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Affordable Care Act

The Trump Administration Marketplace Rule — and How States Can Respond

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In April 2017, the Department of Health and Human Services (HHS) finalized a rule creating sweeping changes to health insurance marketplaces. Many of these changes could make it more difficult or more expensive for consumers to enroll in coverage. Fortunately, states have options at their disposal to reduce the harm caused by this rule and create policies that are more consumer-friendly in nature. Some of these policies can be adopted by any state, including those with federally facilitated marketplaces (FFMs), while other options can only be adopted in state-based marketplaces (SBMs).

Open Enrollment Periods

The Affordable Care Act (ACA) gives the Secretary of HHS the authority to determine dates for initial and subsequent open enrollment periods (OEPs).[1] The first OEP was six months long, while more recent OEPs have been three months. However, the next OEP will only be six weeks, from November 1 to December 15, 2017, creating a much shorter window for people to learn about and enroll in coverage. This OEP exists throughout the individual market—inside and outside of exchanges.

What's at Risk?

A shorter enrollment period has the potential to mean fewer, less healthy people will enroll in coverage, driving up premiums for everyone. This could happen for a number of reasons:

Consumers may miss the opportunity to enroll

In the past, consumers have had limited knowledge about the annual opportunity to enroll in coverage.[2] Many consumers will continue to have knowledge gaps about coverage options because the abbreviated timeframe is paired with general uncertainty and confusion about the federal coverage landscape. This could lead to many not learning about the OEP until it is too late to enroll.

Consumers who do enroll may skew the risk pool

Many of those who are most aware of their coverage options and ability to enroll will be sicker and more in need of coverage and care. This means the risk pool will be more imbalanced.

Enrollment assistance will be more limited

Enrollment assisters—those who help millions of people enroll in coverage—will be stretched to capacity and will have less ability to help

This brief provides an overview of state options related to open enrollment periods, special enrollment periods, policies for consumers who owe past premiums, actuarial value and affordability of plans, network adequacy, and essential community providers.

consumers learn about and enroll during the compressed timeframe. Agents and brokers, too, will have limited capacity because the OEP overlaps with many employer plan and Medicare Advantage OEPs.

State Options

States can respond to these risks by adopting policies to ensure people enroll in coverage. The main state options are to:

Tack on a special enrollment period to the end of the federal open enrollment period in SBMs

In the finalized rule, the Centers for Medicare and Medicaid Services (CMS) states, "[SBMs] may elect to supplement the open enrollment period with a special enrollment period, as a transitional measure, to account for those operational difficulties." This may be a good option for SBMs that are facing difficulty implementing the shortened OEP, given that these changes take place only about six months after the rule was finalized.

In the past, SBMs have used their existing authority to add special enrollment periods (SEPs) to the end of OEPs for certain situations. Most notably perhaps, some SBMs have extended deadlines for the first OEP due to continued lack of awareness about the marketplaces in their first year. Recently, for example, Minnesota added a one-week SEP to the end of the fourth OEP, providing more consumers with the ability to enroll.[3]

Invest in robust outreach, education, marketing, and enrollment activities

All marketplaces, including SBMs, are required to create navigator programs and provide grant funding for those programs.[4] Navigator programs, among other things, are required to provide in-person assistance and conduct public education activities to help people learn about coverage options and enroll.[5] The funding levels that are provided, however, are at the discretion of the SBM. The ACA requires that this funding come from operational funds of the marketplaces.[6]

SBMs with a vested interest in making their marketplaces work can enhance existing funding for in-person assistance, outreach, education, and marketing. These investments have paid off in terms of increased enrollment.[7] They can do so by allocating more of the operational funds they previously set aside for these programs. They can also work with relevant entities in the state to allocate or create additional funding that does not come out of operational funds for the marketplace. SBMs can also explore whether they have options for working with other health and human services agencies in the state to promote the OEP. For example, they can look at working with agencies that oversee Medicaid or Children's Health Insurance Program (CHIP) coverage to add information about OEPs to their materials, website, or call center.

