CMS rule meant to firm up individual market could harm patients

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Tanya Albert Henry
Contributing News Writer

With insurance companies exiting some health insurance markets and increasing rates in numerous geographic areas, Centers for Medicare and Medicaid Services (CMS) officials in February released a proposed rule change to the Affordable Care Act (ACA) that they believe will shore up the health and competitiveness of state exchanges and individual and small group markets.

A shorter enrollment period, a lower threshold for essential community providers, tightened up special enrollment periods and modified variations allowed in actuarial value are among the areas in which CMS is proposing changes. But the AMA does not agree that the 19-page proposed rule is the best way to achieve a more stable health care market.

In a five-page letter, AMA CEO and Executive Vice President James L. Madara, MD, commented to CMS Acting Administrator Patrick Conway, MD, that physicians and medical students understood that "a stable individual health insurance market is necessary to ensure health insurer participation and competition." But Dr. Madara said physicians are concerned how a shorter enrollment period, a tightening up of special enrollment periods, proposed pathways to regulate networks, lower requirements for essential community providers (ECP) and other suggested changes would affect physicians and patients.

For example, the proposed 45-day open enrollment period for 2018 scheduled to take place between Nov.1 and Dec. 15—a period with holiday distractions—may not be enough time for consumers, especially young adults, to focus on and understand their options and enroll. "We recommend that CMS consider either delaying this change or consider moving the open enrollment period so that it begins in October," Dr. Madara said in his letter.

A proposal to reduce the ECP requirement from 30 percent to 20 percent "would result in serious access issues for some of the nation's most vulnerable patients," the AMA said, noting that ECPs care for individuals in low-income and/or medically underserved communities.

The AMA also expressed concern about a proposed change to guaranteed issue. Under current regulations, individuals cannot be denied coverage simply because they owe a debt to an insurer for a previous year's coverage as long as the consumer is not re-enrolling in the same product from which the consumer was terminated for nonpayment. In addition, enrollees are protected by a three-month grace period before being terminated for non-payment of premium.

CMS is proposing that an insurer can condition coverage for a new enrollment period under the same or a different product on payment of the amount due by the consumer. The insurer could refuse to enroll a consumer—as long as state law does not prohibit such action—until an individual has paid all past due premiums owed to that insurer. The AMA commented that if insurers are going to be made whole, then physicians who have treated enrollees during the second and third months of the grace period should also be made whole for any claims submitted during this period.

Another problematic element of the proposed CMS rule would allow greater variation in the actuarial value (AV) of Qualified Health Plans. AV is the percentage of the total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70 percent, on average, the insured patient would be responsible for 30 percent of the costs of all covered benefits. Although the proposed change of a few percentage points for the four metal levels of plans offered on exchanges seem minor, the AMA said a closer look shows they are problematic.

"The changes would allow insurers to offer plans with higher deductibles and other out-of-pocket costs, but with slightly lower premiums," Dr. Madara wrote. "We are concerned that this change would, in turn, reduce the value of the advanced premium tax credits. … Consumers with moderate incomes would be confronted with higher out-of pocket costs, either through premiums or cost-sharing. This would mean that for consumers who wanted to keep the same coverage they currently have, tax credits would cover less of the cost. Either way, patients will end up paying higher premiums or opting for worse coverage."

The comment period on the proposed rule ended March 7. More than 4,000 individuals and organizations submitted comments. The rule is at the White House Office of Management and Budget for final review.

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