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CMS Finalizes Enrollment Changes Aimed at Stabilizing ACA Marketplaces

CMS issued final rules designed to stabilize the ACA marketplaces while the Trump administration works with Congress on ACA repeal and replace efforts. Specifically, aiming to improve risk pools and thereby encourage insurers to stay in the marketplaces in 2018, CMS shortened the marketplace open enrollment period by 45 days and tightened special enrollment rules. Employers wishing to provide marketplace-related information to qualified COBRA beneficiaries, early retirees, employees on leave, and others who are about to lose, or have already lost, employer-sponsored coverage should pay attention to these changes.

Background

Under the Affordable Care Act (ACA), states either established a state-based health insurance marketplace (also known as an exchange) to facilitate the purchase of health insurance or participated in the federally facilitated marketplace (FFM). Electing marketplace coverage is generally permitted only during an annual open enrollment period. However, similar to employer plans, the marketplaces also offer "special enrollment" periods that allow individuals to enroll in a marketplace plan or change from one marketplace plan to another following particular qualifying events. (See our August 4, 2014 *For Your Information*.)

The Trump administration and GOP-led Congress plan to move forward with ACA repeal and replace despite lack of GOP unity having derailed initial repeal efforts. (See our April 3, 2017 *Legislate*.) In the meantime, however, premium spikes and insurer exits threaten the stability of the ACA marketplaces – and some insurers have pointed to marketplace special enrollment periods as a particular source of adverse selection. They maintain that the current rules allow too many individuals to enroll in coverage only after they discover that they require health services, undermining the risk pool. This phenomenon has led some insurers to stop offering marketplace coverage in certain geographic areas and to increase rates where they continue to offer coverage. Higher rates, in turn, can discourage healthier people from obtaining coverage – further damaging the risk pool.

On February 15, 2017, the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) proposed rules designed to encourage insurers to stay in the market for the 2018 benefit year. (See our February 28, 2017 *For Your Information*.)

The Changes

On April 13, 2017, CMS issued a final rule, largely mirroring its proposal, along with an accompanying press release. In the final rule, CMS:

- **Shortened the 2018 open enrollment period by 45 days to November 1, 2017 through December 15, 2017**. The goal in this change is to improve the risk pool by weeding out people who learn in late December 2017 or early January 2018 that they will need health services in 2018, and encourage healthier people who might have otherwise enrolled in partial year coverage (meaning coverage starting later than January 1, 2018) to enroll instead in full-year coverage. State-based exchanges can "supplement this open enrollment period as a transitional measure" to account for operational difficulties in implementing the shorter open enrollment time frame.
- **Tightened special enrollment rules.** Concerned that abuse of special enrollment rules allows consumers to enroll in coverage only after realizing that they need health services, CMS increased the scope of pre-enrollment verification of eligibility for FFM special enrollment. Starting in June 2017, all consumers will have 30 days to provide documentation of eligibility for special enrollment, during which time their application is "pended." The final rule encourages state-based exchanges that do not already require verification to do so.

  CMS also limited changes to levels of coverage in connection with special enrollment, permitted insurers to reject special enrollment where there is a record of termination due to non-payment of premiums, expanded verification requirements for special enrollments related to marriages and permanent moves, and curtailed the availability of the "exceptional circumstances" special enrollment category.

Additionally, CMS revised its interpretation of the "guaranteed availability" requirement, which generally mandates that insurers accept every individual who applies for coverage. The final rule allows insurers to apply a premium payment to an individual's past debt owed for coverage with that insurer within the prior 12 months – and in this manner limit the incentive to pay premiums only when an individual needs health services. CMS also changed actuarial values used to determine metal levels of coverage for the 2018 benefit year as a way to give insurers more flexibility in plan design and options for keeping cost sharing the same from year to year.

In Closing

While the future of the ACA is unclear, the ACA marketplaces will continue through 2018 in any scenario. It remains to be seen if and how the changes in these final rules help stabilize the marketplaces going forward.

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