Regulatory Steps to Try to Stabilize the Individual Market			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**
Cost Sharing Reductions	Cost Sharing Reductions (CSR) are built into the plans that issuers sell and must be covered by carriers regardless of whether the federal government off-sets the cost as the law intended by paying them CSRs for low-income individuals up to 250 % of FPL • CSRs must continue through the transition: State markets and insurance policies have been operating under existing policies that enroll exchange consumers into plans that have the CSR subsidies. With the change in Administration and court challenge, the CSRs must continue to be fulfilled either through appropriation or executive action at least through the transition to avoid massive destabilizing changes.	1. Allow cost-sharing reductions to continue and make contracted reimbursement to health insurers to avoid disruption in coverage for millions of Americans.	1. Release sub-regulatory guidance assuring issuers that they will continue to receive contracted CSR reimbursement in 2017, and issue guidance explaining how CSRs will be funded for any transition period. Recall December 16, 2016 guidance on transferring accumulated cost-sharing when an enrollee switches CSR plans during a benefit year.
Transitional Reinsurance Payments	• Reinsurance receivables must be paid: State markets have also been operating under existing rules that incorporated reinsurance dollars into 2016 pricing. Those liabilities must be paid in 2017 to avoid disruption.		Issue Executive Order or sub-regulatory guidance stating that the scheduled $4 billion payments in reinsurance will be made to issuers for 2016 in the Spring of 2017. See Preamble to the Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30240, 30258 (May 27, 2014) (providing that CMS "will not allocate reinsurance collections to administrative expenses or the U.S. Treasury until the reinsurance payment pool for a benefit year is funded. Thus, if our reinsurance collections fall short of our estimates for a particular benefit year, we will allocate reinsurance contributions collected first to the reinsurance payment pool, with any remaining amounts being then allocated to administrative expenses and the U.S. Treasury, on a pro rata basis.") See also CMS, Summary Report on RI Payments and RA Transfers for the 2015 Benefit Year, June 30, 2016.

Regulatory Steps to Help Stabilize the Individual Market			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**
Special Enrollment Periods (SEPs)	Individuals are improperly and inappropriately enrolling in exchange coverage only when, and for the length of time that, they need health care services instead of during open enrollment. This is happening because eligibility for using the Special Enrollment Periods is not being confirmed prior to enrollment. This activity is driving up premiums for all consumers and placing the market on an unsustainable path.	1. Current regulations should be modified to limit the number of categories of SEPs. 2. Additional regulations should be issued to provide for pre-enrollment verification of SEP eligibility. 3. Regulation can also help advance the Republican principle of continuous coverage by eliminating the option of enrolling in an SEP unless the individual has continuous coverage.	1. Modify Regulation 45 CFR 155.420 to limit SEP enrollment to the following categories: • Loss of minimum essential coverage; • Gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or due to a child support or other court order. • Losing a dependent or losing dependent status through divorce, legal separation or death. 2. Remove the following SEP provisions 45 CFR §§ • 155.420(d)(9) [exceptional circumstances] • 155.420(d)(12) [material error caused enrollment] • 155.420(d)(13) [verified eligibility late] • Make conforming changes to 45 CFR. § 147.104. 3. Issue a new regulation providing that as soon as possible CMS will ultimately verify eligibility for all categories of SEPs prior to enrollment. • Add language to 45 CFR § 155.420(d) to require both state and federal exchanges to verify SEP eligibility before enrollment. • Expand the Pre-Enrollment Verification for Special Enrollment Periods pilot program to verify all new enrollees, and extend the program to state exchanges. *See* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Pre-Enrollment-SEP-fact-sheet-FINAL.PDF (December 12, 2016). 4. To the extent that it takes CMS time to set up this verification process, in the meantime, issue subregulatory guidance and implement necessary operational changes to allow issuers the option to verify eligibility for an SEP. • Issue subregulatory guidance.

