

The Trump Administration's Attempt to Slow Obamacare's Collapse through Rulemaking

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by John R. Graham

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Obamacare is enrolling too many sick people and too few healthy ones to prevent a death spiral. The Centers for Medicare & Medicaid Services (CMS), a unit of the U.S. Department of Health & Human Services (HHS), has proposed a new rule to stabilize the Obamacare markets for individual health insurance. This was the first rule issued since Dr. Tom Price was appointed HHS secretary. The proposed Market Stabilization rule includes a number of measures to prevent people from entering the market when sick and exiting when healthy.



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Executive Summary

There is an urgent need for immediate action. It is increasingly likely that many Americans who have been forced to get coverage in the exchanges will have one or zero health plans in 2018. Insurers are unwilling to continue losing money in the exchanges. The proposed rule cannot rescue Obamacare, but it can buy some time for Americans who are suffering from dwindling choices in the exchanges.

The proposed rule addresses the Obamacare death spiral through a number of fixes in the areas of open enrollment period, special enrollment period, nonpayment of premiums, network adequacy and actuarial value. Specifically, the proposed rule would:

- Reduce the annual open enrollment period from 60 days to 45 days.
- Tighten the rules for special enrollment by requiring timely verification of qualifying events, such as marriage, change of employment or a long-distance move.
- Replace the three-month grace period for nonpayment of premiums with a 12-month look-back to prevent people from gaming the system.
- Allow insurers to reduce the number of “essential community providers” included in their networks from 30 percent to 20 percent.

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- Broaden the range of actuarial values insurers must cover based on projected costs.

While the rule moves in the right direction, CMS should consider strengthening it with the following changes:

- Reduce open enrollment to 29 days, as in the Federal Employee Benefits Health Program.
- Require continuous coverage with no gap longer than 30 days for special enrollment periods when people change jobs or marry, as in the employer-based market.
- Require state-based exchanges to enforce the same regulations on special enrollment as Federally Facilitated Marketplaces (that is, healthcare.gov).
- Clarify the exact legal basis in the Affordable Care Act for requiring enrollees who are delinquent in their premium payments to pay up to 12 months of overdue premiums before being enrolled in the next year's plan.
- Limit the Secretary's authority over network adequacy to ensuring that health plans adhere to standards established by the states.
- Recognize that minor changes to actuarial value (AV) standards cannot change the fundamental problem of AV as defined by the ACA.

The proposed Market Stabilization rule is an improvement over the previous administration's ACA regulations. Further rulemaking is to be expected; however, it is not possible to fix Obamacare by rulemaking alone. New legislation is required.

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Introduction

The new administration did not wait for repeal of Obamacare before taking action. On February 17, 2017, the Centers for Medicare & Medicaid Services (CMS) proposed a new rule to stabilize Obamacare markets for individual health insurance, which are in a death spiral.

This was the first rule issued since Dr. Tom Price was appointed U.S. Secretary of HHS. It follows an Executive Order issued by President Trump on Inauguration Day directing the Secretary of Health & Human Services to “waive, defer, grant exemptions from, or delay the implementation” of Obamacare’s harmful provisions to the greatest extent legally possible, and to grant states flexibility in reducing the harm of Obamacare as best they can.¹

There is an urgent need for immediate action. It is increasingly likely that many Americans who have been forced to get coverage in the exchanges will have one or zero health plans in 2018. Insurers are unwilling to continue to lose money in the exchanges. The proposed rule cannot rescue Obamacare, but it can buy some time for Americans who are suffering from dwindling choices in the Affordable Care Act exchanges.

