence of prior coverage, if applicable, through the pre-enrollment verification process. If finalized, we intend to release guidance on what documentation would be acceptable. We seek comment on this proposal.

Fourth, for the remainder of 2017 and for future plan years, we propose to significantly limit the use of the exceptional circumstances special enrollment period described in paragraph (d)(9). In previous years, this special enrollment period has been used to address eligibility or enrollment issues that affect large cohorts of individuals where they had made reasonable efforts to enroll but were hindered by outside events. For example, in past years, the FFEs have offered exceptional circumstances special enrollment periods to groups of consumers who were enrolled in coverage that they believed was minimum essential coverage at the time of enrollment, but was not. HHS proposes to henceforth apply a more rigorous test for future uses of the exceptional circumstances special enrollment period, including requiring supporting documentation where practicable, under which we would only grant this special enrollment period if provided with sufficient evidence to conclude that the consumer's situation was truly exceptional and in instances where it is verifiable that consumers were directly impacted by the circumstance, as practicable. We would provide guidance on examples of situations that we believe meet this more rigorous test and what corresponding documentation consumers will be required to provide, if requested by the FFE. We seek comment on this proposal.

Over the past few years, the Exchange has, at times, offered special enrollment periods for a variety of circumstances related to errors that occurred more frequently in the early years of operations. However, as the Exchanges continue, HHS will evaluate existing special enrollment periods to determine their continued utility and necessity. This rule proposes to formalize previous guidance¹² from HHS that the following

special enrollment periods are no longer available. We are publishing this list in this proposed rule in response to confusion by stakeholders about whether current special enrollment periods previously made available through guidance are still available to consumers, for the purposes of clarity.

- Consumers who enrolled with advance payments of the premium tax credit that are too large because of a redundant or duplicate policy;
- Consumers who were affected by a temporary error in the treatment of Social Security Income for tax dependents;
- Lawfully present non-citizens that were affected by a temporary error in the determination of their eligibility for advance payments of the premium tax credit
- Lawfully present non-citizens with incomes below 100% FPL who experienced certain processing delays; and
- Consumers who were eligible for or enrolled in COBRA and not sufficiently informed about their coverage options.

Because of concerns that improper uses of the special enrollment periods outlined in this section will lead to adverse selection and immediate, unexpected financial losses in the remaining months of this year, which could lead to premium increases or issuers exiting the market, we believe that the changes discussed above are needed to stabilize the risk pool and encourage robust issuer Exchange participation, which will also benefit both consumers and the individual market as a whole in the future.

3. Continuous Coverage

Because of the challenges in the individual market related to adverse selection, HHS believes it is especially important in this market to adopt policies that promote continuous enrollment in health coverage and to discourage individuals from waiting until illness occurs to enroll in coverage.

While the proposals in this rule relating to guaranteed availability, the annual open enrollment period, and special enrollment periods would encourage individuals to maintain coverage throughout the year, we are also actively exploring additional policies in the individual market that would promote continuous coverage and seek input on which policies would effectively do so consistent with

existing legal authorities. For example, with respect to special enrollment periods that require evidence of prior coverage, we are considering policies for the individual market that would require that individuals show evidence of prior coverage for a longer "look back" period. For example, we could require prior coverage for 6 to 12 months, except that we might consider an individual to have had prior coverage, even if there was a small gap in coverage (for example, up to 60 days). Alternatively, for individuals who are not able to provide evidence of prior coverage during such a look back period, an exception could allow them to enroll in coverage if they otherwise qualify for a special enrollment period, but impose a waiting period of at least 90 days before effectuating enrollment, or assess a late enrollment penalty. These policies could provide a disincentive for individuals to drop out of coverage, thus promoting continuous coverage.

HHS is also interested in whether policies are needed for the individual market similar to those that existed under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA), which required maintenance of continuous, creditable coverage without a 63-day break in the group market if individuals wished to avoid the pre-existing condition exclusions, and allowed waiting periods to be imposed under certain circumstances. Although the HIPAA rules did not require that individuals maintain coverage, the rules were designed to provide an important incentive for individuals to enroll in coverage year-round, not just when in need of health care services; reduce adverse selection; and help prevent premiums from climbing to levels that would keep most healthy individuals from purchasing coverage.

With these policies, we likely would seek not only to encourage uninsured individuals to enroll in coverage during the open enrollment period, but also to encourage those with coverage to maintain continuous coverage throughout the year.

We note that we seek comment on additional policies that would promote continuous coverage, but are not, at this time, proposing any of the policies described in this section III.B.3. of this notice.

4. Enrollment Periods Under SHOP

Because the proposed changes to § 155.420(a)(3) through (5) are being proposed for special enrollment periods in the individual market only, we propose to amend § 155.725(j)(2)(i) to

¹² HHS, *Clarifying, Eliminating and Enforcing Special Enrollment Periods* (January 19, 2016),

available at <http://wayback.archive-it.org/2744/20170118130449/https://blog.cms.gov/2016/01/19/clarifying-eliminating-and-enforcing-special-enrollment-periods/>.

specify that these paragraphs do not apply to special enrollment periods under the Small Business Health Options Program (SHOP). A more detailed discussion of the proposed changes in § 155.420(a) is provided in section III.B.2. of this proposed rule.

5. Exchange Functions: Certification of Qualified Health Plans (Part 155, Subpart K)

In light of the need for issuers to make modifications to their products and applications to accommodate the changes proposed in this rule, should they be finalized, we would issue separate guidance to update the QHP certification calendar and the rate review submission deadlines to give additional time for issuers to develop, and States to review, form and rate filings for the 2018 plan year that reflect these changes.