Regulatory Steps to Help Stabilize the Individual Market			
Problem	**Background (CONTINUED)**	**Necessary Steps (CONTINUED)**	**Regulatory Changes (CONTINUED)**
Special Enrollment Periods (SEPs) (CONTINUED)	Individuals are improperly and inappropriately enrolling in exchange coverage only when, and for the length of time that, they need health care services instead of during open enrollment. This is happening because eligibility for using the Special Enrollment Periods is not being confirmed prior to enrollment. This activity is driving up premiums for all consumers and placing the market on an unsustainable path.		4. Modify Regulation 45 CFR 155.420 (d) to prohibit SEP enrollment if an individual cannot demonstrate continuous coverage through documentation. (Except newborns, adoption/ foster care/ court order, domestic violence, individuals wrongly determined Medicaid or CHIP eligible, and citizenship). Dependents added through marriage would be able to join the existing policy of a spouse but not granted an SEP for other coverage. 5. Amend 45 CFR 155.420(d)(2), but allow existing enrollees to change from self-only to family coverage at the same metal level. 6. Amend regulations to ensure birth allows only new dependents to gain coverage. Currently, for example, parents and siblings of a new baby are permitted to enroll or change coverage during a birth SEP. 6. Amend regulations to reduce the length of SEPs from 60 to 30 days and limit the window for applicants to access SEPs prior to certain life events. • Amend 45 CFR 155.420(c) to reduce the length of SEPs from 60 to 30 days. • Amend 45 CRF 155.420(c)(2) to limit the window of availability to either 30 days before or 30 days after the triggering event, at the option of the consumer. 7. Amend regulations to prohibit consumer choice of sliding SEP effective dates based on their need for medical services. • Remove 45 CFR 155.420(b)(5), which was finalized in the 2018 NBPP.

Regulatory Steps to Help Stabilize the Individual Market			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**
Inappropriate Steerage from Public Programs to Exchanges	Individuals who are eligible for and should be enrolled in Medicare and/or Medicaid are being enrolled with financial assistance from third party entities into the individual market in order to improve reimbursements for services rendered. Limiting these payments is critical to the stability of the individual market. This practice is also harming individuals who may not be adequately informed of the consequences of enrolling in these programs in lieu of publicly subsidized programs.	1. Regulations should be revised to prohibit third parties with financial interests, such as providers and groups receiving funding from providers, from steering individuals who are eligible for Medicaid and Medicare into exchange coverage. 2. Allow insurers to ensure Medicare-eligible beneficiaries are enrolled in Medicare.	1. Revise Regulation 45 CFR 156.1250 to: • Prohibit third parties with financial interests, such as providers and groups receiving funding from providers, from steering individuals who are eligible for Medicaid and Medicare into exchange coverage. • Clarify that health plans may deny any third-party payments that are outside federal requirements and that these requirements supersede any state guidance to the contrary. • Require that third-party organizations that are making premium or cost sharing payments on behalf of individual market enrollees to report certain information related to those payments to CMS and attest that they meet the requirements as specified by CMS guidance and FAQs. 2. Additionally, revise Regulation Sections 45 CFR 147.106(h)(2) and 45 CFR 148.122(b)(2) to clarify that issuers may non-renew coverage for those individuals enrolled in or eligible for Medicare. • Amend regulations at 45 CFR §§ 147.106 and 147.104 with respect to Medicare eligible individuals to limit guaranteed renewability and guaranteed availability to only members that can demonstrate denied eligibility for Medicare under 42 CFR 406.20, and those eligible for ESRD programs but in a waiting period. • Amend regulations at 45 CFR 155.305 to provide explicitly that non-eligibility for Medicare and non-enrollment in Medicare are eligibility requirements for enrollment in a QHP though Exchange.