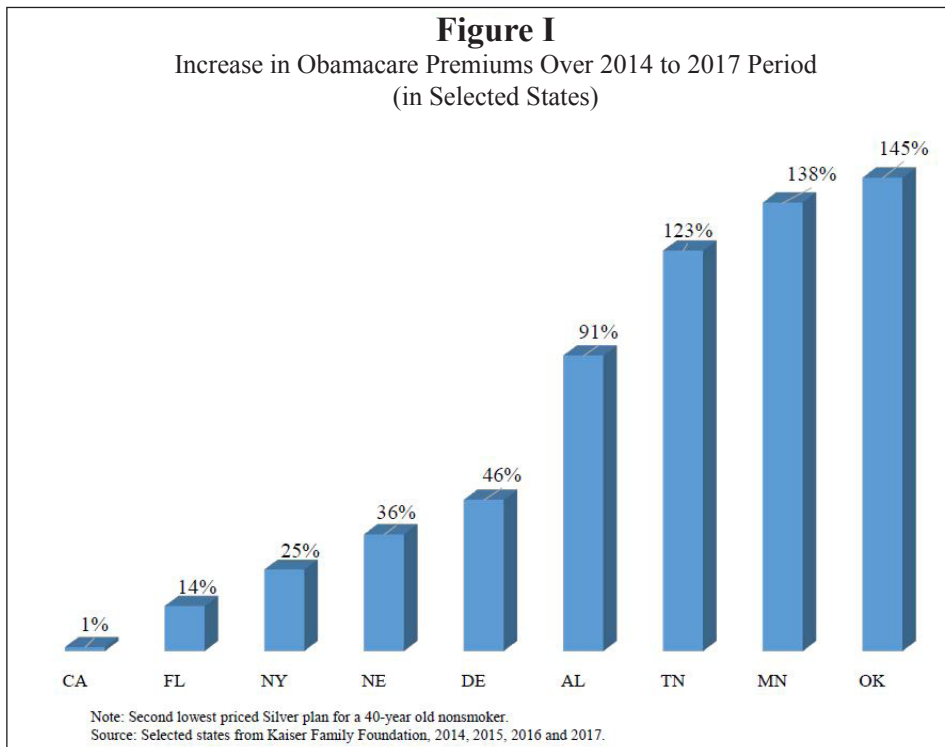
Projected Enrollment and Premium Increases.

The average premium increase for the second-lowest cost Silver (benchmark) plan was 2 percent in 2015, 7 percent in 2016 and 25 percent in 2017.² [See Figure I for premium increases in selected states.] This is going to get worse, despite the claims of the former administration’s Council of Economic Advisers (CEA), which asserted in January that the exchanges were healthy because 11.3 million people enrolled in December 2016, 300,000 more than in December 2015.³ While it is true enrollment in Obamacare’s market is a little higher than last year, it is still well below the Congressional Budget Office’s March 2015 estimate of 21 million enrollees in 2016.⁴ The CEA asserted:

“The available data indicate that insurers underpriced for 2014, the first year of the new market, and incurred significant losses. Insurers appear to have then fallen further behind in subsequent years, despite slow growth in underlying claims costs, because they implemented premium increases that were insufficient to accommodate the phasedown of the ACA’s transitional reinsurance program. Stemming the resulting losses necessitated larger increases for 2017.”

However, there is no evidence that insurers will be better at estimating claims costs and therefore premiums:

- The data suggests insurers did *not* learn from 2014 to 2017. Indeed, they became *worse* at estimating the premium revenue they needed to cover claims. There are no grounds to expect insurers will finally become effective at executing their Obamacare business plans.
- For 2014 through 2016, insurers had special funds (reinsurance and risk corridors) that were supposed to protect them from underpricing. The insurers themselves claimed they would learn enough in the first



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three years to ensure that future premium hikes were reasonable. The 2017 hikes show that was not the case.

- The CEA suggests the 2017 premium hikes were so high because insurers had to gouge enrollees to fill in the holes they dug for themselves in the first three years. However, those losses are sunk costs. If insurers thought 2017 and future years were going to be profitable, they would have priced premiums competitively to win market share.

Obamacare Enrollees Were Sicker than Expected. The evidence shows that the exchanges are in a death spiral: Sick people sign up and incur expensive claims, premiums go up, the healthy drop out due to plans' unaffordability and so forth. According to the Blue Cross Blue Shield Association, which represents 36 mostly employer-sponsored plans covering 105 million Americans:⁵

“Members who newly enrolled in BCBS individual health plans in 2014 and 2015 have higher rates of certain diseases such as hypertension, diabetes, depression, coronary artery disease, human immunodeficiency virus (HIV) and Hepatitis C than individuals who had BCBS individual coverage prior to health-care reform.

