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House and the Administration Begin to Show Their Hands

House Republicans Unveil a Health Care “Policy Menu”; Trump Department of Health and Human Services Proposes First Major Health Care Regulation

Although there is still no specific ACA repeal and replace proposal from the hill, both Congressional Republicans and the Trump Administration released documents last week articulating their approach to replacing the ACA and addressing concerns with the Marketplaces in the meantime. Congressional Republicans released a Health Care Policy Brief that is intended to serve as a menu of potential elements for a forthcoming ACA replacement bill. This Brief includes elements that have been found in previous ACA replacement proposals and that present concerns for access to care. Further, the Department of Health and Human Services (HHS) released a proposed rule entitled “Patient Protection and Affordable Care Act; Market Stabilization” (proposed rule), which is intended to help stabilize the Marketplaces until an ACA replacement is completed. Unfortunately, some of its changes may limit access to care for vulnerable individuals and make the Marketplaces less friendly to those living with chronic illnesses and disabilities. Advocates should be sure to understand both documents as well as send comments on the proposed rule to HHS by March 7, 2017.

Advocates Should:

1. Review the Health Care Policy Brief released by House Republicans last week to better understand which ideas are popular among Congressional Republicans and likely to make it into any ACA repeal and replace proposal.
2. Understand the proposed Market Stabilization regulation released by the Department of Health and Human Services and how it will impact access to care in the 2018 qualified health plans.
3. Submit comments on the proposed rule to HHS urging them to consider the impact the proposed regulations will have on access to care for vulnerable individuals.

House Republicans Unveil Health Care Policy Brief

On February 16, 2017, after a closed-door meeting, House Republicans unveiled a [policy brief and resource document](#) to explain major elements of their plan to repeal and replace key programs and protections of the ACA. House Leadership is terming this strategy “repeal plus.” The policy brief should not be considered an actual legislative proposal but rather a “menu” of replacement ideas such as tax credits for purchasing health care, health savings accounts, and high risk pools. Part of the intention of this document is to encourage Congressional Republicans, who have found it [difficult to coalesce](#) around a health care policy strategy, to find consensus on these issues. Unfortunately, many of the components of this “repeal plus” strategy would curb access to care for vulnerable individuals, including those living with chronic illnesses and disabilities.

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Among the ideas proposed in the policy brief are:

- **Moving Subsidies to Reflect Age and Not Income.** Although the plan is short on specifics, it would replace the ACA's current tax subsidies for purchasing insurance on the exchanges with tax credits. Limited detail is provided regarding these tax credits except that they would be refundable (similar to the current subsidies) and would be age-rated. These tax credits, however, would not scale to reflect an individual's income. This means that lower income individuals will receive the same amount of support as middle or upper class Americans. While this support may be enough to help higher income individuals, it will likely not be enough to provide meaningful access to care for a person who is unable to supplement the tax credit with his or her own income. This is especially alarming for access to care for individuals living with chronic illnesses and disabilities because [lower income Americans](#) tend to be sicker and more likely to be disabled than higher income individuals.
- **Encouraging Health Savings Accounts (HSAs).** Republicans have long been proponents of HSAs, especially coupled with high deductible health plans, and the policy brief is no exception. The plan allows for individuals to contribute more to health savings accounts, which are tax free, and to deposit any tax credit funds left over after purchasing a health care plan, to their HSA. HSAs often do not work for lower income individuals, who cannot adequately fund such accounts. They also do not work for individuals with high anticipated health care costs, such as those living with certain chronic illnesses and disabilities, because their medical spending quickly outstrips any savings they can contribute to their HSA. While HSAs can allow higher income individuals with low medical costs to save, they should not be considered a good solution to access to care problems for vulnerable individuals.
- **Sharply Curtailing Federal Support of Medicaid.** The policy brief calls for the federal government to limit its financial support of Medicaid. The plan calls for repealing the ACA's Medicaid expansion. Additionally, it calls for the federal government to fund expansion enrollees at the basic Medicaid level, rather than at the 90% level currently promised by the ACA. This would force states to bear more of the cost of their expansion populations, which may lead states to limit their eligibility for Medicaid or end expansion altogether. The policy brief also gives states the choice of moving their Medicaid program to a block grant or per capita cap funding formula. Block grants would limit federal financial support of Medicaid programs, and likely force states to tighten enrollment requirements or cut benefits. The [Congressional Budget Office](#) determined that a similar block grant proposal would cut federal Medicaid spending by 35%.