Regulatory Steps to Help Stabilize the Individual Market			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**

Nonpayment of Premium	Prior to the ACA, state laws determined how long individuals were permitted to have a "grace period" to pay premiums before coverage is cancelled. The ACA created a problematic federal 90-day grace period for subsidized enrollees which individuals are manipulating to take advantage of the rules. Individuals in many instances are not paying premiums for 90 days and are still accessing/obtaining covered services because insurers cannot hold/pend claims from being paid ("pend") in case the consumer never pays.
	
	Additionally, regulations allow consumers to stop paying towards the end of the year with no consequence because issuers are not allowed to use consumer payments for the next year's coverage to first satisfy prior debts.
		1. There are incremental regulations that can help mitigate the enrollment gaming:
		
		• Require individuals with outstanding premiums with a given issuer to pay their balance before reenrolling.
		
		• Not obligate plans to pay for claims in a new coverage year if the consumer has not paid January premiums.
		
		• Provide issuers greater flexibility in setting minimum premium payment policies, including tolerances and thresholds.
			1. Issue a regulation stating the Administration, during the transition period, will not be enforcing Section 2708 of the Public Health Service Act. This would effectively defer to states on how to handle the grace period.
			
			2. If a full non-enforcement approach is not possible, modify Regulation 45 CFR 155.400 as follows:
			
			• Amend regulations so issuers are not required to pay claims during the 3 months of the ACA grace period.
			  ○ In 45 CFR § 156.270 to remove (d)(1), requiring QHP issuers to pay claims for services during the first month of the 3-month grace period.
			
			• Require individuals with outstanding premiums with a given issuer to pay their balance before reenrolling.
			  ○ Amend 45 CFR § 147.104 to provide an exception to guaranteed availability for individuals that owe outstanding premiums with an issuer.
			  ○ Revise the 2016 FFM and SHOP Enrollment Manual, which supersedes Revised Bulletin 10 and Bulletin 16, to provide that QHP issuers may apply newly received premium to past due amounts.
			
			• Do not obligate plans to pay for claims in a new coverage year if the consumer has not paid January premiums.
			
			• Allow issuers to establish minimum premium payment policies, including tolerances and thresholds.

Regulatory Steps to Help Stabilize the Individual Market			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**
Transition Plans (Grandmothered/ Grandfathered Plans)	Over 1 million individuals in many states are still in "grandfathered" and "grandmothered" plans that allowed individuals and groups to keep many of the pre-ACA benefits and rules. Allowing these individuals to keep these plans, some of which expire at the end of 2017, will help maintain stability for those individuals.	1. Immediately extend the transition plans for "grandmothered" coverage. 2. Allow more flexibility to issuers to make necessary changes to pre-ACA plans while maintaining "grandfathered" status.	1. Issue guidance to extend indefinitely the transition plans for grandmothered coverage provided for under the transitional policy implemented by CMS in 2013, which was extended in 2014, and most recently in a CMS Bulletin published on February 29, 2016. 2. Modify Regulation Section 45 CFR Parts 144, 146 and 147 to allow more flexibility to issuers to make necessary changes to pre-ACA plans while maintaining "grandfathered" status.
Health Insurance Tax (HIT)	The health insurance tax is driving up premiums substantially and regulatory interpretation states that funds collected by carriers to pay the tax constitute income. This exacerbates the extent to which the cost is passed onto individuals.	1. A regulatory non-enforcement approach could be taken. 2. Reinterpret the treatment of funds collected solely to pay the tax to be excluded from income.	1. Issue a regulation stating the Administration, during the transition period, will not be enforcing Section 9010 of the ACA. This would effectively eliminate the HIT until legislation is enacted that repeals the tax. 2. If a full non-enforcement approach is not possible, modify Regulation 26 CFR Part 57 to allow for-profit insurers to deduct HIT payments for federal income tax purposes. 3. Modify regulations on the treatment of funds collected to pay the tax.
Limits on Deductibility of Remuneration	Generally, employers may deduct the remuneration paid to employees as "ordinary and necessary" business expenses. The ACA added a limitation for certain health insurance providers that exceed $500,000 paid to an officer, director or employee, creating an unlevel playing field.	1. A regulatory non-enforcement approach could be taken.	1. Issue a regulation stating the Administration, during the transition period, will not be enforcing paragraph (6) of Section 162(m) of the Internal Revenue Code of 1986, as created by the ACA. This would effectively eliminate the nondeductibility of remuneration provision until legislation is enacted that repeals the provision.
3.5% Federal Exchange User Fee	The federal exchange user fee could be eliminated to lower premium costs in 2018 and beyond.	Regulations should be modified to lower or eliminate the federal exchange user fee.	Delete Regulation 45 CFR 156.50(c) to eliminate the user fee. • Modify the user fee amount of 3.5% for the federal exchange, as provided in 2018 Notice of Benefit & Payment Parameters Final Rule. 81 Fed. Reg. 94058, 94138 (Dec. 22, 2016). Alternatively, issue new subregulatory guidance reducing the user fee from 3.5% to a lower amount.