“Consumers who newly enrolled in BCBS individual health plans in 2014 and 2015 received significantly more medical care, on average, than those with BCBS individual plans prior to 2014 who maintained BCBS individual health coverage into 2015, as well as those with BCBS employer-based group health insurance.

“The new enrollees used more medical services across all sites of care — including inpatient admissions, outpatient visits, medical professional services, prescriptions filled and emergency room visits.

“Medical costs of care for the new individual market members were, on average, 19 percent higher than employer-based group members in 2014 and 22 percent higher in 2015. For example, the average monthly medical spending per member was \$559 for individual enrollees versus \$457 for group members in 2015.”

The proposed rule addresses this problem through a number of approaches, including the open enrollment period, special enrollment periods,

nonpayment of premiums, network adequacy and actuarial value.

Open Enrollment Period

Like Medicare and employer-based plans, ACA exchanges limit enrollment for most applicants to an open enrollment period. This is because the ACA guarantees policies will be issued at the same premium to all applicants regardless of health status. If open enrollment lasted 365 days a year, people could wait until they became sick to acquire health insurance. If it were just one day a year (for example, the day after Christmas to choose the next year's coverage), applicants would not have the option of waiting. On the other hand, there would be a confusing rush to get coverage. So, a balance has to be struck.

Because the exchanges were brand new, the open enrollment period for their first year (2014) ran for six months, but was shortened to three months for 2015 and later years. Under the proposed rule, the open enrollment period would be reduced to 45 days.

However, it appears longer than other open enrollment periods for working-age beneficiaries. Remarkably, there is no estimate of average open enrollment periods in employer-based plans. However, the Federal Employee Health Benefits Program (FEHBP) has an open enrollment period of just 29 days, from the second Monday of November through the second Monday of December, which is adequate for beneficiaries to make a plan selection. CMS should consider replicating the FEHBP open enrollment period for exchange beneficiaries.

Special Enrollment Periods

There is a similar problem with special enrollment periods. As with employer-based plans, health insurers in exchanges must accept applicants at any time of the year if they qualify for special enrollment. However, these qualifying events are not related to health status. Marriage, change of employment, or a long-distance move are examples of events that qualify an applicant for special enrollment.

However, there is evidence that special enrollment is abused. In 2015, special enrollees cost 5 percent more than those who enrolled during open season. Further, they only enrolled for an

average of 3.6 months versus 7.8 months for those who enrolled during open season.⁶ This suggests some applicants have figured out how to game special enrollment. They apply for coverage once they have become sick, and drop it after treatment.

Some analysts claim health insurers are exaggerating this problem, and that tightening rules for special enrollment will dissuade healthy people from applying for coverage. This leads to the conclusion that rules for special enrollment should be eased to attract healthy applicants.⁷ However, if that were the case, health insurers would surely be lobbying for such changes. After all, insurers cannot claim Obamacare tax credits unless they enroll people. If they thought loosening standards for special enrollment would attract more healthy people, that is what they would endorse.

This adverse selection of the unhealthy for special enrollment is likely due to the Obama administration having allowed applicants to “self-attest” to their qualifying event. The proposed rule demands verification. For example, if an applicant gets married, he or she will have to provide evidence of having married within 30 days of the wedding. That is not too high a hurdle.

The proposed rule also seeks to impose a continuous coverage requirement for special enrollment. For example, a person who moves to a new city cannot apply for special enrollment unless he had coverage in his previous city, with a look-back of 60 days. This is too long. The ACA indicates that the continuous coverage provisions for special enrollment should replicate the legal requirement for the employer-based market, where individuals eligible for group coverage who lose other coverage must apply for group coverage within 30 days (unless coming from Medicaid or Children’s Health Insurance Program, in which case they have 60 days to apply).⁸ The exchanges should replicate this rule.

Another problem is that the proposed rule would only enforce this requirement in states using Federally Facilitated Marketplaces (that is, healthcare.gov). Anticipating that state-based exchanges would have trouble enforcing this rule for 2018, CMS seeks comment on whether there should be a transition period for state-based exchanges, or even that it remain optional for them.