FFM states and nongovernmental entities also have a role to play. Though options are more plentiful for SBMs, FFM states have options, too. These states can devote funding

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toward these programs, such as the examples mentioned above about Medicaid/CHIP, or allocate other state-based funding. Lastly, while not a state policy per se, all states can look to other funding streams outside of the government, such as health-focused foundations.

Special Enrollment Periods

There are a number of changes that were made to SEPs that are available to provide opportunities for consumers to enroll in coverage outside of OEPs. Some of the changes affect only the FFM, while others affect all marketplaces. Many of these changes build on recent changes made to SEPs.[8]

One of the most significant SEP changes relates to those who get married. Previously, getting married triggered an SEP regardless of whether the couple had coverage previously. Now, generally, at least one spouse will need to have had coverage for one day in the prior 60 days in order to be eligible for the marriage SEP.[9] This change is for all marketplaces, and will go into effect in the FFM in June 2017. HHS is asking that SBMs implement this change as "quickly as possible."

Another significant change to SEPs is about new coverage types that will be available to those who are already enrolled in marketplace coverage and who become eligible for an SEP. The rule makes changes to prior rules in that it largely prohibits people from changing metal levels (e.g., from bronze to silver, from gold to platinum, etc.) when they enroll through an SEP.[10] Generally, enrollees will only be able to change to silver plans if they become newly eligible for cost-sharing reductions (CSR). So, for example, if a newly married couple is eligible for the marriage SEP, the original enrollee cannot change metal levels when they enroll with their spouse unless the couple *also* became newly eligible for CSRs. If they did not, the spouse being added to that coverage would be able to either enroll in the same plan as their spouse or enroll in a plan on their own at a different metal level, based on their specific needs.

The final rule also creates changes to the loss-of-coverage SEP. Issuers will now be able to reject coverage for those whose coverage ended because of nonpayment of premiums; prior to this rule, issuers were not permitted to make such a decision.

It is worth noting one major change to SEPs that is only being required in FFMs because HHS is encouraging states to adopt these changes, as well. This is the change that requires consumers enrolling through SEPs in the FFM to prove their eligibility for all SEPs before they enroll in coverage. This is a change from prior policies that required consumers to prove their eligibility for SEPs after they enrolled in coverage for the five most common SEPs (marriage, birth, adoption/placement for adoption/placement in foster care, moving, and loss of coverage). These changes will take place beginning in June 2017 for the FFM and will require consumers to either prove eligibility by providing documentation or verifying electronically. While these changes are not yet being required in SBMs, HHS is encouraging SBMs to implement them.

What's at Risk?

The SEP changes described above have the potential to make enrollment more difficult, and thus undermine the success of the marketplaces. In the FFM, only about five percent of eligible SEP consumers actually enroll in coverage but, with these changes, that number may be even lower—and vulnerable populations may be adversely affected.

Market stability also requires that young, healthy consumers are not deterred from enrolling, which would serve to create an imbalanced risk pool that drives up premiums for everyone. A troublesome finding when the FFM instituted policies that tightened rule for SEPs was that younger people were about 20 percent less likely to finish the process than older enrollees.[11]

State Options

States have options to mitigate the harm of this rule in a number of ways. The most significant options are to:

Create additional SEPs

The ACA requires marketplaces to have SEPs, but does not specify the types of SEPs to be created.[12, 13] Thus, HHS and marketplaces have a good deal of discretion when creating SEPs. As noted on page 3 of this document, SBMs have historically exercised their authority to create SEPs in difficult or "exceptional" circumstances, such as during the first OEP. The rule says that "[SBMs] should retain the flexibility to determine what constitutes an exceptional circumstance," but goes on to say that HHS will provide guidance in the future as to what constitutes an exceptional circumstance. SBMs should assess what flexibility they need in order to ensure consumers in their SBM get enrolled, and should weigh in on those decisions. For example, a SBM may be able to create an SEP for an enrollee to change a plan they were unknowingly automatically enrolled in, if it is significantly different than their prior plan.