C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Levels of Coverage (Actuarial Value) (§ 156.140)

Section 2707(a) of the PHS Act and section 1302 of the Affordable Care Act direct issuers of non-grandfathered individual and small group health insurance plans, including QHPs, to ensure that these plans adhere to the levels of coverage specified in section 1302(d)(1) of the Affordable Care Act. A plan's coverage level, or actuarial value (AV), is determined based on its coverage of the EHB for a standard population. Section 1302(d)(1) of the Affordable Care Act requires a bronze plan to have an AV of 60 percent, a silver plan to have an AV of 70 percent; a gold plan to have an AV of 80 percent; and a platinum plan to have an AV of 90 percent. Section 1302(d)(2) of the Affordable Care Act directs the Secretary to issue regulations on the calculation of AV and its application to the levels of coverage. Section 1302(d)(3) of the Affordable Care Act authorizes the Secretary to develop guidelines to provide for a *de minimis* variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

In the EHB Rule, at § 156.140(c), HHS established that the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is ± 2 percentage points. As finalized in the 2018 Payment Notice, § 156.140(c) permits a *de minimis* variation of ± 2 percentage points, except if a bronze

health plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), the allowable variation in AV for such plan is -2 percentage points and $+5$ percentage points. We established this additional flexibility for certain bronze plans in the 2018 Payment Notice to provide a balanced approach to ensure that a variety of bronze plans can be offered, including high deductible health plans, while ensuring that bronze plans can remain at least as generous as catastrophic plans. As discussed in the EHB Rule, our intention with the *de minimis* variation of ± 2 percentage points was to give issuers the flexibility to set cost-sharing rates that are simple and competitive while ensuring consumers can easily compare plans of similar generosity. While the *de minimis* range is intended to allow plans to float within a reasonable range and is not intended to freeze plan designs preventing innovation in the market, it was also intended to mitigate the need for annual plan redesign, allowing plans to retain the same plan design year to year while remaining at the same metal level.

At this time, we believe that further flexibility is needed for the AV *de minimis* range for metal levels to help issuers design new plans for future plan years, thereby promoting competition in the market. In addition, we believe that changing the *de minimis* range will allow more plans to keep their cost sharing the same from year to year. Although the AV Calculator is not a pricing tool, changing the *de minimis* range could also put downward pressure on premiums. Thus, we anticipate that this flexibility could encourage healthier consumers to enroll in coverage, improving the risk pool and increasing market stability. For these reasons, we believe that changing the AV *de minimis* range would help retain and attract issuers to the non-grandfathered individual and small group markets, which would increase competition and help consumers. Therefore, we propose amending the definition of *de minimis* included in § 156.140(c), to a variation of $-4/+2$ percentage points, rather than ± 2 percentage points for all non-grandfathered individual and small group market plans that are required to comply with AV. Under the proposed standard, for example, a silver plan could have an AV between 66 and 72 percent. We believe that a *de minimis* amount of $-4/+2$ percentage points

would provide the necessary flexibility to issuers in designing plans while striking the right balance between ensuring comparability of plans within each metal level and allowing plans the flexibility to use convenient and competitive cost-sharing metrics.

We also note that as established at § 156.135(a), to calculate the AV of a health plan, the issuer must use the AV Calculator developed and made available by HHS for the given benefit year. The AV Calculator represents an empirical estimate of the AV calculated in a manner that provides a close approximation to the actual average spending by a wide range of consumers in a standard population. For the 2018 AV Calculator, we made several key updates to the AV Calculator, including updating the claims data underlying the continuance tables that represent the standard population to reflect more current claims data. For example, all previous versions of the AV Calculator had been using 2010 (pre-Affordable Care Act) claims data and the 2018 AV Calculator is using 2015 (post-Affordable Care Act) claims data. As discussed in the 2018 AV Calculator Methodology, due to the scope and number of updates in the 2018 AV Calculator, the impact on current plans' AVs will vary.¹³ Indeed, issuers have reported that the AV of 2017 plans have varied in unexpected ways when entered into the 2018 AV Calculator. Therefore, the proposed flexibility in the *de minimis* range is also intended to help provide some stability to those plans that are being impacted by the updates to the AV Calculator.

We are proposing to provide the increased flexibility in the *de minimis* range starting with the 2018 AV Calculator. We seek comment on whether making the change effective for the 2019 plan year would be preferable, given the lead time issuers require to design plans.

While we are proposing to modify the *de minimis* range for the metal level plans (bronze, silver, gold, and platinum), we are not proposing to modify the *de minimis* range for the silver plan variations (the plans with an AV of 73, 87 and 94 percent) under §§ 156.400 and 156.420 at this time. The *de minimis* variation for a silver plan variation of a single percentage point would still apply. In the Actuarial Value and Cost-Sharing Reductions Bulletin we issued on February 24, 2012,¹⁴ we

¹³ 2018 AV Calculator Methodology is available at <https://www.cms.gov/ccio/resources/regulations-and-guidance/#Plan>.

¹⁴ Available at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf>.

explained why we did not intend to require issuers to offer a cost-sharing reduction plan variation with an AV of 70. However, given our proposal, we also are considering whether the ability for an issuer to offer a standard silver level plan at an AV of 66 would require a plan variation to be offered at an AV of 70 or some other mechanism to provide for cost-sharing reductions for eligible individuals with household incomes that are more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved.

We also would maintain the bronze plan *de minimis* range policy finalized in the 2018 Payment Notice at § 156.140(c) with one modification. We propose to change the *de minimis* range for the expanded bronze plans from +5/-2 percentage points to +5/-4 percentage points to align with the policy in this rule. Therefore, for those bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), we are proposing the allowable variation in AV would be -4 percentage points and +5 percentage points.¹⁵

We seek comment on this proposal, including on the appropriate *de minimis* values for metal level plans and silver plan variations, and whether those values should differ when increasing or decreasing AV.

To implement the amended AV *de minimis* range in this proposed rule, we would update the 2018 AV Calculator in accordance with this policy.

2. Network Adequacy (§ 156.230)

At § 156.230, we established the minimum criteria for network adequacy that health and dental plan issuers must meet to be certified as QHPs, including stand-alone dental plans (SADPs), in accordance with the Secretary's authority in section 1311(c)(1)(B) of the Affordable Care Act. Section 156.230(a)(2) requires a QHP issuer to maintain 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.