On the contrary, giving state-based exchanges a “pass” on enforcing reasonable standards of verification and continuous coverage for special enrollment would be completely against the spirit (and arguably the letter) of the ACA. The original intent of ACA was that each state would establish an exchange. Indeed, there is strong legislative history indicating the federal government wanted and sought to induce every state to establish an exchange.⁹

States that didn’t establish exchanges did federal taxpayers a favor. States establishing exchanges received grants totaling \$3.9 billion through 2014 to help finance their exchanges. Those states enrolled about 2.6 million people in 2014, costing federal taxpayers \$1,503 per enrollee. The majority of states, which did not establish exchanges, enrolled about 5.4 million people but only received grants totaling less than one billion dollars, or an average of just \$152 per beneficiary.¹⁰

States that established their own exchanges took billions of dollars of federal taxpayers’ money for the express purpose of being ready to execute Obamacare enrollment according to the law and regulations. CMS must enforce the new regulations equally among all the states. Non-enforcement would continue to put federal taxpayers at risk because states with their own exchanges would not take important steps to stabilize the market.

Nonpayment of Premiums

Many Obamacare beneficiaries receive advance premium tax credits. If they do not pay their premiums, the ACA allows them a three-month grace period before insurers can cancel their coverage. In that case, the insurers must refund the tax credits to the U.S. Treasury.¹¹

However, the real problem insurers have identified is that enrollees will drop coverage for up to three months at the end of the year and then sign up at the next open enrollment period. They bear no risk because if they become sick in the last quarter of the year they can pay their premiums due. However, if they stay healthy, they can just forget about it. This is a long grace period. Most state laws require insurers to give only a month’s grace.¹²

The ACA amends the Public Health Act to require guaranteed availability of policies in

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(among other conditions) open enrollment.¹³ According to the Obama administration's interpretation, "continuous availability" means that if an enrollee owes premiums from a previous period and re-enrolls in the plan for the next enrollment year, coverage cannot be denied unless he is subscribing to the same policy from which he was dropped. Although the insurer may take the enrollee to debt collection, it cannot apply current premiums paid by the enrollee toward the debt.

This is a serious problem. In 2015, 21 percent of Obamacare enrollees stopped making payments, as Figure II illustrates. Did they get employer-based coverage? Not many:¹⁴

- Of the individuals who stopped paying premiums in 2015, 87 percent re-enrolled in an Obamacare plan in 2016, and 49 percent of them re-enrolled in the same plan for which they had stopped paying premiums in 2015!
- Only 36 percent of these delinquents reported gaining other coverage (for example), while 26 percent reported they could no longer afford to pay premiums.
- That suggests the remainder, 38 percent, were gaming the Obamacare rules.

They are not just abusing the three-month grace period:¹⁵

- Over half the delinquents stopped payments before the fourth quarter.

- Further, 67 percent of the 2015 delinquents were insured in the individual market in 2014, and 67 percent of them had stopped payment on 2014 premiums!

In other words, these enrollees were serial delinquents.

This is also a problem for providers because the insurer can suspend claims payments after the first month that premiums are not paid. So, providers expect to be paid but will not be paid if insurers cannot collect the premiums due.

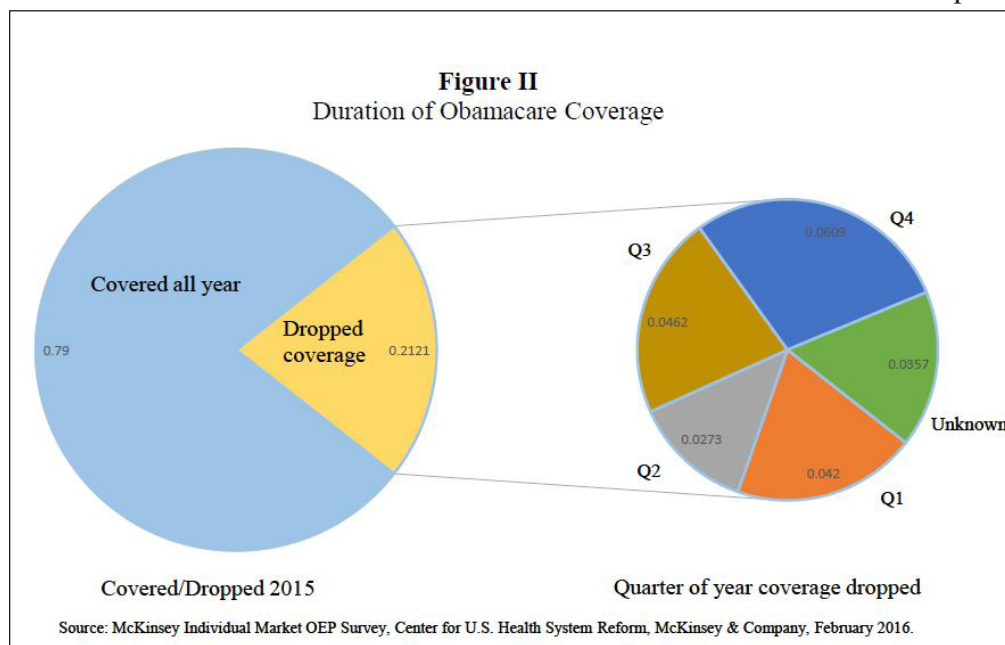
The proposed rule would allow insurers to look back over the previous plan year and apply premiums to up to 12 months' coverage. CMS clearly understands the problem. However, there are two issues with the proposed rule. First, it would only apply to the incumbent insurers. So, delinquents would be motivated simply to go to another insurer for coverage, which could not be denied. Insurers could expect a growing portion of their new enrollees to be serial delinquents.

More seriously, there does not appear to be a legal basis in the ACA for the 12-month look-back. "Guaranteed availability" appears to mean "guaranteed availability." In the final rule, CMS should clarify exactly where in the black-letter law this power is found.

Network Adequacy

The ACA charges the Secretary with ensuring network adequacy, which is not defined, but consists of a health plan "being accredited" to "local standards."¹⁶ Further, the ACA requires insurers to have "essential community providers" in their networks "that serve predominately low-income, medically-underserved individuals."¹⁷ Again, this is not a regulated term. Currently, CMS requires insurers to have 30 percent of such providers in their network. As of 2017, providers have to apply to be recognized as "essential community providers" by CMS, effectively creating a new, federally regulated class of entity.

Figure II
Duration of Obamacare Coverage



The proposed rule would reduce this requirement to having 20 percent of essential community providers and would allow insurers to “write in” essential community providers that have not been recognized as such by CMS.

This appears to contradict the proposed rule’s goal of relinquishing as much regulatory power as possible to states. The black letter of the law does not appear to require the HHS Secretary to do anything more than ensure plans’ networks are adequate according to the laws of the states in which they operate. As state governments are better placed to observe and determine network adequacy than the federal government, CMS should consider amending the rule to limit the Secretary’s role to ensuring (“accrediting”) health plans’ networks are adequate, given the standards of the states in which they operate. This could be executed by asking state Insurance Commissioners, or other relevant state authorities, to report periodically to CMS.

Actuarial Value

Obamacare has Bronze, Silver, Gold and Platinum plans. A Bronze plan covers 60 percent of expected costs attributable to Obamacare’s Essential Health Benefits, and each higher metal plan covers 10 percentage points more. These percentages are called actuarial values (AVs).¹⁸ Enrollees bear the balance of their medical care costs through deductibles and copays.

Because it is impossible to forecast costs exactly, the ACA allows the Secretary to make minor changes in AVs.¹⁹ Current rules allow a variation of plus or minus two percentage points. That is, a Silver plan can actually cover 68 percent to 72 percent of costs. The proposed rule broadens this to minus four to plus two percentage points for Silver and higher plans, and minus four to plus five percentage points for Bronze plans.²⁰ That is, a Silver plan could cover just 66 percent of costs and be in compliance.

As the proposed rule points out, this “generates a transfer from consumers to insurers,” and therefore presumably meets with insurers’ approval. However, it does not address fundamental problems of AVs as proposed by the ACA.

