BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

February 1, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via www.regulations.gov

RE: Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Exchanges, Medicaid and CHIP (CMS–10440)

Dear Acting Administrator Slavitt,

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services' ("CMS") Paperwork Reduction Act (PRA) package on the exchange application process (CMS–10440).

BCBSA is a national federation of 36 independent, community-based, and locally operated Blue Cross and Blue Shield Plans ("Plans") that collectively provide healthcare coverage for nearly 105 million – one in three – Americans. Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program (FEHBP).

As CMS considers changes to the exchange application process through this PRA, we continue to strongly urge immediate changes to reduce the number of special enrollment periods (SEPs) and verify SEP eligibility. CMS should also improve the process by ensuring consumers eligible for or enrolled in Medicare are not enrolled in a QHP, and by minimizing data matching inconsistency issues.

Our recommendations are included below and summarized as follows:

1. **CMS should reduce the number of SEPs** by aligning qualifying life events more closely with those used in Medicare Advantage (MA), FEHBP and the private market.
2. **CMS should verify** that applicants qualify for their attested SEPs prior to coverage.
3. **Issuers should also be allowed to collect information to validate SEPs**, as they routinely do off-exchange and in other guaranteed issue markets.
4. **CMS should establish processes for sharing SEP data between issuers and CMS.**
5. **CMS should ensure consumers eligible for or enrolled in Medicare are not enrolled in a QHP** through the exchange application process.

6. **CMS should make applicants' data matching inconsistencies and the process for resolving them more prominent** in the application and on notices.

The initial steps CMS took in its recent SEP guidance are encouraging, however, more is needed to stabilize the risk and prevent improper use of SEPs. New initiatives should focus on ensuring program integrity up front, rather than allowing inappropriate enrollments that must be chased down and reversed. Retroactive terminations cause disruption to consumers and present operational hurdles for issuers and providers because paid claims are rescinded. The high cost to the consumer at the point of retroactive termination can easily outweigh the minimal burden of verifying SEP eligibility.

Below we detail our recommendations. We urge CMS to implement as many of these improvements as soon as possible in 2016, understanding that some improvements will require more time to operationalize. Specific recommendations for improvements to the FFM application are referenced throughout our recommendations below and compiled in Appendix A.

1. **CMS should reduce the number of SEPs** by aligning qualifying life events more closely with those used in MA, FEHBP and the private market. Consistent with our recommendations on the proposed Notice of Benefits and Payment Parameters for 2017 and draft Annual Letter to Issuers for 2017, we urge CMS to address the proliferation of SEPs that are threatening the sustainability of the market. While we appreciate the initial steps CMS took to reduce SEPs in recent guidance, individuals can still use SEPs as a way to delay buying coverage until they need medical services. This undermines both the individual requirement to purchase coverage and the limited open enrollment period which were put into the law to prevent erosion of the risk pool. Our recommendations, including detailed changes to regulatory language, are summarized in Appendix E.

2. **CMS should verify that applicants qualify for their attested SEPs prior to coverage.** Consumers are accustomed to providing information for SEP eligibility since it is an exception to the annual open enrollment period. CMS should:

    - **Begin verifying immediately by leveraging other existing consumer data to check for SEP eligibility in 2016.** The FFM application currently does a good job of automatically granting the APTC/CSR SEP to consumers whose eligibility redeterminations result in their being newly eligible or ineligible for an Advanced Premium Tax Credit (APTC), or in a different cost-sharing reduction (CSR) bracket. The application also automatically grants the birth SEP when it recognizes a dependent added with a birthday in the last 60 days. CMS should build on this automation to streamline other aspects of the application. For example, the FFM application should check against issuers' recent non-payment terminations when applicants claim the "Loss of Minimum Essential Coverage (MEC)" SEP which should disqualify them for the SEP under 45 CFR 155.420(e). Additionally, the FFM application should compare QHPs available to applicants at their new and previous addresses, to ensure there are indeed new QHPs available as a result of a permanent move as required under 45 CFR 155.420(d).

    - **Amend the exchange application to collect proof of SEP eligibility to verify SEPs.** We urge CMS to begin verification as soon as possible in 2016, understanding that some changes will require more time to operationalize. It is common practice for issuers to ask consumers to provide documentation, such as a current utility bill or lease/rental

agreement to validate a permanent move in the private market. Issuers also seek proof of loss of coverage and certificates of marriage/birth to document new dependents. Consumers enrolling through SEPs in the exchange should be required to provide this same kind of documentation. The healthcare.gov application process should be modified for consumers to upload verification documents on-line. We recommend specific questions to ask and documents that could be collected in Appendix A.

