

## HYPER CHANGE IN A FRAGILE MARKET

*Improving quality and lowering costs through different partnerships and aligned incentives remain a constant in an uncertain market.*

The Affordable Care Act brought about guaranteed insurance coverage regardless of one's health status and a reduction in the uninsured rate based on Medicaid expansion, low-income premium subsidies, and tax penalties for those with less than nine months of coverage during the year. According to a Kaiser Foundation study, the number of uninsured Americans fell by 13 million in the 2 years following the January 1, 2014, implementation of the major portions of ACA. The uninsured rate for children has dropped to 5%. Per the Department of Health and Human Services, coverage effective January 1, 2017, exceeded 6.3 million consumers; a 400,000 increase over 2016 with 2 million new consumers and 4.3 million returning consumers.

Insurance carriers have been pushed to the edge of viability because of an unbalanced risk pool and therefore insufficient premium levels. Other headwinds to a balanced risk pool include flawed and unintended consequences of ACA rules such as special enrollment period not being enforced, grace periods, and risk adjustment formulas.

Special Enrollment Periods are designed for those who are already in the healthcare system and lose coverage allowing them to maintain continuous coverage. Insurance carrier data has shown that special enrollment claims are significantly higher than for open enrollment consumers. If enforced appropriately, the opposite should be the case as open enrollment consumers consist of many previous uninsured and those with pent up demand to care for their health care needs. Recent HHS changes to sporadically audit enrollees or verify eligibility before enrollment do not go far enough. Grace periods for premium payments have led to carriers being on the risk to pay claims without receiving premium payment. Risk adjustment is skewed where young and healthy are unprofitable and older and sicker are profitable. This needs to be juxtaposed with the need for a balanced risk pool of all ages and health status.

Change keeps coming. President Elect Trump has referenced repealing and/or replacing the Affordable Care Act. He is also proposing that guarantee issue with no pre-existing conditions clauses and children covered under their parents' plans to age 26 remain intact. The new head of HHS, Tom Price, has a history of opposition to the Affordable Care Act. As a member of the House of Representatives, he introduced legislation in multiple sessions of Congress to repeal and replace the ACA. His replacement proposals include tax credits to buy private insurance, expansion of HSA's (Health Savings Accounts), limiting employer deductions toward employee premium payments (discouraging overly generous employer coverage), and reintroduction of state high-risk pools.



So, where are we heading in 2017? Any material regulatory changes made in 2017 will most likely not take effect until 2018 or later based on the following: Insurance carriers are now deep into preparing 2018 offerings including the development of products, provider networks, and premium rates. These need to be complete by April or May depending on the state for filing purposes. They are also adjusting to the Final 2018 Benefit and Payment Parameters published in the Federal Register on December 22, 2016 including:

1. New language requirements for issuers and web brokers.
2. New standards for direct enrollment for issuers and web brokers (keeping a customer on the site with a behind the scenes connection with CMS for subsidy calculation and verification).
3. SEP risk adjustment changes.
4. Strategies and execution of standardized options.
5. Network adequacy changes.
6. Out of network out of pocket changes.
7. New use of RX data in risk adjustment formula.
8. Risk funding changes for high-risk enrollees.
9. New risk adjuster issuer data requirement.
10. Data validation process.
11. RADV discrepancy reporting.
12. AV calculator updates.

Any major changes that occur in early or mid 2018 that reduce the size of the insurance pool such as through elimination of premium subsidies and/or cost-sharing reductions, cause greater anti-selection than it is already inherent in the rules, or increase the administrative expenses of compliance will cause insurance carriers to pause, raise premium rates, and perhaps withdraw or reduce their footprint in 2018. This will result in higher uninsured rates and provider revenue reductions. Neither of these is good from a political standpoint and should be the impetus for the administration to move slowly and deliberately when making changes to an already delicate marketplace.

Regulatory change is needed to improve many deficiencies of the Affordable Care Act. Payers and providers will continue down the continuum of improving quality and lowering costs through different partnerships and aligned incentives of payers, providers, and consumers. These initiatives will continue regardless of the changes in regulation because it is the right thing to do.



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