Prohibit issuers from rejecting enrollment for loss of coverage

States have the ability to create policies that prohibit issuers from denying coverage through SEPs to those who lost coverage due to nonpayment of premiums. This is similar to state policies related to nonpayment of premiums explained on page 6.

Take necessary time to implement changes so they are seamless for consumers

HHS says in the rule that they want SBMs to "implement these provisions as quickly as possible." They also rightly note, however, that it will take time to implement the changes correctly. SBMs should use their best judgment to ensure they are not rushing forward with policies and processes that are not ready for consumers. The changes are significant and will require consumers and assisters to be educated and trained, so the changes should not be unnecessarily rushed.

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Choose to not implement pre-enrollment verification

As noted above, HHS is not requiring SBMs to implement pre-enrollment verification. They are encouraging them to, however, and many issuers will likely push for these changes as well. SBMs, therefore, have to make a decision about whether to adopt this policy. If they do decide to implement these changes, they have to make a number of critical decisions, such as: which SEPs to include; when to implement the changes; the timeframe for consumer verification; the timeframe for SBM review; what documentation to accept; how to inform assisters and consumers about the changes; and the amount of money, if any, they are willing to spend to create automated processes. It is critical that SBMs make any changes with the consumer in mind, so that consumers are encouraged, not discouraged, from enrolling.

Invest in education and training for consumers and assisters

Consistent with the discussion about OEPs, there is a significant need for education and training on these changes in order to make sure consumers know that when certain events happen, they can enroll through a SEP.

Nonpayment of Premiums

The finalized rule changes previous HHS interpretations of guaranteed availability. To the extent permitted by state law, issuers will now be able to prohibit consumers from re-enrolling in their plan if they owe that issuer premiums from the past 12 months. Issuers will not be permitted to block consumers from enrolling with them if they owe past premiums to a different issuer, however.

What's at Risk?

The ability for plans to deny coverage to consumers if they owe premiums will make it more difficult for consumers to maintain continuous coverage. Nonpayment of premiums is a significant issue facing low-income enrollees, who generally have tighter budgets: a study found that the overwhelming majority of enrollees who stopped paying premiums in 2015 had incomes below 250 percent of the federal poverty level.[14] It will also affect those living in areas with only one issuer, because they may now be blocked from enrolling in coverage at all.

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State Options

There are options for states related to this rule that are outlined in the rule's preamble. The main options for states are to:

Prohibit issuers from instituting this policy

States can and do have laws prohibiting issuers from instituting this policy by requiring that issuers accept returning consumers regardless of whether they owe back premiums.

If allowing issuers to institute this policy, create consumer-friendly policies to lessen the burden

States can require issuers to accept installments for premium payments or accept a certain threshold of a premium payment be paid to be considered payment in full. These policies would help consumers by not requiring them to pay a large sum of money for their premiums all at once.

Create appeals processes

The rule itself does not create an appeal process for consumers who disagree with an issuer's decision to deny coverage, but states can create such procedures on their own.

Inform consumers and create clear notices

It is important for consumers to know these rules exist and what the ramifications are for not paying premiums. Some consumers may not understand the difference between terminating a plan they no longer want to be enrolled in versus no longer paying their premiums. Notices and consumer education can help ensure that consumers understand that if they want to terminate coverage, they need to actively take steps to do so in order to be able to enroll with that issuer at a later date.

It is important to also remember that issuers are not required to institute this policy. If they do, they also have the flexibility to accept installments or threshold payments. However, many issuers have long advocated for this policy, and may find the option appealing.

Actuarial Value

Under the ACA, plans of the same metal level are meant to have similar levels of cost-sharing, and this is measured by a plan's actuarial value (AV). Plans in the same metal level must all have the same target AV, as spelled out in the ACA. The Secretary of HHS determines a fair "de minimis" range of AVs that plans at each metal level can have. In previous years, HHS has required that plans at every metal level meet an AV that is within -2/+2 percent of their required AV under the law, with limited exceptions for certain bronze plans to have a higher AV.[15] For example, the ACA requires silver plans to have an AV of 70 percent. With a -2/+2 percent de minimis range, this means silver plans must have an AV between 68 and 72 percent.

