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Passing the Buck: The Trump Administration Delegates Marketplace Oversight to the States

As insurers prepare to submit their applications to offer Qualified Health Plans (QHPs) on the 2018 Marketplaces, the Department of Health and Human Services (HHS) is issuing new regulations and sub-regulatory guidance that will significantly impact the Marketplaces. On April 13, 2017, HHS finalized their first major Marketplace regulation, the [Market Stabilization Final Rule \(Final Rule\)](#). They also issued two guidance documents, including [Guidance to the States on Health Plan Certification Standards in Federally-facilitated Marketplaces for Plan Years 2018 and Later](#). A common theme among these documents is that under the Trump Administration, HHS “[is committed to returning to the states their traditional authority to regulate health plans](#).” It is clear that HHS intends to delegate oversight of key QHP requirements, such as provider network adequacy, to the states. What is less clear is whether the states are equipped and willing to provide meaningful oversight.

This trend towards state delegation is concerning, particularly from the standpoint of geographic disparities and access to care. Some states have historically been proactive about regulating their health plans and may have the infrastructure to do so. Other states, however, have traditionally had much less oversight, and may fail to adequately regulate their QHPs. As a result, patients in these states may face discriminatory plan designs and other obstacles to accessing the care they need. There has been little to suggest that HHS has evaluated state capacity or appetite for these additional oversight responsibilities or is willing to provide support to build such capacity. In some states at least, the Final Rule is likely to result in less robust coverage and potentially discriminatory practices.

Advocates should:

1. Be aware that states regulators will be responsible for much of the evaluation of the proposed 2018 QHPs. Advocates should reach out to their Departments of Insurance to build relationships and educate them on discriminatory plan design.
2. Hold HHS accountable for its statutory responsibilities, including oversight of the Marketplaces, and express concerns to the Administration regarding the trend towards delegation.

In First Major Health Care Regulation, Trump Administration Cedes Authority and Pushes Marketplace Oversight to the States

Last week, HHS finalized its first major health care regulation, the Market Stabilization Final Rule. The Final Rule was intended to make changes to the Marketplaces that would attract insurers for the 2018 Plan Year. As the accompanying [press release](#) notes, one third of counties in the United States had only one insurer for 2017 and health care costs increased by an average of 25 percent from 2016 to 2017. To address these trends, HHS [proposed changes](#) reflecting many of the [requests](#) from the insurance industry. Many of these changes, however, are potentially harmful to access to care, particularly for vulnerable patient populations.¹ For example, some changes that HHS has now finalized include:

¹ For an in depth discussion of these changes, please see our previous *Health Care in Motion* piece on the proposed Market Stabilization Rule [here](#).



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- Shortening the open enrollment period for 2018 by a month and a half.
- Tightening qualifications for special enrollment periods (SEPs), including requiring pre-enrollment verification, limiting eligibility for certain SEPs, and prohibiting using an SEP to upgrade from one metal level to another.
- Allowing greater variation in actuarial value among QHPs, which would allow insurers to increase cost sharing requirements.

In response to its proposed rule, HHS received over 4,000 comments, despite a short submission window of only twenty days. Unsurprisingly, [insurers](#) generally supported these proposed changes, while [consumer advocates](#) were concerned that they would have a chilling effect on access to care. While HHS acknowledged the access to care concerns in the preamble of the Final Rule, ultimately it finalized the Rule with few to no changes responding to the significant concerns advocates raised.

Delegating Authority for Provider Network Oversight

A particularly concerning change finalized in the Final Rule is a delegation of provider network oversight from HHS to state regulators and private accreditation organizations. The Affordable Care Act (ACA) directs HHS to require that all health plans offering QHPs “ensure a sufficient choice of providers” and make information on their provider networks available. Under the Obama Administration, insurers were required to make network provider directories accessible and ensure that they were updated as appropriate. The Obama-era HHS reviewed the provider networks of proposed QHPs, using quantitative standards similar to those applied to Medicare Advantage plans, to ensure that these networks were satisfactory.

Under the Final Rule, however, HHS will no longer review QHP provider networks. Instead, state regulators will review network adequacy. In situations in which the state regulators lack the authority or means to perform this review, HHS will instead rely on the insurer’s accreditation from certain private accreditation bodies. If an insurer is not accredited, only then will it be required to submit a network adequacy access plan to HHS.