In recognition of the traditional role States have in developing and enforcing network adequacy standards, we

¹⁵ Although we are expanding the *de minimis* range for bronze plans to -4 percentage points, we recognize that achieving an AV below 58 percent is difficult with the claims distribution underlying the current AV calculator.

propose to rely on State reviews for network adequacy in States in which an FFE is operating, provided the State has a sufficient network adequacy review process, rather than performing a time and distance evaluation. For the 2018 plan year, we propose to defer to the States' reviews in States with the authority that is at least equal to the "reasonable access standard" defined in § 156.230 and means to assess issuer network adequacy, regardless of whether the Exchange is a State-based Exchange (SBE) or FFE, and regardless of whether the State performs plan management functions.

We are also proposing a change to our approach to reviewing network adequacy in States that do not have the authority and means to conduct sufficient network adequacy reviews. In those States, we would, for the 2018 plan year, apply a standard similar to the one used in the 2014 plan year.¹⁶ As HHS did in 2014, in States without the authority or means to conduct sufficient network adequacy reviews, we would rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. HHS has previously recognized 3 accrediting entities for the accreditation of QHPs: the National Committee for Quality Assurance, URAC, and Accreditation Association for Ambulatory Health Care.¹⁷ We would recognize these same three accrediting entities for network adequacy reviews for the 2018 plan year. Unaccredited issuers would be required to submit an access plan as part of the QHP Application. To show that the QHP's network meets the requirement in § 156.230(a)(2), the access plan would need to demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with the National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act (the Model Act is available at <http://www.naic.org/store/free/MDL-74.pdf>). This approach would supersede the time and distance criteria described in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces.¹⁸

¹⁶ Letter to Issuers on Federally-facilitated and State Partnership Exchanges (April 5, 2013). Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

¹⁷ Recognition of Entities for the Accreditation of Qualified Health Plans 77 FR 70163 (November 23, 2012) and Approval of an Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans 78 FR 77470 (December 23, 2013).

¹⁸ 2018 Letter to Issuers in the Federally-facilitated Marketplaces (December 16, 2016).

We would further coordinate with States to monitor network adequacy, for example, through complaint tracking. As noted elsewhere in this rule, we intend to release a proposed timeline for the QHP certification process for plan year 2018 that would provide issuers with additional time to implement proposed changes that are finalized prior to the 2018 coverage year.

We seek comment on these proposals.

3. Essential Community Providers (§ 156.235)

Essential community providers (ECPs) include providers that serve predominantly low-income and medically underserved individuals, and specifically include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. Section 156.235 establishes requirements for inclusion of ECPs in QHP provider networks and provides an alternate standard for issuers that provide a majority of covered services through employed physicians or a single contracted medical group.

In conducting reviews of the ECP standard for QHP and SAPP certification for the 2018 plan year, HHS proposes to follow the approach previously finalized in the 2018 Payment Notice and outlined in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces, with two changes as outlined below. States performing plan management functions in the FFEs would be permitted to use a similar approach.

Section 156.235(2)(i) stipulates that a plan has a sufficient number and geographic distribution of ECPs if it demonstrates, among other criteria, that the network includes as participating practitioners at least a minimum percentage, as specified by HHS. For the 2014 plan year, we set this minimum percentage at 20 percent, but, starting with the 2015 Letter to Issuers in the Federally-facilitated Marketplaces, we increased the minimum percentage to 30 percent.¹⁹ For certification for the 2018 plan year we propose to return to the percentage used in the 2014 plan year, and would instead again consider the issuer to have satisfied the regulatory standard if the issuer contracts with at least 20 percent of

Available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>.

¹⁹ 2015 Letter to Issuers in the Federally-facilitated Marketplaces. Available online at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

available ECPs in each plan's service area to participate in the plan's provider network. The calculation methodology outlined in the 2018 Letter to Issuers in the Federally-facilitated Marketplaces and 2018 Payment Notice would remain unchanged.

We believe this standard will substantially lessen the regulatory burden on issuers while preserving adequate access to care provided by ECPs. In particular, we believe this proposal would result in fewer issuers needing to submit a justification to prove that they include in their provider networks a sufficient number and geographic distribution of ECPs to meet the standard in § 156.235. For the 2017 plan year, six percent of issuers were required to submit such a justification. Although none of their networks met the 30 percent ECP threshold, all of these justifications were deemed sufficient, and each network would have met the 20 percent threshold. We anticipate that issuers will readily be able to contract with at least 20 percent of ECPs in a service area.

We also propose to modify our previous guidance regarding which providers issuers may identify as ECPs within their provider networks. Under our current guidance, issuers would only be able to identify providers in their network who are included on a list of available ECPs maintained by HHS ("the HHS ECP list"). This list is based on data maintained by HHS, including provider data that HHS receives directly from providers through the ECP petition process for the 2018 plan year.²⁰ In previous years, issuers were also permitted to identify ECPs through a write-in process. Because the ECP petition process is intended to ensure qualified ECPs are included in the HHS ECP list, we indicated in guidance that we would not allow issuers to submit ECP write-ins for plan year 2018. However, we are aware that not all qualified ECPs have submitted an ECP petition, and therefore have determined the write-in process is still needed to allow issuers to identify all ECPs in their network. Therefore, as for plan year 2017, for plan year 2018, we propose that an issuer's ECP write-ins would count toward the satisfaction of the ECP standard only for the issuer that wrote in the ECP on its ECP template, provided that the issuer arranges that the written-in provider has submitted an ECP petition to HHS by no later than the deadline for issuer submission of

changes to the QHP application. For example, issuers may write in any providers that are currently eligible to participate in 340B programs that are not included on the HHS list, or not-for-profit or state-owned providers that would be entities described in section 340B but do not receive federal funding under the relevant section of law referred to in section 340B, as long as the provider has submitted a timely ECP petition. Such providers include not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act. We believe this proposal would (1) help build the HHS ECP list so that it is more inclusive of qualified ECPs; and (2) better recognize issuers for the ECPs with whom they contract.

As in previous years, if an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider networks, as presently constituted, provide an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider networks in future years. At a minimum, such narrative justification would include the number of contracts offered to ECPs for the 2018 plan year, the number of additional contracts an issuer expects to offer and the timeframe of those planned negotiations, the names of the specific ECPs to which the issuer has offered contracts that are still pending, and contingency plans for how the issuer's provider network, as currently designed, would provide adequate care to enrollees who might otherwise be cared for by relevant ECP types that are missing from the issuer's provider network.