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What is a Health Plan's Actuarial Value?

Actuarial value is the percentage of total costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70 percent, the plan pays 70 percent of the cost of covered care, looking at the care used by all its members. On average, its members pay 30 percent of the cost for covered services through deductibles, copays, and other cost-sharing. However, an individual could pay a higher or lower percentage of his or her individual health care costs for the year, depending on his or her actual health care needs.

The final market stability rule widens this de minimis variation on the bottom end, allowing plans at each metal level to have an AV within -4/+2 percent of their target AV under the law. For example, under this new policy, insurers can sell silver plans with an AV as low as 66 percent. The maximum AVs of plans at each metal level are not changing. This policy will apply to plans in the individual market, both on and off exchanges, starting in 2018. This policy change will not affect the enhanced AV of plans for people who receive CSR subsidies.

What's at Risk?

The lower a plan's AV, the higher its cost-sharing. As a result, lowering the minimum AV of plans at each metal level by two percent will effectively allow insurers to sell plans with even higher cost-sharing than has been allowed to date. This new policy has particularly harmful implications for people receiving premium tax credits, as it could reduce the amount of financial help with premiums that they receive. Here is a breakdown of the harmful consequences of this policy:

Consumers' premium tax credits could be cut by hundreds of dollars

The size of premium tax credits that people receive is tied to the premium for the second-least-expensive silver plan in their local market (i.e., benchmark plan). Under this new policy, that assistance will very likely be tied to the cost of plans with lower AVs than in the past. These new benchmark plans will have lower premiums but higher out-of-pocket costs. This will result in the

dollar value of people's premium tax credits dropping. Under one scenario, a family of four making $65,000 could see their premium tax credit cut by $327 if it is tied to a 66 percent AV silver plan.[16]

The lowest-value silver plan's cost-sharing features, such as its deductible, could increase significantly

While a two percent decrease in AV doesn't sound like much, it translates into drastically higher cost-sharing. Different analyses have found that a 66 percent AV silver plan could have a deductible that is between $500 and $1,300 higher than a 68 percent actuarial value plan, depending on the plan design.[17] If premium tax credits are based off the premium for a 66 percent AV plan, people receiving this help will have to decide between paying hundreds of dollars more in premiums to stay in the higher value plan they have today, or moving to a plan with hundreds of dollars in higher cost-sharing. Either way, their out-of-pocket costs will go up.

Consumers may struggle to understand the difference between metal levels

Reducing the minimum AV for plans at each metal level also means that it will sometimes be harder for consumers to distinguish between plans in different metal levels. In particular, there are limited circumstances in which a bronze plan could have an AV as high as 65 percent. This could make it very challenging for a consumer to distinguish between a 65 percent AV bronze plan and 66 percent AV silver plan, making plan comparison more challenging.

State Options

The final rule explicitly confirms that states have the option to maintain a stricter -2/+2 percent AV de minimis range for plans at each metal level, noting that "States are the enforcers of AV policy and nothing under this policy precludes States from applying stricter standards, consistent with Federal law. For example, a State may apply a -2/+2 percent for the AV de minimis range for metal level plans." The main state policy options are:

Preserve a smaller de minimis range across all plan metal levels

States could pursue a policy, either through legislation or regulation, that requires plans at each metal level to have an AV that is within -2/+2 percent of their required AV under the ACA. Some states may already have this existing policy in state law, and advocates should push policymakers and insurance officials to maintain the more protective standard moving forward.

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Preserve a smaller de minimis range exclusively for plans at the silver level

At a minimum, states could pursue a policy that maintains a +2/-2 percent de minimis AV range specifically for silver level plans. This would protect people who receive premium tax credits from having their credit amount be based on the cost of a lower value plan, effectively reducing the financial assistance they receive.