- **Focus resources on working with issuers to integrate SEP verification in the healthcare.gov application process.** Overall, upfront verification is a more consumer friendly approach because it avoids conflicts on the back end that consumers, issuers and exchanges must reconcile. CMS can strengthen and streamline its SEP program integrity initiative by drawing on issuers' experience and willingness to aid in its SEP verification efforts. Currently, the FFM uses the same enrollment process for SEPs that it uses for the millions of individuals that enroll during the annual enrollment period. Because SEPs are by definition unique circumstances, CMS should work with issuers to detail any changes to the existing enrollment process to accommodate verification.

3. **Issuers should be allowed to collect information to validate SEPs prior to effectuating coverage.** At a minimum, CMS should explicitly allow issuers the option to validate SEP eligibility. The Affordable Care Act (ACA) and CMS regulations require products sold off the exchange to meet almost all of the same requirements as certified QHPs sold on exchange. Almost all of the SEPs required of issuers off-exchange are the same as those required on-exchange. Issuers are required to ensure the same risk pool for individuals regardless of whether they enroll on- or off-exchange, so issuers should be permitted to align SEP processes.

4. **CMS should work with issuers to establish processes for sharing SEP enrollment data and validation information.** We anticipate CMS will soon release additional details on policies and procedures, funding, and results of its SEP investigation. It's unclear if CMS envisions enforcement processes including issuer findings as well. As previously stated, we strongly recommend upfront validation to accompany the post-enrollment enforcement approach CMS is taking.

   Below are recommendations for an enforcement process that is less burdensome on CMS, issuers and consumers. CMS should:

   - **Leverage information collected by issuers to assist CMS' program integrity initiative.** There should be a reporting process for issuers to send information to the CMS enforcement unit. Obvious contradictions to SEP eligibility, such as loss-of MEC SEPs for consumers recently terminated for non-payment, should be accepted by CMS through formalized processes.

   - **Send FFM issuers distinct SEP reason codes for each SEP, including separate codes for each of the sub-regulatory SEPs.** This will allow issuers to better track and verify SEPs, and more effectively aid in CMS' program integrity efforts.

   - **Formalize how CMS establishes whether an individual qualifies for an SEP or intentionally provided false information.** All stakeholders should know what CMS is requiring for purposes of proving eligibility for SEPs. The list should be made available

for input through a public process. Further, CMS should clarify how it establishes whether an individual intentionally provided false information.

5. **CMS should ensure consumers eligible for or enrolled in Medicare are not enrolled in a QHP.** We recommend revisions to the application process to ensure it actively prohibits individuals eligible for or enrolled in Medicare from applying for and enrolling in a QHP. Similar to current screening for Medicaid or CHIP eligibility, the application process should identify individuals who are eligible for or enrolled in Medicare to avoid enrolling these individuals in QHPs.

   All applicants should be required to attest to Medicare eligibility and enrollment status, regardless of whether they are seeking financial assistance. The current Marketplace application does little to discourage Medicare-eligible or enrolled individuals from applying for and enrolling in a QHP.

   We recognize that the CMS Annual Letter indicates that certain Medicare-eligible and enrolled individuals –those under age 65 with end stage renal disease (ESRD) and those who do not have Medicare Part A or Part B – are eligible to enroll in individual market coverage. However, the ACA did not intend for exchanges to facilitate enrollment into QHPs for individuals already enrolled in Medicare or Medicare-eligible.

   Screening questions at the time of an exchange application for enrollment or renewal should identify applicants who meet Medicare age (over age 65) or disability (including ESRD) criteria. If an individual meets those criteria, a pop-up notice should inform the individual of their potential Medicare eligibility, explain that Medicare-eligible individuals are not eligible for exchange subsidies (and that they may face penalties if they do receive APTC), and redirect those individuals to additional information about Medicare eligibility and enrollment. If an applicant who meets these criteria proceeds to submit an application, the exchange should verify Medicare enrollment against HHS databases and deny eligibility for individuals enrolled in Medicare.