We seek comment on these proposals.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget for review and approval. This proposed rule contains information collection requirements (ICRs) that are subject to review by OMB. A description of these provisions is given in the following paragraphs, with an estimate of the annual burden, summarized in Table 1. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995

requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this proposed rule that contain ICRs.

A. ICRs Regarding Verification of Eligibility for Special Enrollment Periods (§ 155.420)

This proposed rule proposes that, starting in June 2017, HHS would begin to implement pre-enrollment verification of eligibility for all categories of special enrollment periods for all States served by the *HealthCare.gov* platform. Currently, individuals self-attest to their eligibility for many special enrollment periods and submit supporting documentation, but enroll in coverage through the Exchanges without any pre-enrollment verification. As mentioned earlier in the preamble, we planned to implement a pilot program to conduct pre-enrollment verification for a sample of 50 percent of consumers attempting to enroll in coverage through certain special enrollment periods. Under the proposed rule, we propose to expand pre-enrollment verification to all new consumers for certain categories of special enrollment periods, so that enrollment would be delayed or "pending" until verification of eligibility is completed. Individuals would have to provide supporting documentation within 30 days. Where applicable, the FFE would make every effort to verify an individual's eligibility for the applicable special enrollment period through automated electronic means instead of through documentation. Since consumers currently provide required supporting documentation, the proposed provisions would not impose any additional burden. We seek comment on this impact.

Based on enrollment data, we estimate that HHS Eligibility Support Staff members would conduct pre-enrollment verification for an additional 650,000 individuals. Once individuals have submitted the required verification documents, we estimate that it will take a staff member approximately 12 minutes (at an hourly cost of \$40.82) to review and verify submitted verification

²⁰List available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/FINAL-CMS-ECP-LIST-PY-2018_12-16-16.xlsx.

documents. The verification process would result in an additional annual burden for the federal government of 130,000 hours with an equivalent cost of \$5,306,600. We will revise the information collection currently approved under OMB control number 0938–1207 (Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment) to account for this additional burden.

State-based Exchanges that currently do not conduct pre-enrollment verification for special enrollment periods would be encouraged to follow the same approach. States that choose to do so would change their current approach. Under 5 CFR 1320.3(c)(4), this ICR is not subject to the PRA as it would affect fewer than 10 entities in a 12-month period.

B. ICRs Regarding Network Adequacy Reviews and Essential Community Providers (§ 156.230, § 156.235)

In this proposed rule, we are proposing that, for the 2018 plan year, HHS would defer to the State’s reviews in States with authority and means to

assess issuer network adequacy; while in States without authority and means to conduct sufficient network adequacy reviews, HHS would rely on an issuer’s accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. This would reduce the burden related to the time and distance evaluation for issuers. Unaccredited issuers would be required to submit an access plan as part of the QHP Application. We are not aware of any unaccredited issuer that plans to enter the market in 2018, therefore we expect that none of the issuers will need to submit an access plan. We estimate that this would reduce the burden related to the review by 15 hours per issuer on average. The total annual reduction in burden for 450 QHP issuers and would be 6,750 hours with an equivalent reduction in cost of \$519,750 (at an hourly cost of \$77). For stand-alone dental issuers, the estimated reduction in burden would be 10 hours on average annually for each issuer. For 250 issuers, the total annual reduction in burden would be 2,500 hours with an equivalent reduction in cost of \$192,500 (at an hourly rate of \$77).

We expect to collect access plans from all stand-alone dental issuers in states without adequate review. We assume

that approximately 125 stand-alone dental issuers would need to submit access plans, and each issuer would require approximately 1 hour to prepare and submit a plan. For all 125 issuers, the total annual burden would be 125 hours, with an annual equivalent cost of \$9,625 (at an hourly rate of \$77).

The proposed change in the ECP standard would reduce the burden for issuers that previously needed to submit a justification to prove that they include in their provider networks a sufficient number and geographic distribution of ECPs to meet the standard in § 156.235. We estimate that in the absence of this change, approximately 20 QHP and stand-alone dental plan issuers would have each spent 45 minutes on average to prepare an submit a justification. The total reduction in burden for 20 issuers would be 15 hours with an equivalent reduction in cost of \$1,155 (at an hourly rate of \$77).

We will revise the information collection currently approved under OMB control number 0938–1187 (Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations) to account for this reduction in burden.

TABLE 1—ANNUAL REPORTING, RECORDKEEPING AND DISCLOSURE BURDEN

Regulation section	OMB control number	Number of respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting (\$)	Total labor cost of reporting (\$)	Total cost (\$)
Network Adequacy—Access Plan (§ 156.230)	0938–1187	125	125	1	125	77	9,625	9,625
Network Adequacy—QHP issuers (§ 156.230)	0938–1187	450	450	(15)	(6,750)	77	(519,750)	(519,750)
Network Adequacy—Stand-alone dental plan issuers (§ 156.230)	0938–1187	250	250	(10)	(2,500)	77	(192,500)	(192,500)
ECP justification (§ 156.235)	0938–1187	20	20	(0.75)	(15)	77	(1,155)	(1,155)

Note: There are no capital/maintenance costs associated with the information collection requirements contained in this rule; therefore, we have removed the associated column from Table 1.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

As noted previously in the preamble, the Exchanges have experienced a

decrease in the number of participating issuers and many States have recently seen increases in premiums. This proposed rule, which is being published as issuers develop their proposed plan benefit structures and premiums for 2018, aims to ensure market stability and issuer participation in the Exchanges for the 2018 benefit year. This proposed rule also aims to reduce the fiscal and regulatory burden on individuals, families, health insurers, patients, recipients of health care services, and purchasers of health insurance. This proposed rule seeks to lower insurance rates and ensure a dynamic and competitive market in part by preventing and curbing potential

abuses associated with special enrollment periods and gaming by individuals taking advantage of the current regulations on grace periods and termination of coverage due to the non-payment of premiums.