Network Adequacy

The 2018 marketplace rule makes another significant change by deferring to the states the authority for network adequacy reviews in marketplace plans. This change will end the federal oversight and accountability measures put in place by the previous administration. HHS previously reviewed qualified health plan (QHP) networks using quantitative metrics of time and distance to providers for enrollees to ensure that networks were adequate.

Under the new rule, if states do not have the authority and means to conduct network adequacy reviews, HHS will rely on QHPs receiving accreditation from a nationally recognized accreditor such as the National Committee for Quality Assurance (NCQA) or URAC. If a plan in such a state is not accredited, HHS will require the plan to submit an access plan demonstrating that it meets network adequacy standards as described in the National Association of Insurance Commissioners Network Access and Adequacy Model Act.[18]

What's at Risk?

Deferring responsibility for reviews to the states creates new problems for consumers living in states without sufficient metrics for assessing networking adequacy. Specifically, it means they will no longer have a guarantee that marketplace plans will provide access to the care they need, in a timely manner, without having to travel too far. Ultimately, removal of federal oversight will lead to narrower networks and poorer access to care for enrollees.

State Options

States, including those with state-based marketplaces, can respond to these risks by adopting strong network adequacy standards for insurers.[19] These standards should include quantitative metrics and actionable rights for consumers, including:

- Travel time and distance to provider standards
- Appointment wait time standards
- The right for consumers to receive out-of-network care at in-network costs if they cannot find an appropriate participating provider who accepts their insurance, and does not require them to travel too far or wait too long for care

Essential Community Providers

The marketplace rule weakens requirements for QHPs to include in their networks essential community providers (ECPs)—those who serve predominately low-income, medically-underserved individuals. Previously, insurers were required to contract with at least 30 percent of available ECPs in the area they serve. Under the new rule, that threshold has been lowered to 20 percent.

What's at Risk?

Weakening ECP inclusion standards will narrow networks for marketplace plans. In particular, this change will make it less likely that marketplace plans will provide access to health care professionals who can meet the needs of their most vulnerable enrollees—those in low-income communities and those who are medically underserved.

State Options

States can implement their own, more robust standards for the inclusion of essential community providers in health plan networks. For example, in Montana, insurers must include at least 80 percent of essential community providers on the state's list of ECPs in their networks.[20] In Connecticut, insurers must include 90 percent of Federally Qualified Health Centers (FQHCs) and 75 percent of other essential community providers in the state in their networks, based on an ECP list maintained by the state's exchange.[21]

There is little question that the new HHS rule will affect consumers enrolling in coverage under the Affordable Care Act—whether these effects are driven by changes to rules governing open or special enrollment periods, nonpayment of premiums, actuarial value, network adequacy, or essential community providers. But as noted in this brief, states have options to lessen the impact of these changes on their residents. State officials should act quickly to determine how the new rules will affect their residents and take effective steps to protect residents' access to coverage and care in response.

Endnotes

[1]Patient Protection and Affordable Care Act, Title 1, Subtitle D, Part 2, Section 1311(c)(6)(B).

[2]PerryUndem, *Informing Enroll America's Campaign: Findings from a National Study* (Washington, DC: Enroll America, January 2013), available online at http://familiesusa.org/sites/default/files/documents/enroll-america/2013-Perry-Undem-PreOE1-Report.pdf.

[3]MNSure, *MNsure Announced One-Week Special Enrollment Period to Help Minnesotans Take Advantage of Recently Enacted Premium Relief* (St. Paul: January 28, 2017), available online at https://www.mnsure.org/news-room/news/index.jsp#/detail/appId/1/id/275168.

[4]Patient Protection and Affordable Care Act, Title 1, Subtitle D, Part 2, Section 1311(i)(1).

[5]Patient Protection and Affordable Care Act, Title 1, Subtitle D, Part 2, Section 1311(i)(3).