   We also recommend that CMS post more educational items on www.healthcare.gov related to Medicare with a link to www.ssa.gov and www.medicare.gov so that persons eligible for or enrolled in Medicare do not apply for a QHP. Pop-up messages and other such notifications to applicants entering data in www.healthcare.gov is strongly encouraged to ensure applicants have a coordinated enrollment in Medicare during their initial open enrollment period.

   Finally, we recommend that the three websites, www.ssa.gov, www.medicare.gov and www.healthcare.gov have coordinated messages and links to ensure persons approaching their Medicare initial eligibility period are fully informed of the steps they need to take to enroll in Medicare, and are redirected from one site to another to ensure appropriate enrollment.

6. **CMS should make applicants' data matching inconsistencies and the process for resolving them more prominent on the application and notices.** Plans have found that consumers are unaware of the importance of resolving their data matching inconsistencies and the impact on their coverage or subsidy if such inconsistencies are not resolved. The exchange application and enrollment screens and notices do not clearly explain when consumers have a data matching inconsistency, how to resolve it, or the consequences of ignoring it.

We recommend exchange application and enrollment screens and notices include more prominent information about the inconsistency, a timeline for resolution, outreach the consumer can expect, specific steps and documentation for resolution, and the consequences of failure to resolve the inconsistency. Consumers should be made aware that their coverage could end or financial assistance could be reduced.

In addition, enrollment files to QHPs (834s) should include an indicator so issuers can immediately conduct outreach. Consumers are more likely to take action if they hear from their plan. If 834 indicators cannot be added in the near term, we recommend CMS send applicants' inconsistency information to issuers in separate files as soon as possible, rather than waiting months as is currently the case.

We further recommend the agent or broker who assists with the enrollment also receive a prominent indicator communicating that the consumer's enrollment is at risk. This will allow the agent or broker to also help the consumer resolve the inconsistency as quickly as possible.

We also urge CMS to ensure that any stakeholders working with consumers through the application process are required to certify in their training and as a condition of receipt of any federal grant dollars that they will ensure consumers are fully aware of criteria for eligibility and enrollment requirements, including criteria to qualify for an SEP and that individuals eligible for Medicare do not enroll in QHPs.

Finally, as we previously recommended on the proposed Notice of Benefits and Payment Parameters for 2017 and draft Annual Letter to Issuers for 2017, CMS proposed rules could make it easier for some people to remain uninsured and exacerbate the unbalanced risk pool by permitting third parties, especially those related to healthcare providers or manufacturers, to target particular individuals and pay their premiums and cost-sharing rather than basing such assistance on financial need. We continue to recommend that CMS not expand the list of entities for which issuers must accept premium and cost sharing payments. Third party premium payment should be based on financial need and not health condition, consistent with the overall design of the ACA.

We look forward to partnering with the states and the federal government to provide access to high quality, affordable health coverage that meets the diverse needs of consumers. Please let us know if you have any questions or would like additional information.

Sincerely,

Justine Handelman
Vice President, Legislative and Regulatory Policy

Appendix A - Recommended Application Changes, Potential Verification, and Back-end Improvements

The FFM application should be modified for consumers to upload verification documents on-line. The application should display a list of acceptable documents, and should prioritize documentation for the SEPs listed below.

SEP or Eligibility Section	Application Improvements	Verification documents that could be collected	Back-end Improvements
Loss of Minimum Essential Coverage	Questions that should be asked of consumers: 1. Did you lose coverage or will you lose coverage because you stopped paying your premium? 2. Did you lose coverage or will you lose coverage because you voluntarily ended your coverage? 3. To verify you lost minimum essential coverage, submit one of the following pieces of information: [list acceptable documents]	• Medicaid or Medicare notification of loss of coverage • Carrier coverage cancellation notice or certificate of creditable coverage • Letter from employer confirming recent or upcoming termination of coverage and reason • Pay subs showing reduction in hours • Employer letter confirming no longer contributing to health insurance or other reason • COBRA election form (for ESI loss) • COBRA termination letter including reason • Certificate of Release or Discharge from Active Duty • HHS notice confirming loss of Marketplace coverage • Renewal letter from carrier or written verification from agent (for non-calendar year plan anniversaries) • Proof of loss of dependent status due to reaching maximum allowable age • Recent Medicaid/CHIP denial	The FFM should automatically verify applicants' attestation that they did not lose coverage due to non-payment of premium. This can be accomplished by checking the FFM's database of issuer non-payment records, ideally in real-time as the applicant is applying for the loss-of-MEC SEP.

SEP or Eligibility Section	Application Improvements	Verification documents that could be collected	Back-end Improvements
		confirming application was submitted within open enrollment	
Permanent move	Questions that should be asked of consumers: 1. What was your prior address? 2. Do you intend to reside at your new address permanently? 3. To verify your new address, submit one of the following pieces of information: [list acceptable documents]	• Current utility billing statement or work order dated within 60 days of the application • Lease or rental agreement • Deed, mortgage, monthly mortgage statement, mortgage payment booklet • New driver's license or state photo ID card • State vehicle registration or title or automobile payment booklet • Prison release form, certified letter or notarized document • Paperwork confirming release or discharge from active duty • Post office address change	The FFM should compare QHPs available to applicants at their new and previous addresses, to ensure there are indeed new QHPs available as a result of a permanent move. In the case of current enrollees who are updating an address, automatically compare the address on the prior version of their application to their new address. The FFM should automatically search its database of QHPs available for each address, ideally in real-time as the applicant is applying for the permanent move SEP.
Gain or become a dependent through marriage	Application step that should be required of consumers: 1. To verify you are adding a new dependent, submit one of the following pieces of information: [list acceptable documents]	• Marriage certificate • Domestic partnership certification or agreement • Birth certificate (for children gained through marriage)	CMS should only grant the SEP to the newly added spouse. Current enrollees should not be permitted to change plans.
Gain or become a dependent through birth, adoption, foster care, court order	Application step that should be required of consumers: 1. To verify you are adding a new dependent, submit one of the following pieces of information: [list acceptable documents]	• Birth certificate • Medical records from hospital or pediatrician indicating name and DOB • Adoption or foster care certificate or legal papers • Dependency verification letter	CMS should only grant the SEP to the newly-added dependent. Current enrollees should not be permitted to change plans.

SEP or Eligibility Section	Application Improvements	Verification documents that could be collected	Back-end Improvements
		for foster care • Medical authorization form • Relinquishment form • Evidence of medical guardianship • Court order • Copy of legal document requiring health coverage • Letter from insurer	
Residency	The following should be required for all new Marketplace applicants: 1. Do you intend to reside at this address permanently? 2. To verify your address, submit one of the following pieces of information: [list acceptable documents]	• Current utility billing statement or work order dated within 60 days of the application • Lease or rental agreement • Deed, mortgage, monthly mortgage statement, mortgage payment booklet • New driver's license or state photo ID card • State vehicle registration or title or automobile payment booklet • Prison release form, certified letter or notarized document • Paperwork confirming release or discharge from active duty • Post office address change	
Data Matching Inconsistencies	Marketplaces should include more prominent information about an inconsistency, a timeline for resolution, outreach the consumer can expect, specific steps and documentation for resolution, and the consequences of failure to resolve the inconsistency.	List documentation specific to the inconsistency	Enrollment files to plans (834s) should include an indicator so issuers can immediately conduct outreach. The agent or broker who assists with the enrollment should also receive a prominent indicator communicating the consumer's enrollment is at risk to allow the

SEP or Eligibility Section	Application Improvements	Verification documents that could be collected	Back-end Improvements
	Consumers should be made aware that their coverage could end or financial assistance could be reduced.		agent or broker to also help the consumer resolve the inconsistency as quickly as possible.
Report a Life Change	Questions that should be asked of consumers: 1. Have you had any other changes like these? [include complete list] a. Yes b. No	List all eligibility changes, including SEP qualifying events. Caveat age-off is not age 26 for all states or plans.	A “yes” answer should route the applicant directly into a new version of the application for them to update.

Appendix B - Recommended SEPs to Keep, Eliminate or Strengthen

While we appreciate the initial steps CMS took to reduce SEPs in recent guidance, people continue to use SEPs as a way to delay buying coverage until they need medical services. CMS should streamline SEP application questions and discourage applicants from enrolling only when they need care. Over 30 SEPs continue to be available, and the chart below recommends changes to or retiring of specific SEPs.