This delegation of authority is concerning because provider networks are crucial to access to care, especially for those living with chronic illnesses or disabilities that require specialists or are better managed within longstanding patient-provider relationships. While health care regulation, including evaluation of provider networks, is a traditional state role, not all states have taken an active role in carrying out this responsibility. Additionally, state standards for provider network adequacy can vary significantly. Delegating QHP provider network oversight to state regulators runs the risk of exacerbating geographic disparities, with some regulators allowing QHPs to have problematically narrow provider networks. Accreditation organization oversight is even more concerning because these organizations are not intended to meet governmental oversight requirements. Many accreditation organizations do not make their network adequacy standards publically available, nor can they resolve consumer grievances or take action against an insurer with inadequate provider networks.

Advocates should work to establish relationships with the state agencies, usually Departments of Insurance, now responsible for evaluating QHP provider networks. Advocates should educate these agencies on the importance of broad provider networks for people living with chronic illnesses and disabilities and urge agencies to make their adequacy standards public. Advocates should urge all state agencies, at a minimum, to adopt the National Association of Insurance Commissioner’s [Health Benefit Plan Network Access and Adequacy Model Act](#) to allow for some consistency across states and to ensure that all states meet a minimum standard of provider network review.

In light of these changes, advocates should encourage HHS to adopt this Model Act to provide consistent standards across all network evaluators. Advocates should also continue to voice to HHS that relying on private accreditation agencies to perform a public function is unacceptable, and push states without the regulatory capacity to review network adequacy to expand their agencies’ abilities to do so. Advocates should urge HHS to avoid shirking its responsibility to ensure QHP provider network adequacy. Further, if advocates identify examples of network inadequacy in a 2018 QHP, they should report their concerns to HHS and remind the Administration that robust federal oversight is still needed.

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Further Delegation to the States Through Sub-Regulatory Guidance

HHS also released two sub-regulatory guidance documents to accompany the Final Rule on April 13, 2017. Both of these documents suggest that HHS is looking to take a much less active role in overseeing and regulating the 2018 Marketplaces.

One of these documents re-establishes the [good faith compliance policy](#) for 2018, meaning that HHS will not impose civil monetary penalties against or decertify QHPs that act in “good faith” and make reasonable efforts to address regulatory concerns. This policy was in place for 2014 and 2015, but discontinued for 2016 and 2017 under the theory that the Marketplaces were mature enough that QHPs needed to meet higher standards of regulatory compliance. Re-establishing this policy suggest that HHS will not take an active role in policing the Marketplaces or pressuring insurers who offer problematic 2018 QHPs. Instead, insurers will be able to argue that they acted in good faith and avoid consequences for regulatory compliance issues.

The other sub-regulatory guidance document builds upon the Final Rule’s policy of delegating oversight to the state regulators by announcing HHS’s [intention to defer to state regulators](#) on the licensure and good standing of QHPs. For all states, HHS will defer to state review for licensure, good standing, and network adequacy for QHPs. In 2018 and beyond, HHS will rely on states with plan management responsibility to review QHP service areas, prescription drug formularies, and cost sharing for evidence of discriminatory plan design. These states include: Delaware, Kansas, Illinois, Iowa, Maine, Michigan, Montana, Nebraska, New Hampshire, Ohio, South Dakota, Virginia, and West Virginia. The guidance document did not discuss state capacity to perform these reviews, nor did it suggest that states would be receiving additional funds to build capacity for these new responsibilities. This new policy also raises concerns that HHS will forgo enforcement of the anti-discrimination provisions of the ACA, including Section 1557, altogether or rely on motivated state regulators and attorney generals to do so.

In the guidance document, HHS noted that this new policy is in keeping with the Trump Administration’s January 20, 2017 [Executive Order](#) urging all federal agencies to minimize the impact of the ACA.² HHS notes that this delegation is just the beginning, and that they “intend to engage with state regulators, issuers, and other stakeholders to determine whether we can further streamline the QHP certification process by relying on additional state reviews in future plan years and the appropriate timeframe for implementing such changes.” This suggests that this guidance document is merely the first step towards broader federal deregulation of the Marketplaces and QHPs.

Advocates should educate HHS on the importance of strong federal involvement in the Marketplaces and the need for consistent federal oversight across state lines for QHPs. Advocates should make sure to understand HHS’s responsibilities to adequately oversee the Marketplaces as imposed by the ACA, which remains the law of the land. Advocates should continue to stress the importance of HHS’s role in enforcing the anti-discrimination provisions of the ACA, even with states taking an increasingly larger role in evaluating QHPs for discriminatory benefit design. Advocates should also build relationships with the state regulators who are increasingly in charge of overseeing the Marketplaces and evaluating QHPs and urge them to take leadership roles in the regulation of health plans.

² For an in depth discussion of the Executive Order, please see our previous *Health Care in Motion* piece [here](#).

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