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REFORM Update

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The Centers for Medicare and Medicaid Services (CMS) recently released interim final rules that make several changes to the operations of the Marketplaces (also called Exchanges). Due to issues with the Healthcare.gov website, the federal Marketplace has gotten off to a very rocky start. These new rules are specifically designed to address the unexpected barriers to enrollment in Qualified Health Plans (QHPs) in the Marketplace. Many of the changes give people more time to select coverage.

These new rules, effective on December 15, 2013, change the following with regard to Marketplace operations:

- QHPs must ensure a January 1, 2014 effective date for plan selections received on or before December 23, 2013 (previously, the date was December 15, 2013):
  - Applies to all plans sold within the Marketplace (small group, individual and stand-alone dental plans).
  - Applies only to the federally-run Marketplace. State-run Marketplaces have the option to extend the enrollment date, but are not required to do so.
  - Does **not** apply to individual or group coverage purchased outside the Marketplace.
  - The Small Business Health Options Program (SHOP) offers coverage to small employers in the Marketplace. Small employers are defined by the state. In 2014 and 2015, it can be defined as fewer than 50 or fewer than 100 employees. In 2016, all states will define small employers as fewer than 100 employees. For SHOP plans elected in the small group market, enrollment forms for all employees electing coverage must be provided by December 23, 2013.
- QHPs would provide a February 1, 2014 effective date for plan selections made between December 24, 2013 and January 15, 2014. Enrollment dates after January 15 will follow the effective date designated in the Marketplace regulations. A plan selection made during the first 15 days of the month will be effective on the first of the following month. If the selection is made between the 16th and the end of the month, then coverage is effective as of the first day of the next following month. (For example, a plan selection made between January 16, 2014 and January 31, 2014 will be effective on March 1, 2014.)
- Marketplaces have the option to allow a coverage effective date of January 1, 2014 for individuals making plan selections between December 24, 2013 and January 31, 2014. QHPs in the Marketplace must be willing to offer retroactive coverage effective dates. This applies to both federally-run and state-run Marketplaces. Although it is optional, CMS is strongly encouraging QHPs to allow retroactive effective dates because of the difficulty in enrolling during October and November 2013.
- For the initial enrollment period (October 1, 2013 – March 31, 2014), the regulations had required premiums to be paid as of the coverage effective date in the federally-run Marketplace. The new regulations permit greater flexibility. QHPs in the federally-run Marketplace may accept premium payments after January 1, 2014 for coverage retroactive to January 1, 2014. State-run Marketplaces have the ability to set their own payment rules. More guidance is expected in the future to clarify the payment policies applicable to the federally-run Marketplace.

Additional policies are suggested in this guidance to ease the transition from other coverage options to the new QHPs. The issues addressed in this guidance include network changes, episodes of treatment and prescription drug coverage variation. The policies outlined below are optional to QHPs.

- **Network changes:** If a QHP offers a network, members will usually choose a plan based on whether the network includes their health care providers. The government has found that many QHPs have evolving networks, with some networks having outdated information online. After enrolling in a plan, members may discover that their health care providers are actually not in the QHP's network. If they want to continue using their health care providers, their claims will be treated as out-of-network. CMS is recommending that QHPs make current provider directories available online. If a QHP is unable to keep their online directory current, CMS recommends accommodations for members. If a provider was listed in the directory as of the date the member enrolled for coverage, then the QHP should process claims for that provider in-network for the first few months of coverage, even if the provider is actually outside the network.
- **Episodes of treatment:** Whenever a member enrolls in a new health plan, there is a chance the providers used will not be in the new network. For members in the course of medical treatment, these network disruptions can interrupt treatment in progress. For acute episodes of care, this could affect a patient's health. CMS is encouraging QHPs to make allowances to prevent disruption in a member's care for an acute condition. This may involve treating providers as in-network until treatment is complete or can be transferred to a participating provider. CMS anticipates addressing treatment in progress in the future regulations.
- **Prescription drugs:** The latest guidance also addresses how various QHPs will have different formularies and medical management programs for prescription drug coverage. New enrollees in a QHP may find that drugs they have taken for years are not covered, or they must satisfy new protocols before their medication will be approved. Enrollees may be unfamiliar with a new plan's formulary and medical management programs. To ease the transition, CMS is urging QHPs to cover non-formulary drugs as formulary drugs for the first 30 days of coverage following January 1, 2014. In addition, if a medication requires prior authorization or step therapy, CMS urges coverage for that drug as well, even if the medical management protocols have not been met. CMS suggests this approach because it will allow members to have initial fills of their regular prescriptions. Members would then have 30 days to discuss changing medications if their current prescriptions are not on the formulary. The 30 days will also allow members to meet any medical management requirements.

Again, QHPs are not required to adopt these policies, but the federal government strongly recommends them as a way to ease the transition into new QHPs.

The purpose of these changes and recommendations for Marketplace operations is to address the unexpected issues that arose when the Healthcare.gov website opened for enrollment on October 1, 2013. Because the federally-run Marketplace was essentially inoperable during October and November, some changes were needed to provide potential enrollees with sufficient time to make coverage elections.