[6]Patient Protection and Affordable Care Act, Title 1, Subtitle D, Part 2, Section 1311(i)(6).

[7]Emily Curran, Sabrina Corlette, Kevin Lucia, and Justin Giovannelli, *2017 Federal and State Marketplace Trends Show Value of Outreach* (New York: Commonwealth Fund, May 5, 2017), available online at http://www.commonwealthfund.org/publications/blog/2017/may/2017-federal-state-marketplace-trends-show-value-of-outreach.

[8]For example of changes to SEPs, see Families USA's blog: Elizabeth Hagan and Kara Nester, *Changes to Special Enrollment Period Process Could Hurt Consumers* (Washington, DC: Families USA, March 10, 2016), available online at http://familiesusa.org/blog/2016/03/changes-special-enrollment-period-process-could-hurt-consumers.

[9]See 155.420(a)(5), which provides exceptions for those who are moving from a foreign country or U.S. territory or are Indians as defined by section 4 of the Indian Health Care Improvement Act.

[10]There are some exceptions to this, including for members of federally recognized tribes or Alaska Native Claims Settlement Act Corporation Shareholders.

[11]Centers for Medicare and Medicaid Services, *Pre-Enrollment Verification for Special Enrollment Periods* (CMS: Baltimore), available online at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf.

[12]Patient Protection and Affordable Care Act, Title 1, Subtitle D, Part 2, Section 1311(c)(6)(C).

[13]Section 1311(c)(6)(C) of the ACA requires that marketplaces have SEPs consistent with group health plans (specific in section 9801 of the Internal Revenue Code of 1986) and "similar" to those for Medicare Part D (Title XVIII of the Social Security Act).

[14]McKinsey & Company, *2016 OEP: Reflection on enrollment* (McKinsey & Company U.S. Center for Health System Reform, May 2016), available online at http://healthcare.mckinsey.com/sites/default/files/McK%202016%20OEP%20Consumer%20Survey%20Infographic_vF.pdf.

[15]Under federal regulation, bronze plans that meet IRS requirements for Health Savings Account qualifying high deductible plans, and bronze plans that cover select services before the deductible is met are permitted to have an AV as high as 65 percent.

[16]Aviva Aron-Dine and Edwin Park, *Trump Administration's New Health Rule Would Reduce Tax Credits, Raise Costs, For Millions of Moderate-Income Families* (Washington, DC: Center on Budget and Policy Priorities, February 15, 2017), available online at http://www.cbpp.org/research/health/trump-administrations-new-health-rule-would-reduce-tax-credits-raise-costs-for.

[17]Lydia Mitts and Caitlin Morris, *President Trump's ACA Changes Will Increase Costs to Consumers, Make It Harder to Enroll in Coverage* (Washington, DC: Families USA, April 14, 2017), available online at http://familiesusa.org/blog/2017/04/president-trump-aca-changes-will-increase-costs-consumers-make-it-harder-enroll.

[18]National Association of Insurance Commissioners, *Health Benefit Plan Network Access and Adequacy Model Act* (Model 74) (Washington: NAIC, 2015), available online at http://www.naic.org/store/free/MDL-74.pdf.

[19]For model standards, see: Claire McAndrew, *Standards for Health Insurance Provider Networks: Examples from the States* (Washington, D.C.: Families USA, November 2014), available online at http://familiesusa.org/product/standards-health-insurance-provider-networks-examples-states.

[20]Montana Commissioner of Securities and Insurance, *2017 Requirements for Health Plan Form Filings and Qualified Health Plan Certification* (Helena, MT: State of Montana, March 31, 2016) available online at http://csimt.gov/wp-content/uploads/2017formfilingmemo.pdf.

[21]Connecticut Health Insurance Exchange, *Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplaces: Plan Year 2017* (Hartford, CT: State of Connecticut, April 4, 2016), available online at http://www.ct.gov/hix/lib/hix/2017_QHP_Solicitation_04042016_Final_Website.pdf.

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