Because the policy brief is so short, advocates interested in understanding these proposals in depth should review Speaker of the House [Paul Ryan's "A Better Way"](#) plan, which covers the same elements in greater depth. Although Congressional Republicans have yet to coalesce around a particular proposal, the policy brief is a good indication of which elements will likely be included in a "repeal and replace" bill. Advocates should make sure they understand the impact these elements, could have on vulnerable individuals.

Administration Proposes First Major Health Care Regulation Intended to Stabilize the 2018 Marketplaces

On February 15, 2017 the Department of Health and Human Services (HHS) released its first [major health care regulation](#) under new Secretary Tom Price. The purpose of this proposed rule is to stabilize the individual health insurance Marketplaces until Congress is able to repeal, replace, or repair the ACA. Unfortunately, however, many of the major components of the new regulation may have the opposite effect on the Marketplaces and actually curtail access to care.

The proposed new regulation would implement the following changes in the Marketplaces:

- **Shortening Open Enrollment for 2018:** The proposed rule moves the end of the 2018 open enrollment period from January 31, 2018 to December 15, 2017. HHS promises that they will "conduct extensive outreach to ensure that all consumers are aware of this change." Advocates should be sure to hold HHS accountable for this promise because



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otherwise many consumers, who are used to much longer open enrollment periods from the past several years, may find themselves shut out of enrollment for 2018.

- **Tightening Special Enrollment Periods (SEPs):** The ACA provides for SEPs to recognize that major life changes, such as loss of employer based coverage or the birth of a child, necessitate changes in health insurance coverage. Under President Obama, HHS was already working to fine tune SEPs, in response to insurer complaints, such as requiring documentation for certain SEPs and initiating a pilot program requiring verification for other SEPs. The proposed rule further tightens requirements to qualify for an SEP by: 1) requiring pre-enrollment verification of eligibility for all SEP categories as of June 2017 and expanding on the pre-enrollment verification program to cover about 650,000 individuals; 2) limiting the ability of enrollees to upgrade from one metal level (i.e. gold, silver, bronze) to another during a coverage year by using an SEP; 3) limiting eligibility for certain SEPs such as requiring at least one partner to have minimum essential coverage within the last 60 days prior to marriage for both spouses to qualify for a marriage SEP; and 4) limiting the use of the exception circumstances SEP (although more guidance on this issue will be forthcoming). Advocates should make sure that enrollment assisters and consumers are aware of the tightened restrictions around SEPs. Consumers should not assume that because they qualified for an SEP in the past that they will be able to do so in the coming years and should be strongly encouraged to obtain coverage during the open enrollment period whenever possible.
- **Establishing Continuous Coverage Requirements:** The proposed regulation asks for input on establishing continuous coverage requirements, designed to discourage adverse selection. The ACA has generally relied on the individual mandate instead of a continuous coverage requirement to encourage healthy individuals to maintain coverage. This request for input likely reflects the popularity of continuous coverage requirements as an alternative to the individual mandate among the Administration and Congressional Republicans. Unfortunately, continuous coverage requirements disproportionately burden people living with chronic illnesses and disabilities because any lock out period can prevent them from accessing the care they need to manage their often life-long conditions. The proposed rule does not contain a specific continuous coverage proposal, suggesting that HHS is unsure of whether to proceed on this issue. Advocates should be very vocal on this issue, making it clear to the Administration that a requirement that burdens vulnerable individuals rather than spreading the responsibility among all Americans is unacceptable. Now is the best time to intervene to halt the implementation of continuous coverage requirements in the Marketplaces, before a proposal is fully fleshed out.
- **Undermining Guaranteed Availability:** Under the current regulations and the ACA, consumers who fall behind on their premium payments cannot be terminated by insurers until the end of a three month grace period. During the first month of this grace period the insurer will pay claims as normal and in the second two months the insurer will pend claims until the individual catches up on payments. Under the ACA's guaranteed availability provision, insurers must offer coverage to any consumer during open enrollment periods or appropriate special enrollment periods regardless of whether they owe the insurer for last year's coverage so long as they are picking a different plan. This is intended to preserve access to care for many low income individuals who may fall behind on their premium payments. Under the proposed rule, however, an insurer would be able to attribute payments from a reenrolling consumer to last year's debts and refuse to effectuate further coverage until outstanding premiums were paid. This change may prevent individuals from obtaining coverage because their plans will not begin until they can clear their debts from last year's coverage. For those living with conditions that require continuous care and management to control properly, like diabetes or HIV, this change could result in a disruption of care.
- **Relaxing Actuarial Value (AV) Requirements:** The ACA requires that each metal level of qualified health plans achieve a certain AV. AV is the percentage of the total cost of health care expenses of a standard population that are covered by the insurer using premiums rather than by the enrollee using cost sharing and deductibles. A higher AV protects people with high medical spending, such as those living with chronic illnesses and disabilities, by requiring insurers to spread the costs of treatment around their entire enrollment population rather than asking vulnerable individuals to pay large sums out of pocket. The ACA allows some variation in AV among plans of the same metal

