Issue Brief

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Patient Protection and Affordable Care Act; Market Stabilization

The U.S. Department of Health & Human Services has issued a proposed rule "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."

The rule is scheduled for publication in the February 17 *Federal Register.*

The rule provides an unusual short comment period ending March 7. Most comment periods extend for at least 30, if not 60, days.

CHANGES

First, HHS proposes "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."

HHS anticipates 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 15 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

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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 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."

HHS proposes "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."

NETWORK ADEQUACY (§156.230)

For the 2018 plan year, HHS proposes 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 or federally-facilitated exchange, and regardless of whether the state performs plan management functions.

HHS is also proposing a change to its approach to reviewing network adequacy in states that do not have the authority and means to conduct sufficient network adequacy reviews. In those states, HHS would, for the 2018 plan year, apply a standard similar to the one used in the 2014 plan year.

ESSENTIAL COMMUNITY PROVIDERS (§156.235)

Essential community providers 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.

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

For certification for the 2018 plan year HHS proposes 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 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.

HHS also proposes to modify its previous guidance regarding which providers issuers may identify as ECPs within

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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.

COMMENT

The issues involving the so-called repeal and replacement of the ACA have grown tremendously. While the president and many in congress would like this to occur quickly, the realities and complexities of the issues are enormous and a quick solution does not appear imminent.

Perhaps this proposed suggests the difficulty being encountered by the congress and administration to undo the ACA.

From the provider perspective so much is at stake. For example, will congress reverse, undo, all the payment reductions mandated by the ACA. Of special significance is the Medicare Disproportionate Share reductions. What happens if many millions lose current coverage and become uninsured? The DSH formula could add billions back to overall Medicare outlays.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting