Insight

HHS Hits the Brakes on ACA Death Spiral

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Yesterday, the Department of Health and Human Services (HHS) issued a proposed rule designed to lay the groundwork for stabilizing the individual and small group health insurance markets. We are now in the midst of the fourth plan year since the Affordable Care Act's (ACA) Exchanges began operating, and the markets continue to struggle to provide affordable health care options to all. Exchange enrollment continues to be well-below original projections, and the demographic mix of enrollees is older and sicker than necessary to achieve a well-balanced risk pool. These realities necessitated a surge in premiums of 25 percent, on average, over last year, and many health insurers have left the market leaving consumers with few options. Five states and one-third of counties only have one insurer from which to choose a plan on the Exchange this year.[1] Deductibles have become so unaffordable for many that they are choosing to forgo care. The percentage of Exchange plans that now have provider networks classified as "narrow" has reached 41 percent. The changes in this rule are not drastic, nor will they be sufficient to solve all of the problems currently plaguing the individual market, but they are common sense solutions that will begin the process of stabilizing the market until legislative changes can be made.

Special Enrollment Periods: Pre-Enrollment Verification

Last year, the Obama Administration, in recognition of the abuse—and associated cost—of Special Enrollment Period allowances, finalized plans to implement a pilot program beginning in June 2017. The program would randomly select 50 percent of individuals attempting to enroll through an SEP and require these individuals to verify their eligibility for use of an SEP before coverage was effectuated. This pre-enrollment verification would require submission of documentation proving the individual has indeed experienced a qualifying life event, and coverage would be retroactive to the date of application and plan selection upon eligibility verification. An eligible individual would still be able to go to the

doctor in the interim as services would be retroactively covered by the insurer. This new rule would simply expand this requirement to all individuals attempting to enroll through the healthcare.gov website outside of the open enrollment period. Consumers will have 30 days to provide the necessary documentation. Individuals whose coverage is terminated due to a failure to pay premiums would not be eligible to use the loss of coverage SEP allowance. This policy change protects eligible individuals while also protecting insurers, taxpayers, and other enrolled individuals from the cost of fraud and abuse which appears in the form of increased premium and subsidy costs.

Guaranteed Renewability

HHS is clarifying rules regarding guaranteed renewability and grace period provisions such that an insurer may require an individual attempting to reenroll in a health plan after failing to pay all premiums the previous year to first pay those debts before effectuating enrollment. Under the ACA, individuals are provided a 90-day grace period during which they may remain enrolled in coverage despite not paying their premiums. Additionally, insurers are required to renew coverage for individuals. Some people have figured out that they could get a year's worth of coverage, while only paying for nine months, and reenroll the next year without penalty. This rule would attempt to put an end to this abuse by allowing insurers to require individuals to first pay any unpaid premiums from the previous 12 months before coverage was renewed for the next year.

Actuarial Value

The ACA requires plans to meet certain actuarial value (AV) requirements, placing them into different metal levels based on their AV. Silver plans, the most popular plans, must have an actuarial value of 70 percent, meaning an enrollee, on average, will be responsible for 30 percent of his or her health care costs. Currently, plans are allowed a de minimis variation from this requirement by up to two percent in either direction, and this rule would allow them to vary their AV by an additional to percent below the threshold.

Network Adequacy

Prior to the ACA, states were largely responsible for regulating their own insurance markets. Under this rule, states would regain much of their authority to regulate network adequacy. In addition, insurers would be required to contract with only 20 percent of the area's Essential Community Providers, as opposed to the current 30 percent threshold.

Open Enrollment Period

The Open Enrollment Period will be cut in half this year for the 2018 plan year, from

November 1 to December 15, as opposed to the previous periods which have extended to January 31. This rollback was scheduled to take effect beginning in 2019, so this change is being implemented one year earlier.

Policies to Encourage Continuous Coverage

Additional efforts being considered to protect against adverse selection include provisions to encourage individuals to remain continuously insured. The administration is considering imposing a requirement that individuals attempting to enroll during an SEP would have to prove that they were insured in the previous year, with allowances for small gaps in coverage of as much as 60 days. If an individual was unable to prove prior coverage, one option under consideration would allow them to enroll but face a 90-day waiting period or pay a penalty. These continuous coverage provisions are similar to provisions required in the large group market under the Health Insurance Portability and Accountability Act (HIPAA). While these provisions are not expected to be included in the final rule, the administration is seeking comments on these proposals and may issue subsequent guidance in the future.

The administration plans to release a revised plan certification timeline shortly to provide insurers with additional time to adjust their plans to these new common sense rules. These changes are badly needed—as evidenced by Humana's announcement two days ago that it will completely exit the Exchanges, potentially leaving 50,000 individuals without any insurance option next year. However, while this is a great first step, only so much can be done regulatorily. More will need to be done on a legislative front to truly mitigate the current problems and provide a stable individual insurance market. Congress must act and provide relief to insurers and individuals in the form of certainty.

[1] http://kff.org/health-reform/issue-brief/preliminary-data-on-insurer-exits-and-entrants-in-2017-affordable-care-act-marketplaces/