Affordable Care Act - From Repeal and Replace to Regulatory Reform?

Peter J. Martin, Esq.

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Health care providers who have grown used to a new landscape shaped by the increased availability of health insurance coverage for their patients, made possible by Massachusetts health reform efforts and the federal Affordable Care Act, are understandably nervous about how to keep their footing in the shifting sands of the Trump administration. Will the rules be radically changed in the near future? A recently proposed set of federal rules suggests otherwise. These rules (which may be revised after the end of the public comment period on March 7, 2017) tweak various aspects of the ACA with an eye toward stabilizing the individual and small group health insurance markets in the near term. The question is, will marginal changes such as these remain grafted on to an enduring ACA structure and, in effect, replace the "repeal and replace" approach advocated by the Trump administration and others?

The proposed rules address two large and related issues facing the ACA marketplaces – the threat of adverse selection and upward pressures on health insurance premiums. Encouraging younger, healthier individuals to enroll in health plans is critical to maintaining risk pools that can also accommodate those who are older, sicker or have chronic conditions. Increasing the flexibility of health plan design is considered by some to be an important tool in restraining premium and patient cost-sharing increases. The proposed rules take small steps toward both goals.

One means by which the ACA seeks to reduce adverse selection is through guaranteed availability of health insurance policies. In practice, this means that every individual and employer who applies for coverage must be accepted unless an exception applies. If an individual applies for one insurance plan and is terminated for failure to pay the premium, he can apply for the same or a different plan and be enrolled under the Guaranteed Availability Rule. In that case, the insurer could attribute premium payments under the new or renewed plan to the unpaid premium obligations under the old plan, but not deny coverage under the new or renewed plan. It is feared that this rule encourages individuals to take up and then drop coverage based on whether, and when, they experience illness or injury.

The proposed rule seeks to reduce this type of gaming of the system and encourage continuous coverage by permitting insurers to attribute current plan premium payments to the previous plan offered to the individual by that insurer and refuse to enroll the individual in the new plan until the past debt is paid. (The rule does not, however, prohibit an individual from going from insurer to insurer by failing to pay premiums at the end of a benefit period.) A variant on this proposed new rule would permit insurers to allow enrollment in a subsequent plan if the individual pays a specified portion of the unpaid premium under the prior plan.

Another aspect of the proposed rule addressing adverse selection through individuals signing up for partial-year coverage is to reduce the open enrollment period from the current Nov. 1 to Jan. 31 timeframe to a six-week period from Nov. 1 to Dec. 15 in the year prior to the benefit year. It is thought that this will reduce the number of persons signing up for coverage only if they have a health condition arising in late December or January. Query whether this proposal, as well as other proposed provisions, will be criticized as disguised efforts to reduce accessibility to health insurance coverage for lower-income individuals, who may have difficulty paying even subsidized premiums.

Similarly, under current ACA rules, special enrollment periods are offered to those with prior health insurance coverage who have experienced certain events requiring changes to that coverage or enrollment in a new plan. These events include marriage, the birth of a child or a permanent move. Currently, individuals seeking to take advantage of a special enrollment period self-attest as to their eligibility. Again, the concern has been raised that individuals take advantage of not having to prove they have experienced a qualifying event entitling them to a special enrollment in order to sign up for coverage only when they have experienced illness or injury, leading to adverse selection.

The proposed rules would require that those seeking special enrollment prove their eligibility by submitting documentation within a 30-day period, during which their proposed new plan enrollment would be pended. Also, the proposed rules would prohibit individuals from changing the type of plan – the "metal" level – except in limited cases and, in many cases, only to a plan in an adjacent metal level. Finally, the proposed rules would significantly reduce the availability of "extraordinary circumstances" that currently permit individuals to seek special enrollment. One can anticipate criticism of these proposals as deterring healthy individuals from buying health insurance coverage by requiring additional paperwork.

In addition to addressing the adverse selection problem, the proposed rules seek to give insurers additional flexibility in designing health insurance products. Currently, the various metal levels of plans in the ACA marketplaces are distinguished by the estimated percentage of total medical costs covered by the plan. For example, a bronze-level plan would have an "actuarial value" of 60 percent; a platinum plan would have an AV of 90 percent. Insurers are currently permitted to offer plans that vary from these AVs by plus/minus 2 percent. The proposed rule would change that variance to minus 4 percent/plus 2 percent. For a bronze-level plan that either covers and pays for at least one major service other than preventive services without deductible, or is a high-deductible health plan, the increased AV flexibility would be negative 4 percent/plus 5percent. (This increased flexibility would not apply to silver-level plans.) The anticipated effect of the increased flexibility is to enable insurers to respond to market forces by developing new plan designs, adjusting cost-sharing provisions and potentially reducing premiums while keeping the plans within the same metal level.

Insurers are required under the ACA to ensure that the provider networks within their plans are adequate to ensure accessible services without unreasonable delay. The adequacy of plans' networks has thus far been assessed by the ACA marketplaces. The proposed rule would permit network adequacy to be determined by the accreditation status of the insurer, by a state review process, if available, or by adhering to National Association of Insurance Commissioners' standards. In addition, current rules require that a network consist of at least 30 percent "essential community providers," such as community health centers or critical access hospitals. The proposed rule would reduce that requirement to 20 percent. These proposals are sure to be criticized as causing the creation of health plans that do not include enough providers who predominantly serve low-income and currently underserved populations.

These proposed tweaks, together with the speculated retention of other ACA provisions, such as the ability of parents to keep children up to age 26 as dependents on their family plan, may characterize the near-term future of the ACA, rather than a wholesale "repeal and replace." The continued viability of the marketplaces under a "reformed" ACA may very well determine how long that future will last. What is not speculative is that the health insurance industry is in for an ongoing period of turmoil that will inevitably affect health care providers.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, his practice concentrating on health care and nonprofit law.