SEPs to Keep	SEPs to Eliminate	SEPs to Strengthen
• Contract violations* • Newly eligible or ineligible for subsidies* • American Indian* • Gain citizenship or lawful presence* • Non-Medicaid expansion* • Determined ineligible for Medicaid/CHIP* • Employer-sponsored coverage change* • Release from incarceration* • Loss of dependent or dependent status† • Passive enrollment into wrong plan† • Passive enrollment technical error† • Inconsistency resolution† • Service area errors† • Domestic abuse or spousal abandonment†	• Other situations CMS deems appropriate† • Crosswalk plan suppressed† • Plan change error† • Discontinued Plan with no crosswalk† • Other system errors† • In line† • Unresolved casework† • Error message† • Marketplace outage† • Data Display Error† • Defective Enrollment† • Unaffiliated Issuer Enrollments†	• **Permanent move*** - Exchanges should verify enrollees who are granted this SEP previously had coverage. For example, application questions should ask for the enrollee's previous address and coverage status at that address. Exchanges should also verify that the new address provided is not a provider office, business or other public dwelling. • **Gain or become a dependent*** - Should only be granted for new dependents added. CMS should not allow current enrollees to change plans. • **Loss of MEC*** - Exchanges should validate that this SEP does not apply to enrollees who previously lost coverage due to non-payment, consistent with §155.420(e). For example, CMS should permit issuers to reject an enrollment with a "loss of MEC" reason, when the issuer has a record of non-payment. • **Exceptional Circumstances*** – CMS should narrow the exceptional circumstance SEP (155.420(d)(9)) so it is no longer based on any individual claiming they have an "exceptional circumstance" to the call center. It should be defined using categories that can be clearly articulated in CMS sub-regulatory guidance. A natural disaster or complete technical failure may be an exceptional circumstance, but a recent diagnosis or a problem in paying premium is not. • **Marketplace enrollment errors*** - CMS should clearly articulate the categories of errors that qualify individuals for this SEP in sub-regulatory guidance.

* Required in regulation, §155.420(d). † Required under sub-regulatory guidance

Appendix C - SEPs Shared with Medicare, FEHBP & HIPAA

	Exchange SEPs	Also a Medicare SEP	Also a FEHBP SEP	Also a HIPAA SEP
1.	Loss of Minimum Essential Coverage *	✓	✓	✓
2.	Gain or become a dependent *		✓	✓
3.	Gain citizenship or lawful presence*			
4.	Marketplace enrollment errors*	✓		
5.	Determined ineligible for Medicaid*			
6.	Contract violations*	✓		
7.	Newly eligible or ineligible for subsidies*	✓		
8.	Employer-sponsored coverage change*		✓	
9.	Non-Medicaid expansion*			
10	Permanent move*	✓	✓	
11	American Indian*			
12	Exceptional circumstances*	✓		
13	Domestic abuse or spousal abandonment†			
14	Release from incarceration*	✓		
15	Loss of dependent or dependent status†		✓	✓
16	Inconsistency resolution†			
17	Marketplace outage†			
18	Defective Enrollment†			
19	Data display error†			
20	Error message†			
21	Unresolved casework†			
22	Other system errors†			
23	In line†			
24	Service area errors†			
25	Passive enrollment technical error†			
26	Discontinued Plan with no crosswalk†		✓	
27	Passive enrollment into wrong plan†			
28	Unaffiliated Issuer Enrollments†			
29	Crosswalk plan suppressed†			
30	Plan change error†			
31	Other situations CMS deems appropriate†		✓	