First, the AV is forward looking. Different actuaries come to different conclusions. For

example, an Obamacare silver plan has an actuarial value of 70 percent. With an out-of-pocket maximum of \$6,350, what coinsurance and deductible will result in the standard beneficiary paying 30 percent of the costs? When this question was posed to three highly respected consulting actuaries, they came up with three different answers. Each proposed a 20 percent coinsurance rate. However, their deductibles differed substantially: \$4,200, \$2,050 and \$1,850.²¹

Second, AV focuses on averages. The ACA states “coverage of a plan shall be determined on the basis that the essential health benefits...shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).”²²

Because a small portion of any population accounts for most health costs, an insurer can design a plan that will have extremely high cost-sharing for sick people. One way they do this in Obamacare plans is through an expensive tier of specialty drugs for cancer, HIV/AIDS and other expensive conditions.²³ Because most people will not spend anywhere near their share of the AV, the plan overall will hit its target.

Unfortunately, minor changes to AV percentages can not address this problem properly. So, we should not expect much improvement from this part of the proposed rule.

Conclusion

The proposed Market Stabilization rule is an improvement over the previous administration’s ACA regulations. It will improve the exchanges marginally, but could be improved, as this report has suggested. Further rulemaking is expected as the new administration plows through the thousands of pages of incumbent rules. However, it is not possible to fix Obamacare by rulemaking alone. New legislation is required.

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Notes

1. "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal," Executive Order No. 13765, 82 FR 8351, January 24, 2017.
2. "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace," ASPE Research Brief, U.S. Department of Health & Human Services, October 24, 2016, pages 4-5.
3. "Understanding Recent Developments in the Individual Health Insurance Market," Issue Brief, President's Council of Economic Advisers, January 2017.
4. "Insurance Coverage Provisions of the Affordable Care Act - CBO's March 2015 Baseline," Congressional Budget Office, March 2015, Table 2.
5. "Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience From 2014 and 2015," Blue Cross Blue Shield Association, March 20, 2016.
6. Elizabeth Carpenter, "Consumers Enrolling in Exchanges through Special Enrollment Periods Have Higher Costs, Lower Risk Scores, than Open Enrollment Consumers," Avalere Health, October 5, 2016.
7. Sarah Lueck, "Insurers' Push to Restrict Special Enrollment Periods Would Block Uninsured People," Center on Budget and Policy Priorities, February 10, 2016.
8. Defined at 26 U.S.C. § 9801(f)(1)(a).
9. Jonathan A. Adler and Michael F. Cannon, "King v. Burwell: Desperately Seeking Ambiguity in Clear Statutory Text," *Journal of Health Politics, Policy and Law*, Volume 40, Number 3, June 2015, pages 577-578.
10. Jay Angoff, "Cost-per Enrollee in Each State's Exchange," letter to interested parties, Merhri & Skalet, PLLC (Washington, DC), May 7, 2014.
11. § 1412(c)(2)(B)(iv)(II).
12. Tara Straw, "Marketplace Grace Periods Working As Intended: Restrictions Would Increase Number of Uninsured," Center on Budget and Policy Priorities, October 14, 2016.
13. § 1201 of the ACA amends § 2702 of the Public Health Act.
14. "2016 OEP: reflection on enrollment," McKinsey & Company, Center for U.S. Health System Reform, May 2016.
15. Ibid.
16. § 1311(c)(1)(B) of the ACA charges the Secretary with ensuring network adequacy; § 1311(c)(1)(D) refers to local standards.
17. § 1311(c)(1)(C).
18. "RE: Final 2018 Actuarial Value Calculator Methodology," Centers for Medicare & Medicaid Services, December 16, 2016. As CMS explains, "AV is the anticipated covered medical spending...The denominator of this calculation is the average allowed cost of all services for the standard population in the year for a specified metal tier; the numerator is the share of average allowed cost covered by the plan...."
19. § 1302(d)(3).
20. Silver plans with higher AVs also have to be offered to beneficiaries with low incomes who are eligible for cost-sharing reductions; and bronze plans can have AVs up to 65 percent if they offer one service before the deductible or are eligible for an HSA.
21. "What the Actuarial Values in the Affordable Care Act Mean," Publication No. 8177, Henry J. Kaiser Family Foundation, April 2011.
22. § 1302(d)(2)(A).
23. Caroline F. Pearson, "2016 Exchange Plans Improve Access to Medicines Used to Treat Complex Diseases," press release, Avalere, April 19, 2016.