This proposed rule would address these issues by changing a number of requirements that HHS believes will provide needed flexibility to issuers and help stabilize the individual insurance market, allowing consumers in many State or local markets to retain or obtain health insurance while incentivizing issuers to enter, or remain, in these markets while returning autonomy to the States for a number of issues.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a proposed rule—(1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or

safety, or State, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the OMB. HHS has concluded that this rule is likely to have economic impacts of \$100 million or more in at least one year, and therefore meets the definition of “significant rule” under Executive Order 12866. Therefore, HHS has provided an assessment of the potential costs, benefits, and transfers associated with this proposed rule.

The provisions in this proposed rule aim to improve the health and stability of the Exchanges. They provide additional flexibility to issuers for plan designs, reduce regulatory burden, seek to improve the risk pool and lower premiums by reducing gaming and adverse selection and incentivize consumers to maintain continuous coverage. Issuers would experience a reduction in costs related to network

adequacy reviews. Through the reduction in financial uncertainty for issuers and increased affordability for consumers, these proposed provisions are expected to increase access to affordable health coverage. Although there is some uncertainty regarding the net effect on enrollment, premiums and total premium tax credit payments by the government, we anticipate that the provisions of this proposed rule would help further HHS’s goal of ensuring that all consumers have quality, affordable health care and that markets are stable and that Exchanges operate smoothly.

In accordance with Executive Order 12866, HHS has determined that the benefits of this regulatory action justify the costs.

C. Impact Estimates and Accounting Table

In accordance with OMB Circular A–4, Table 2 depicts an accounting statement summarizing HHS’s assessment of the benefits, costs, and transfers associated with this regulatory action.

The proposed provisions in this rule would have a number of effects, including reducing regulatory burden for issuers, reducing the impact of adverse selection, stabilizing premiums in the individual insurance market, and providing consumers with more affordable health insurance coverage. The effects in Table 2 reflect qualitative impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule.

TABLE 2—ACCOUNTING TABLE

Benefits				
Costs	Estimate (million)	Year dollar	Discount rate percent	Period covered
Annualized Monetized (\$millions/year)	(\$0.7) (\$0.7)	2016 2016	7 3	2017–2021 2017–2021

Includes costs incurred by stand-alone dental issuers for preparing access plans and costs savings to issuers due to reduction in administrative costs related to network adequacy review for QHP certification

Qualitative:

- Improved health and protection from the risk of catastrophic medical expenditures for the previously uninsured, especially individuals with medical conditions (if health insurance enrollment increases)^a
- Cost savings due to reduction in medical service provision (if health insurance enrollment decreases)^{a b}
- Cost savings to issuers from not having to process claims while enrollment is “pending” during pre-enrollment verification of eligibility for special enrollment periods
- Cost savings to the government and plans associated with the reduced open enrollment period;
- Harms to health and reduced protection from the risk of catastrophic medical expenditures for the previously uninsured, especially individuals with medical conditions (if health insurance enrollment decreases)^a
- Cost due to increases in medical service provision (if health insurance enrollment increases)^{a b}
- Decreased quality of medical services (for example, reductions in continuity of care due to lower ECP threshold)
- Administrative costs incurred by the federal government and by States that start conducting verification of special enrollment period eligibility
- Costs to issuers of redesigning plans
- Costs to the federal government and issuers of outreach activities associated with shortened open enrollment period

TABLE 2—ACCOUNTING TABLE—Continued

Transfers

Qualitative:

- Transfers, via premium reductions, from special enrollment period abusers to all other enrollees
- Transfers related to changes in actuarial value from enrollees to issuers and, via possible reductions in subsidies, from some combination of enrollees and issuers to the federal government

Notes:

^a Enrollment could increase due to decreases in premiums resulting from pass-through of administrative cost savings (as listed) and savings associated with reductions in special enrollment period abuse. Enrollment could decrease due to lessened consumer appeal of insurance with reduced actuarial value and less access to ECPs, increases in premiums resulting from pass-through of administrative costs (as listed), former special enrollment period users discontinuing participation, or due to shortened enrollment periods. The net effect on enrollment is ambiguous.

^b These cost and cost savings generalizations are somewhat oversimplified because uninsured individuals are relatively likely to obtain health care through high-cost providers (for example, visiting an emergency room for preventive services).

1. Guaranteed Availability of Coverage

The proposed regulation would allow issuers to apply a premium payment made for new coverage under the same or a different product to the outstanding debt associated with non-payment of premiums for coverage from the same issuer enrolled in within the prior 12 months. This means that issuers would be able to require a policyholder whose coverage is terminated for non-payment of premium in the individual or group market to pay all past due premium owed to that issuer after the applicable due date for coverage in the prior 12-month period in order to resume coverage from that same issuer.

Individuals with past due premium would generally owe no more than 1 to 3 months of past-due premiums. The issuer would have to apply its premium payment policy uniformly to all employers or individuals regardless of health status. This would reduce the risk of gaming and adverse selection by consumers while likely also discouraging some individuals from obtaining coverage.

A recent study²¹ surveying consumers with individual market plans concluded that approximately 21 percent of consumers stopped premium payments in 2015. Approximately 87 percent of those individuals repurchased plans in 2016, while 49 percent of these consumers purchased the same plan they had previously stopped payment on.

Based on available data, we estimate that approximately one in ten enrollees had their coverage terminated due to non-payment of premiums in 2016. We estimated that approximately 86,000 (or 16 percent) of those individuals terminated due to non-payment of premium in 2016 and living in an area where their 2016 issuer was available in 2017 had an active 2017 plan selection with the same issuer at the end of the

open enrollment period. Additionally, for those individuals living in an area where their 2016 issuer was the only issuer available in 2017, 23 percent of those individuals terminated due to non-payment in 2016 had an active 2017 plan selection this issuer at the end of the open enrollment period—equating to approximately 21,000 individuals. In the absence of data, we are unable to determine the amount of past due amounts that consumers would have to pay in order to resume coverage with the same issuer, though individuals would generally owe no more than 3 months of premiums. We are seeking comments on this impact.