* Required in regulation, §155.420(d). † Required under sub-regulatory guidance

Appendix D - Definitions and Origins of Exchange SEPs

1. **Lose other health coverage**:[1] you or your family lose coverage that qualifies as minimum essential coverage (MEC) during the benefit year, including, but not limited to, most employer-sponsored coverage and Medicaid. If you or your family are enrolled in individual coverage or group health plan coverage that ended during the year or you lose Medicaid pregnancy-related coverage or Medicaid coverage for medically-needy, you may also qualify for this special enrollment period.
2. **Gain or become a dependent**:[1] you gain or become a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or due to a child support or other court order.
3. **Gain citizenship, national, or lawfully present status**:[1] you gain status as a citizen, national, or lawfully present individual.
4. **Experience a Marketplace enrollment error**:[1] you weren't enrolled in a plan or were enrolled in the wrong plan because of misinformation, misrepresentation, misconduct, or inaction of someone working in an official capacity to help you enroll.
5. **Being determined ineligible for Medicaid/CHIP**:[1] you applied for Medicaid/the Children's Health Insurance Program coverage during the Marketplace Open Enrollment Period or after qualifying for a special enrollment period and your state Medicaid/CHIP agency determined you weren't eligible.
6. **Experience a plan contract violation**:[1] you adequately demonstrate to the Marketplace that your Marketplace health plan has substantially violated a material provision of its contract.
7. **Become newly eligible or ineligible for help paying for your coverage**:[1] you or your family are enrolled in coverage and are determined newly eligible or ineligible for advance payments of the premium tax credit (APTC) or have a change in eligibility for cost-sharing reductions (CSRs).
8. **Experience changes to employer-sponsored coverage and become newly eligible for help paying for your coverage**:[1] you're now eligible for advance payments of the premium tax credit (APTC) because you're no longer eligible for employer-sponsored coverage, your coverage is discontinued, or your coverage is no longer considered minimum essential coverage (MEC).
9. **Live in a state that hasn't expanded Medicaid and become newly eligible for help paying for your coverage**:[1] you live in a state that hasn't expanded Medicaid and you weren't eligible for Medicaid or advance payments of the premium tax credit (APTC) when you first applied because your income was too low, but due to a change in household income, you're now eligible for APTC.
10. **Gain access to new health plans because of a permanent move**:[1] you permanently move to a new area and have new Marketplace health plan choices.

[1] 45 CFR 155.420(d)

11. **Gain or maintain status as an American Indian or Alaska Native**:[1] you gain or maintain status as a member of a federally recognized tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders.
12. **Experience an exceptional circumstance**:[1] you demonstrate to the Marketplace that you've experienced an exceptional circumstance that prevented you from enrolling in coverage, like a serious medical condition or natural disaster.
13. **Experience domestic abuse/violence or spousal abandonment:**[2] you're a victim or survivor of domestic abuse/violence or spousal abandonment and want to enroll in your own health plan separate from your abuser or abandoner.
14. **Release from incarceration:**[3] you are released from jail.
15. **Loss of dependent or dependent status:**[4] you lose a dependent or lose dependent status through divorce, legal separation or death.
16. **Inconsistency Resolution:**[5] you attest to having submitted timely documentation to resolve an inconsistency, after your 90-day window to submit documentation expired, or you are auto-enrolled following resolution of your inconsistency, and wish to change plans.
17. **Marketplace Outage:**[6] the Marketplace has a planned system outage, such as an SSA outage, that occurs on or around plan selection deadlines
18. **Defective Enrollment:**[7] you enrolled through the Marketplace, but the QHP issuer could not receive or process the enrollment due to technical errors with the data or systems
19. **Data display errors:**[8] incorrect plan data was displayed at the time you selected a plan, such as plan benefit and cost-sharing information
20. **Error message**:[9] you are unable to complete enrollment due to a Marketplace error message
21. **Unresolved casework**:[10] you are working with a caseworker on an enrollment issue that is not resolved prior to the plan selection deadline.
22. **Other systems errors:**[11] other systems errors, as determined by CMS, which hinder enrollment completion
23. **In line:**[12] you begin, but cannot complete the enrollment process before the end of open enrollment, due to high call center or website volume
24. **Service area errors:**[13] your address is outside the service area of your selected plan, which you were able to select due to a Marketplace or QHP issuer error

[2] 7/27/15 CCIIO memo
[3] March, 2012 Exchange Final Rule Preamble, and SEP qualifying question in the Marketplace application
[4] 155.420(d)(2)(ii). Effective January 1, 2017, or earlier, at the option of the Exchange.
[5] Bulletin #11
[6] Bulletin #3
[7] Bulletin #3
[8] Bulletin #3
[9] Bulletin #3
[10] Bulletin #3
[11] Bulletin #3
[12] 3/26/14 CCIIO memo

25. **Passive enrollment technical error:**[14] you were not auto-renewed due to an error in the auto-renewal process
26. **Discontinued plan with no crosswalk:**[15] you were not auto-renewed because your plan was discontinued
27. **Passive enrollment into incorrect plan:**[16] you were auto-renewed into a plan that does not match your QHP issuer's renewal notice or renewal materials
28. **Unaffiliated Issuer Enrollment:**[17] your coverage or subsidies were terminated 12/31/15 due to conflicting enrollment records between the FFM and your issuer. Expires 4/30/16.
29. **Crosswalk plan suppressed:**[18] you were not auto-renewed due to the fact that your auto-renewal plan was suppressed by the Marketplace
30. **Plan change error:**[19] you changed plans, but your original coverage was not terminated, due to a Marketplace system error
31. **Other situations CMS deems appropriate**[20]