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level. The proposed rule would allow for greater variation in AV among these plans, which would allow insurers to market qualified health plans with higher cost sharing but lower premiums on the Marketplaces. These plans would be attractive to healthy higher income consumers but would potentially dissuade higher cost sicker individuals who could not afford the increased out of pocket costs. The crowding effect would in turn raise premiums on the plans that did not use the change in AV requirements to offer lower premiums because these plans would have a disproportionately sicker enrollment group. [The Center on Budget and Policy Priorities](#) estimates that the proposed change in AV requirements would require a family of four with an income of \$65,000 to either pay \$327 more per year in premiums for a plan that meets the current AV requirements or face a \$550 increase in their deductible if they purchased a plan with the new, lowered AV. Advocates should understand how AV requirements affect their communities, especially when it comes to lower income individuals who cannot shoulder higher out of pocket costs for their medical care. Advocates should submit comments to educate HHS on how AV requirements protect the most vulnerable and how relaxing these restrictions could affect these individuals.

- **Relaxing Network Standards:** Under the ACA, insurers must offer a sufficient choice of providers in their plans' networks. The proposed regulation seeks to weaken this provision by relying on state regulators and accreditation organizations to ensure network adequacy rather than HHS itself. There are some state regulators who will be able to handle this task, but other regulators are ill-equipped to do so. HHS also proposed to relax the requirement for insurers to include essential community providers, such as community health centers, safety-net hospitals, Ryan White Providers and Indian Health Services Centers, by requiring insurers to include within their network only 20% of essential community providers in their area rather than the 30% currently required. Advocates should reach out to their state regulators to understand how they anticipate reviewing network adequacy and pressuring insurers to include as many essential health providers who serve low-income medically-underserved individuals as possible in their networks.

One interesting aspect of the proposed rule is that it encompasses many of the demands presented by [America's Health Insurance Plans and the Blue Cross Blue Shield Association of America](#). This perhaps reflects the Trump Administration's desire to keep as many insurers in the Marketplaces for 2018, especially with [Humana's high profile pull back](#) from the 2018 Marketplaces. Advocates should make sure that the Administration does not forget that insurers are only one key stakeholder in the Marketplaces and that it is important for any new regulations also to reflect the need of consumers, particularly those living with chronic illnesses and disabilities who depend the most on their insurance to deliver the care they need.

Comments are due to HHS on March 7, 2017 and may be submitted electronically [here](#). Advocates should also keep their eyes open for a comment template focused on access to care concerns, to be released by the Center for Health Law and Policy Innovation in the next few days, and which can be easily modified to facilitate submission of comments.

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