2. Open Enrollment Periods

The proposed regulation proposes to amend § 155.410(e) and change the annual open enrollment period for coverage year 2018 to begin on November 1, 2017 and end on December 15, 2017. This is expected to have a positive impact on the risk pool by reducing the risk of adverse selection. However, the shortened enrollment period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period. The change in the open enrollment period could lead to additional reductions in enrollment if Exchanges and enrollment assisters do not have adequate support, which could lead to potential enrollees facing longer wait times. In addition, this change is expected to simplify operational processes for issuers and the Exchanges. However, the Federal government, State-based Exchanges, and issuers may incur costs if additional consumer outreach is needed.

We are seeking comments regarding the potential effects of the shortening of the open enrollment period on all stakeholders.

3. Special Enrollment Periods

Special enrollment periods ensure that people who lose health insurance during the year (for example, through non-voluntary loss of minimum

essential coverage provided through an employer), or who experience other qualifying events such as marriage or birth or adoption of a child, have the opportunity to enroll in new coverage or make changes to their existing coverage. While the annual open enrollment period allows previously uninsured individuals to enroll in new insurance coverage, special enrollment periods are intended to promote continuous enrollment in health insurance coverage during the plan year by allowing those who were previously enrolled in coverage to obtain new coverage without a lapse or gap in coverage.

However, allowing previously uninsured individuals to enroll in coverage via a special enrollment period that they would not otherwise qualify for can increase the risk of adverse selection, negatively impact the risk pool, contribute to gaps in coverage, and contribute to market instability and reduced issuer participation.

Currently, in many cases, individuals self-attest to their eligibility for most special enrollment periods and submit supporting documentation, but enroll in coverage through the Exchanges without further pre-enrollment verification. As mentioned earlier in the preamble, in 2016 we took several steps to further verify eligibility for special enrollment periods and planned to implement a pilot program to conduct pre-enrollment verification for a sample of 50 percent of consumers attempting to enroll in coverage through certain special enrollment periods. The provisions in this proposed rule would increase the scope of pre-enrollment verification, strengthen and streamline the parameters of several existing special enrollment periods, and limit several other special enrollment periods. Starting in June 2017, individuals attempting to enroll through certain special enrollment periods would have to undergo pre-enrollment verification of eligibility, so that their enrollment would be delayed or “pended” until verification of eligibility is completed. Where applicable, the FFE would make

²¹ 2016 OEP: Reflection on enrollment, Center for U.S. Health System Reform, McKinsey&Company, May 2016, available at <http://healthcare.mckinsey.com/2016-oep-consumer-survey-findings>.

every effort to verify an individual's eligibility for the applicable special enrollment period through automated electronic means instead of through documentation. Based on past experience, we estimate that the expansion in pre-enrollment verification to all individuals seeking to enroll in coverage through all applicable special enrollment periods would result in an additional 650,000 individuals having their enrollment delayed or "pending" annually until eligibility verification is completed. As discussed previously in the Collection of Information Requirements section there would be an increase in costs to the federal government for conducting the additional pre-enrollment verifications. State-based Exchanges that begin to conduct pre-enrollment verification would incur administrative costs to conduct those reviews. We anticipate that there would be a reduction in costs to issuers since they would not have to process any claims while the enrollments are "pending".

The proposed changes would promote continuous coverage and allow individuals who qualify for a special enrollment period to obtain coverage, while ensuring that uninsured individuals that would not qualify for a special enrollment period obtain coverage during open enrollment instead of waiting until they get sick, which is expected to protect the Exchange risk pools, enhance market stability, and in doing so, limit rate increases. On the other hand, it is possible that the additional steps required to verify eligibility might discourage some eligible individuals from obtaining coverage, and reduce access to health care for those individuals, increasing their exposure to financial risk. If it deters younger and healthier individuals from obtaining coverage, it could also worsen the risk pool.

If pre-enrollment verification causes premiums to fall and all individuals that inappropriately enrolled via special enrollment periods continue to be covered, there would be a transfer from such individuals to other consumers. On the other hand, if some individuals are no longer able to enroll via special enrollment period, they would experience reduced access to health care.

The net effect of pre-enrollment verification and other proposed changes on premiums and enrollment is uncertain. If there is a significant decrease in enrollment, especially for younger and healthier individuals, it is possible that premiums would not fall, and potentially might increase. We seek

comment on the impacts of these provisions.

4. Levels of Coverage (Actuarial Value)

In this proposed rule, we are proposing amending the de minimis range included in § 156.140(c), to a variation of $-4/+2$ percentage points, rather than $+/-2$ percentage points for all non-grandfathered individual and small group market plans that are required to comply with AV (We also propose to change the de minimis range for the expanded bronze plans from $+5/-2$ percentage points to $+5/-4$ percentage points to align with the policy in this rule) for plans beginning in 2018. While we are proposing to modify the de minimis range for the metal level plans (bronze, silver, gold, and platinum), we are not proposing to modify the de minimis range for the silver plan variations (the plans with an AV of 73, 87 and 94 percent) under §§ 156.400 and 156.420 at this time. In the short run, the impact of this proposed change would be to generate a transfer from consumers to insurers. The proposed change in AV could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks associated with high medical costs. However, in the longer run, providing issuers with additional flexibility could help stabilize premiums, increase issuer participation and ultimately provide some offsetting benefit to consumers. We estimate that the proposed change in AV could lead to up to a 1 to 2 percent reduction in premiums. This, in turn, would increase enrollment. A reduction in premiums would likely reduce the benchmark premium for purposes of the premium tax credit, leading to a transfer from credit recipients to the government. An increase in enrollment would likely result in an increase in total premium tax credit payments by the government. The net effect is uncertain. We seek comments on the impact of this proposed change.

5. Network Adequacy

Section 156.230(a)(2) requires a QHP issuer to maintain 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. In this proposed rule, we are proposing that, for the 2018 plan year, HHS would defer to the State's reviews in States with authority and means to assess issuer network adequacy; while in States without

authority and means to conduct sufficient network adequacy reviews, HHS would rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. As discussed previously in the Collection of Information Requirements section, this would reduce related administrative costs for issuers. Unaccredited issuers would be required to submit an access plan as part of the QHP Application. Reduced burden for issuers could ultimately lead to reduced premiums for consumers.