Provide Immediate Relief Via Regulatory Changes to Employers			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**
Summary of Benefits and Coverage (SBC)	Plans and Self-insured employers have had to use federal templates, instructions, examples and page limits to describe coverage options. These SBCs have been costly, cumbersome and confusing to employers and individuals alike.	Allow issuers and employers to provide summaries as prior to the ACA.	• Eliminate the SBC content requirements at 45 CFR §§ 147.140(a)(2) and 147.200, the distribution requirements for employers and issuers at 45 CFR 147.200, as well as the corresponding SBC templates, instructions, and coverage examples. *Available at*: https://www.cms.gov/cciio/resources/Forms-Reports-and-Other-Resources/index.html#Summary of Benefits and Coverage and Uniform GlossaryAmend 45 CFR § 147.106(f)(1) and (2) to remove the requirement that notice be provided "in a form and manner specified by the Secretary." • Modify the subregulatory guidance to remove specific language for notices. Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Updated-Federal-Standard-Renewal-and-Product-Discontinuation-Notices-508.pdf.
Mandated Embedded Maximum Out of Pocket Limits	Plans and employers are required to imbed the individual maximum out of pocket limit to individuals who have coverage under non-individual plans. This means that plans and employers must pay 100% of costs at a lower threshold which will force plans and employers to increase premiums.	Guidance can modify the sub-regulatory language issued that previously interpreted this embedded limit requirement.	Modify language in the Preamble of 80 FR 10749 and related subregulatory guidance to eliminate the requirement that an individual MOOP apply to persons enrolled under a family plan, (i.e., embedded MOOP). • Rescind FAQs about Affordable Care Act Implementation, Part XXVII, Qs 1 and 2, and discussion preceding those FAQs.
Cadillac Tax	Beginning in 1/1/18, the ACA's Cadillac tax requires self-insured employers and issuers to pay a 40% excise tax on the amount that a high-cost health plan that exceeds $10,200 for self-only coverage or $27,500 for other than self-only coverage.	Issue an immediate non-enforcement policy.	Given that the 2014 employer mandate was delayed in July of 2013 because reporting requirements regulations were not final, the Trump administration should delay the 2018 Cadillac tax since no proposed rule has been issued to date and the agencies that will be promulgating the rules are still staffing up. President Obama signed into law a two-year delay of the Cadillac Tax on December 18, 2015 as part of the Consolidated Appropriations Act, 2016.