[13] Bulletin #12
[14] Bulletin #15
[15] Bulletin #15
[16] Bulletin #15
[17] Issuer Guidance for Handling 2015 Unaffiliated Issuer Enrollments. Posted to Regtap 12/4/15.
[18] Bulletin #15
[19] 3/2/15 Regtap presentation
[20] 9/30/15 FFM Enrollment Manual, section 5.3.1

Appendix E – Steps should be taken to reduce and validate SEPs

Issue

A system where people can get health insurance regardless of preexisting conditions can only be viable if people maintain continuous coverage. Current rules allow some people to use special enrollment to purchase coverage only when they need medical care. SEPs are negatively impacting the overall risk pool of exchange enrollees, resulting in higher costs for plans, and ultimately higher costs for all consumers. As premiums increase, it becomes increasingly difficult to enroll younger and healthier people – an unsustainable cycle.

Recommendations

- Exchanges should reduce the number of SEPs by aligning qualifying life events more closely with those used in Medicare Advantage and the employer market.

- Exchanges should be required to verify that applicants actually qualify for their attested SEPs.

- Issuers should be able to collect information to validate SEPs, as they routinely do off-exchange and in other guaranteed issue markets. Issuers and Exchanges should work together so issuers can make Exchanges aware of obvious contradictions to eligibility prior to an applicant being enrolled in coverage.

Immediate Regulatory Changes

- Permanent move. This SEP should only be granted to those who previously had coverage. Specifically, the regulations should be modified as follows:

  §155.420(d)(7) The qualified individual or enrollee, or his or her dependent is currently enrolled in minimum essential coverage and gains access to new QHPs as a result of a permanent move

- Gaining or becoming a dependent. This SEP should only be granted for coverage of new dependents. Current enrollees should not be able to change plans. Specifically, the regulations should be read as follows:

  §155.420(d)(2)(i) The qualified individual ~~gains a dependent or~~ becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order

- SEP Verification. CMS should update the regulations to require that all exchanges verify qualifications for an SEP. In particular, exchanges must ensure individuals can no longer claim “Loss of minimum essential coverage” if they lost coverage due to non-payment, consistent with §155.420(e).

Rationale

The current risk pool is out of balance, with a disproportionate number of people who need significant health care services and a growing population of individuals that do not enroll for 12 months of continuous coverage. Current rules and procedures allow millions of consumers who enroll through SEPs to have an adverse effect on the overall market stability because they can

purchase coverage only when they need medical care. An increasing number of consumers are not paying the premium for a full year. This makes health insurance more expensive for everyone, increasing the cost of premiums and subsidies for exchanges, and discourages younger, healthier people—who are critical to a stable risk pool – from enrolling.

The large number of SEP-qualifying events, combined with the attestation-based approach makes it too easy for consumers to enroll only when they need coverage. Plans are analyzing SEP enrollment, utilization and costs, and are uncovering troubling trends.

- Plans are finding a high percentage of their overall Exchange membership is enrolling through SEPs. BCBS plans estimate as much as one third of their membership has enrolled through an SEP. Their findings are consistent with United's and Aetna's findings that 20% and 25% of their respective Exchange membership enrolled outside the open enrollment period last year, and United expects that number to increase to 30% this year. BCBS plans report that prior to the ACA, their SEP membership was about 5% of their total.

- BCBS plans are finding individuals enrolling through SEPs are utilizing more services, and are accessing those services more quickly following enrollment, suggesting that SEP enrollees are waiting until they need care to enroll. For example, one BCBS plan found the average paid cost per member for claims incurred within 30 days of a member's effective date is 27% higher for members who enrolled during the special enrollment period versus members who enrolled during the open enrollment period.

- Finally, despite risk adjustment, plans are finding SEP enrollees are more expensive than their open enrollment counterparts. BCBS plans report their costs for SEP members are as high as 43% more than their costs for members enrolling during the open enrollment period.

A course correction is needed now or this unsustainable trend will get worse in the future. As we enter the fourth year of the new market, it is critical that CMS adopt policies to maximize enrollment every year during the Annual Enrollment Periods. The recommended changes outlined above would discourage individuals and their family members from foregoing coverage until they need it mid-year.