Depending on the level of review by State regulators and accrediting entities, this could have an impact on plan design. Issuers could potentially use network designs to encourage enrollment into certain plans, exacerbating selection pressures. The net effect on consumers is uncertain. We are seeking comments on the potential impacts.

6. Essential Community Providers

Section 156.235(2)(i) stipulates that a plan has a sufficient number and geographic distribution of ECPs if it demonstrates, among other criteria, that the network includes as participating practitioners at least a minimum percentage, as specified by HHS. For the 2014 plan year, this minimum percentage was 20 percent, but starting with the 2015 Letter to Issuers in the Federally-facilitated Marketplaces, we increased the minimum percentage to 30 percent. In this proposed rule, we are proposing that, for certification and recertification for the 2018 plan year, we would instead 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. In addition, we are proposing to reverse our previous guidance that we were discontinuing the write-in process for ECPs, and would continue to allow this process for the 2018 plan year. If an issuer's application does not satisfy the ECP standard, the issuer would be required to include as part of its application for QHP certification a satisfactory narrative justification describing how the issuer's provider networks, as presently constituted, provide an adequate level of service for low-income and medically underserved individuals and how the issuer plans to increase ECP participation in the issuer's provider networks in future years. We expect that issuers would be able to meet this requirement, with the exception of issuers that do not have any ECPs in their service area.

Less expansive requirements for network size would lead to both costs and cost savings. Costs could take the form of increased travel time and wait time for appointments or reductions in continuity of care for those patients whose providers have been removed from their insurance issuers' networks.

Cost savings for issuers would be associated with reductions in administrative costs of arranging contracts and, if issuers focus their networks on relatively low-cost providers to the extent possible, reductions in the cost of health care provision. In addition, fewer issuers would need to submit a justification to prove that they include in their provider networks a sufficient number and geographic distribution of ECPs to meet the standard, as discussed previously in the Collection of Information Requirements section.

We seek comments on the impacts of this proposed change.

7. Uncertainty

The net effect of these proposed provisions on enrollment, premiums and total premium tax credit payments are ambiguous. On the one hand, premiums would tend to fall if more young and healthy individuals obtain coverage, adverse selection is reduced and issuers are able to lower costs due to reduced regulatory burden, and offer greater flexibility in plan design. On the other hand, if changes such as shortened open enrollment period, pre-enrollment verification for special enrollment periods, reduced actuarial value of plans, less expansive provider networks result in lower enrollment, especially for younger, healthier adults, it would tend to increase premiums. Lower premiums in turn would increase enrollment, while higher premiums would have the opposite effect. In addition, lower premiums would tend to decrease total premium tax credit payments, which could be offset by an increase in enrollment. Increased enrollment would lead to an overall increase in healthcare spending by issuers, while a decrease in enrollment would lower it, although the effect on total healthcare spending is uncertain, since uninsured individuals are more likely to obtain health care through high cost providers such as emergency rooms.

D. Regulatory Alternatives Considered

In developing the policies contained in this proposed rule, we considered maintaining the status quo with respect to our interpretation of guaranteed availability, network adequacy requirements and essential community

provider requirements. However, we determined that the changes are urgently needed to stabilize markets, to incentivize issuers to enter or remain in the market and to ensure premium stability and consumer choice.

With respect to our proposal regarding essential community providers, we considered proposing a minimum threshold other than 20 percent, but believe that reverting to the previously used 20 percent threshold that issuers were used to would better help stabilize the markets, while adequately protecting access to ECPs.

We also considered keeping the original open enrollment period for 2018 coverage, but determined that an immediate change would have a positive impact on the risk pool by reducing the risk of adverse selection and that the market is mature enough for an immediate transition.

In addition, we considered increasing the scope of pre-enrollment verification for certain special enrollment periods to 90 percent instead of 100 percent. This would have allowed us to maximize the verification of eligibility while providing some population for claims comparison as envisioned by the scaled pilot. We are seeking comment on the issue, but believe that in order to minimize the risk of adverse selection, complete pre-enrollment verification for certain special enrollment periods is necessary. We also considered maintain the existing parameters around special enrollment periods so that the individual market special enrollment periods would continue to align with group market policies. However, HHS determined that aspects of the individual market and the unique threats of adverse selection in this market justified a departure from the group market policies.

With respect to our proposal regarding AV, we considered proposing that the change would be effective for the 2019 plan year. However, given input from stakeholders regarding the 2018 AV Calculator, we determined it was better to make the proposal effective for the 2018 plan year.

E. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601, *et seq.*) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule would not have a significant economic impact on a substantial number of small entities. The RFA generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business

Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of "small entity." HHS uses a change in revenues of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities.

This proposed rule would affect health insurance issuers. We believe that health insurance issuers would be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of \$38.5 million or less would be considered small entities for these North American Industry Classification System codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be \$32.5 million or less.²² We believe that few, if any, insurance companies underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from MLR annual report submissions for the 2015 MLR reporting year, approximately 97 out of 528 issuers of health insurance coverage nationwide had total premium revenue of \$38.5 million or less. This estimate may overstate the actual number of small health insurance companies that would be affected, since almost 74 percent of these small companies belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that would result in their revenues exceeding \$38.5 million.

F. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule that includes any Federal mandate that may result in expenditures in any 1 year by State, local, or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. Currently, that threshold is approximately \$146

²² "Table of Small Business Size Standards Matched to North American Industry Classification System Codes", effective February 26, 2016, U.S. Small Business Administration, available at <https://www.sba.gov/contracting/getting-started-contractor/make-sure-you-meet-sba-size-standards/table-small-business-size-standards>.

million. Although we have not been able to quantify all costs, we expect the combined impact on State, local, or Tribal governments and the private sector to be below the threshold.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

In HHS's view, while this proposed rule would not impose substantial direct requirement costs on State and local governments, this proposed regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. However, HHS anticipates that the Federalism implications (if any) are substantially mitigated because under the statute and our proposals, States have choices regarding the structure, governance, and operations of their Exchanges. This rule strives to increase flexibility for States-based Exchanges. For example, we recommend, but would not require, that State-based Exchanges engage in pre-enrollment verification with respect to special enrollment periods; and we would defer to State network adequacy reviews provided the States have the authority and the means to conduct network adequacy reviews. Additionally, the Affordable Care Act does not require States to establish these programs; if a State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

While developing this proposed rule, HHS has attempted to balance the States' interests in regulating health insurance issuers with the need to ensure market stability. By doing so, it is HHS's view that we have complied with the requirements of Executive Order 13132.

H. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801, *et seq.*), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller for review.

I. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, entitled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. Section 2(a) of Executive Order 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment or otherwise promulgates a new regulation. In furtherance of this requirement, section 2(c) of Executive Order 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations. OMB's interim guidance issued on February 2, 2017, explains that for Fiscal Year 2017 the above requirements only apply to each new "significant regulatory action that imposes costs." It has been determined that this proposed rule is not a "significant regulatory action that imposes costs" and thus does not trigger the above requirements of Executive Order 13771.

List of Subjects

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant administration, Grant programs—health, Health care, Health insurance, Health maintenance organizations (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Intergovernmental relations, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, Technical assistance, Women and youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, American Indian/Alaska Natives, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Individuals with disabilities, Loan programs—health, Medicaid, Organization and functions (Government agencies), Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 147, 155, and 156 as set forth below:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 1. The authority citation for part 147 continues to read as follows:

Authority: Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 2. Section 147.104 is amended by revising paragraph (b)(2)(i) introductory text to read as follows:

§ 147.104 Guaranteed availability of coverage.

* * * * *

(b) * * *

(2) * * *

(i) Subject to § 155.420(a)(4) and (5) of this subchapter, a health insurance issuer in the individual market must provide a limited open enrollment period for the triggering events described in § 155.420(d) of this subchapter, excluding the following:

* * * * *

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 3. The authority citation for part 155 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083).

■ 4. Section 155.410 is amended by revising paragraphs (e)(2) and (3) to read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * * *

(e) * * *

(2) For the benefit years beginning on January 1, 2016 and January 1, 2017, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

(3) For the benefit years beginning on January 1, 2018 and beyond, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.

* * * * *

■ 5. Section 155.420 is amended by:

■ a. Adding paragraphs (a)(3) through (5);

■ b. Revising paragraphs (b)(5) and (d) introductory text;

■ c. Adding paragraph (d)(2)(i)(A) and reserved paragraph (d)(2)(i)(B); and

■ d. Removing and reserving paragraph (d)(7)(ii).

The additions and revisions read as follows:

§ 155.420 Special enrollment periods.

(a) * * *

(3) Use of special enrollment periods by qualified individuals. The Exchange must allow a qualified individual, and when specified in paragraph (d) of this section, his or her dependent, who are not enrolled in a QHP through the Exchange, to enroll in a QHP if one of the triggering events specified in paragraph (d) of this section occur.

(4) Use of special enrollment periods by enrollees. (i) If an enrollee has gained a dependent in accordance with paragraph (d)(2)(i) of this section, the Exchange must allow the enrollee to add the dependent to his or her current QHP, or, if the QHP's business rules do not allow the dependent to enroll, the Exchange must allow the enrollee and his or her dependents to change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in § 156.140(b) of this subchapter, or enroll the dependent in a separate QHP.

(ii) If an enrollee and his or her dependents become newly eligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) and are not enrolled in a silver-level QHP, the Exchange must allow the enrollee and his or her dependents to change to a silver-level QHP if they elect to change their QHP enrollment.

(iii) If an enrollee qualifies for a special enrollment period through another triggering event specified in paragraph (d) of this section, except for

paragraph (d)(4), (d)(8), (d)(9), and (d)(10), the Exchange must allow the enrollee and his or her dependents to make changes to their enrollment in the same QHP or to change to another QHP within the same level of coverage, as outlined in § 156.140(b) of this subchapter, provided that other QHPs at that metal level are available.

(5) Prior coverage requirement. Qualified individuals who are required to demonstrate coverage in the 60 days prior to a qualifying event can either demonstrate that they had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of the qualifying event or that they lived outside of the United States or in a United States territory for 1 or more days during the 60 days preceding the date of the qualifying event.

(b) * * *

(5) Option for later coverage effective dates due to prolonged eligibility verification. At the option of the consumer, the Exchange must provide for a coverage effective date that is no more than 1 month later than the effective date specified in this paragraph (b) if a consumer's enrollment is delayed until after the verification of the consumer's eligibility for a special enrollment period, and the assignment of a coverage effective date consistent with this paragraph (b) would result in the consumer being required to pay 2 or more months of retroactive premium to effectuate coverage or avoid termination for non-payment.

* * * * *

(d) Triggering events. Subject to paragraphs (a)(3) through (5) of this section, the Exchange must allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from QHP to another if one of the triggering events occur:

* * * * *

(2) * * *

(i) * * *

(A) In the case of marriage, at least one spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.

(B) [Reserved]

* * * * *

■ 6. Section 155.725 is amended by revising paragraph (j)(2)(i) to read as follows:

§ 155.725 Enrollment periods under SHOP.

* * * * *

(j) * * *

(2) * * *

(i) Notwithstanding § 155.420(a)(3) through (5) of this subchapter, experiences an event described in § 155.420(d)(1) (other than paragraph (d)(1)(ii)), or experiences an event described in § 155.420(d)(2), (4), (5), (7), (8), (9), (10), (11), or (12);

* * * * *

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 6. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1313, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

■ 7. Section 156.140 is amended by revising paragraph (c) to read as follows:

§ 156.140 Levels of coverage.

* * * * *

(c) De minimis variation. The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is – 4 percentage points and + 2 percentage points, except if a health plan under paragraph (b)(1) of this section (a bronze health plan) either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is – 4 percentage points and +5 percentage points.

Dated: February 9, 2017.

Patrick Conway,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: February 9, 2017.

Norris Cochran,

Acting Secretary, Department of Health and Human Services.

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 10–90; Report No. 3070]

Petition for Reconsideration of Action in Rulemaking Proceeding

AGENCY: Federal Communications Commission.