Provide Immediate Relief Via Regulatory Changes to Employers			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**
Non-Discrimination Notice Requirements Section 1557	Regulations interpreting and implementing the ACA's Section 1557 are exceedingly burdensome and prescriptive. Required notices and taglines that are not included in the statute but detailed in FAQs and subregulatory guidance are costly, confusing and counter-productive.	Modify and pull back FAQs that are problematic and reissue clarifying bulletins	Modify subregulatory guidance to reduce the volume of notices and taglines issuers send consumers under Section 1557. • Modify HHS OCR Section 1557 FAQs #22, 23, 24 and 26 to limit what is considered a "significant" publication or communication and to increase the number of publications and communications that are considered "small-sized." • Eliminate HHS OCR Section 1557 FAQs #29, 57, and 58 to allow the use of gender-coding to ensure a gender-mismatch for gender-specific medical services is flagged and reviewed. **Issue new subregulatory guidance** to clarify Section 1557 criteria do not apply to EHBs, third-party premium payments, HIPAA-excepted benefits • Issue a FAQ or bulletin clarifying that issuers that follow CMS's third-party premium payment regulations (45 CFR § 156.1250) are not violating section 1557 and its implementing regulations. • Issue a FAQ or bulletin clarifying that issuers that follow CMS's requirements for offering EHBs (45 CFR §§ 156.115, 156.122, 156.125) are not violating section 1557 and its implementing regulations. • Do not enforce the Preamble language in the 1557 final rule stating that HIPAA-excepted benefits are not exempt from the ACA section 1557 requirements. 81 Fed. Reg. 31375, 31383 and 31430 (May 18, 2016). **Amend regulations** to reduce scope of requirements so they only apply to the specific programs that actually receive federal funds from HHS and not the entire operations of an entity. • Amend 92.301 to require administrative exhaustion for all discrimination claims raised under section 1557 before a private right of action may be taken. • Revise the Preamble of the final rule to indicate that an original denial of services, as the result of a gender-mismatch within a claims processing system, for transgender individuals is not discriminatory.

Provide Immediate Relief Via Regulatory Changes to Employers			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**
Health Reimbursement Arrangements	After the ACA was enacted, Treasury interpreted stand-alone HRAs to be in violation of insurance reform rules that applied generally to group health plans. Compromise legislation was enacted as part of 21st Century Cures in the Fall of 2016 to permit employers that are not "applicable large employers" to offer HRAs in some instances. However, these instances are unnecessarily prescriptive.	Reinterpret stand-alone Health Reimbursement Arrangements to be a financing mechanism and not a group health plan for purposes of being subjected to insurance reform rules	Repeal the FAQs and Technical Releases and notices issued by treasury, HHS and Labor: • DOL, HHS and Treasury on January 24, 2013 issued Frequently Asked Questions (FAQs) Part XI • DOL and IRS on September 13, 2013 issued Technical Release No. 2013-03 and Notice 2013-54 respectively • HHS on September 16, 2013 issued guidance • DOL on November 6, 2014 issued FAQs Part XXII • IRS on February 18, 2015 issued Notice 2015-17 to provide transitional relief • IRS on March 4, 2016 issued FAQs reiterating the penalty. Issue non-enforcement guidance indicating that these prior FAQs and Notices are inconsistent with the statute.

Return Authority for Regulating Insurance to the States			
Problem	**Background**	**Necessary Steps**	**Regulatory Changes**
Network Adequacy	States are in the best position to determine and enforce criteria for what constitutes an adequate network.	Regulations, finalized by April 2017, should return authority to the states to: • Determine and enforce network adequacy.	1. Modify Regulations 45 CFR Parts 147, 154, and 156 to return to states the authority to: • Determine and enforce network adequacy
Benefit Design & Rate Review	Reviewing individual and small group market rates and benefit design had long been the purview of states prior to the ACA. The ACA regulations essentially micro-manage states and create duplicative regulation.	Regulations, finalized by April 2017, should return authority to the states to: • Review individual and small group market rates; • Review benefit design;	1. Modify Regulations 45 CFR Parts 147, 154, and 156 to return to states the authority to: • Review individual and small group market rates • Review benefit design Modify Regulation 45 CFR 156.1120 to eliminate individual STARS rating.