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Strengthening the Marketplace – Actions to Improve the Risk Pool

With millions of Americans insured through the Health Insurance Marketplaces, it's clear that Marketplace coverage is a product consumers want and need and an important business for insurers, with several major issuers expanding their Marketplace presence. At the Department of Health and Human Services (HHS), we are constantly monitoring the health of the Marketplace and are always looking to make improvements that benefit both consumers and issuers. Over the past several months, HHS has taken a series of actions to strengthen the Marketplace risk pool, limit upward pressure on rates, and ensure a strong Marketplace for the long term. We believe those actions are bringing positive results. As part of our continued commitment to the long-term strength of the Marketplace, we are announcing new measures to ensure that the Marketplace continues to provide affordable coverage for millions of Americans.

During the month of June, HHS will make three announcements regarding our ongoing efforts to: strengthen the risk pool by spreading the costs of care over a diverse mix of enrollees, work with issuers and state Departments of Insurance to improve coverage options, and step up Marketplace outreach, especially to young adults and uninsured families in advance of Open Enrollment 4.

Today, HHS is announcing a series of actions to strengthen the Marketplace risk pool. These actions include:

- **Curbing abuses of short-term plans** that exploit gaps in current rules to use medical underwriting to keep some of the healthiest consumers out of the Affordable Care Act's single risk pool.

- **Improving the risk adjustment program** to more accurately reflect the cost of partial-year enrollees and to incorporate prescription drug utilization data that provide a more complete picture of enrollees' health status. These improvements will ensure that the program continues to work as intended to compensate issuers with higher-risk enrollees and thereby help issuers sustainably serve all types of consumers.

- **Helping consumers who turn 65 make the transition to Medicare,** so that older consumers are served by the program designed for them and their health needs.

- **Beginning full implementation of the Special Enrollment Confirmation Process,** which ensures that eligible individuals continue to have access to coverage through Special Enrollment Periods (SEPs), but prevents people from misusing the system to enroll in coverage only if they get sick.

- **Continuing our efforts to reduce data-matching issues (DMIs).** CMS outreach, education, and operational improvements have contributed to a sharp reduction in total data matching issues generated and an almost 40 percent year-over-year increase in documents submitted to help resolve income and citizenship and immigration data matching issues. Improving the resolution of DMIs benefits the risk pool because it keeps eligible consumers, often younger and healthier consumers less motivated to overcome obstacles such as extra paperwork, from losing coverage mid-year.

Risk Pool Actions

Curbing Abuse of Short-Term Limited Duration Plans

Short-term limited duration coverage is health care coverage issued for a short period of time. Because short-term limited duration plans are designed to fill only very short coverage gaps, this coverage is not subject to any of the key rules governing the ACA's single risk pool: they can be priced based on health status (medically underwritten), can discriminate against consumers with pre-existing conditions, and do not have to cover essential health benefits. Some issuers are now offering short-term limited duration plans to consumers as their primary form of health coverage for periods that last nearly 12 months, allowing them to target only the healthiest consumers while avoiding consumer protections. As highlighted in recent press accounts, by keeping these consumers out of the ACA single risk pool, such abuses of limited duration coverage increase costs for everyone else, and they could have a greater impact over time if allowed to become more widespread.

Today, the Department of Labor, Department of Treasury, and Department of Health and Human Services (HHS) issued a proposed rule to revise the definition of short-term, limited duration coverage. Under the new rules, short-term policies may be offered only for less than three months, and coverage cannot be renewed at the end of the three month period. The proposed rule also improves transparency for consumers by requiring issuers to provide notice to consumers that the coverage is not minimum essential coverage, does not satisfy the health coverage requirement of the ACA, and will not prevent the consumer from owing a tax penalty. The proposed changes will help strengthen the risk pool by ensuring that short term limited duration plans are used only as intended, to fill truly temporary gaps in coverage.

Maturing the Risk Adjustment Program

By reducing incentives for issuers to try to design products that attract a disproportionately healthy risk pool, risk adjustment lets them design products that meet the needs of all consumers, protecting consumers' access to a range of robust options. Updating risk adjustment to more accurately assess every enrollee's risk makes it more effective in achieving this goal. Earlier this year, CMS made a number of changes to improve the stability, predictability, and accuracy of the risk adjustment program for issuers. These changes include better modeling of costs for preventive services, changes to the data update schedule, and earlier reporting of preliminary risk adjustment data where available. We also published a Risk Adjustment White Paper and hosted a conference on March 31, 2016 to solicit feedback from issuers, consumers, and other stakeholders on additional areas for improvement.

Building off the Risk Adjustment White Paper and stakeholder feedback, today we are announcing two additional important changes to risk adjustment that we intend to propose in future rulemaking. First, we intend to propose that, beginning for the 2017 benefit year, the risk adjustment model include an adjustment factor for partial-year enrollees. By more accurately accounting for the costs of short term enrollees in ACA-compliant risk pool, this change will support the Marketplace's important role as a source of coverage for people who are between jobs, experiencing life transitions, or otherwise need coverage for part of the year. Second, we intend to propose that, beginning for the 2018 benefit year, prescription drug utilization data be incorporated in risk adjustment, as a source of information about individuals' health status and the severity of their conditions. We are also considering proposing additional changes to the model for 2018 and beyond.

Transitioning Consumers to Medicare

The Marketplace serves as an essential backstop for consumers as they transition between different types of coverage over their lifetime. For example, many early retirees access Marketplace coverage until they become eligible for Medicare when they turn 65. But once individuals turn 65, most people should end their Marketplace coverage and switch to Medicare. In fact, if consumers do not enroll in Medicare Part B when they turn 65, they could face financial consequences for years into the future, because they could owe higher Medicare premiums. Meanwhile, the Marketplace is intended to serve consumers who are not Medicare eligible, and continued enrollment by individuals who are eligible for Medicare can raise costs for other consumers.

To make sure consumers understand the steps they need to take to move to Medicare, this summer the Marketplace will start contacting enrollees as they near their 65th birthday. This outreach will provide consumers with the information they need to enroll in Medicare if they are eligible and end their Marketplace coverage if they choose to. This builds off the changes we made to the HealthCare.gov application this year which included new pop ups with reminders for consumers who are about to turn 65 that they may be eligible for Medicare.

Implementing the Special Enrollment Confirmation Process

Over the last several months, the Marketplace has taken a number of steps to ensure that Special Enrollment Periods (SEPs) are there for consumers when they need them while avoiding misuse or abuse. We've strengthened our rules and clarified our processes for SEPs, so that the people who need to can still easily get coverage, while making it hard for anyone thinking about taking advantage. We also eliminated 7 SEPs, including the SEP for individuals who paid the tax penalty for not having health insurance, contributing to an almost 30 percent year-over-year drop in the number of SEP enrollments during the three months after Open Enrollment.

Continuing that work, today we are announcing that, consistent with the process we announced in February, starting June 17 individuals enrolling in coverage through Special Enrollment Periods will be asked to provide certain documents. We are also providing models of the eligibility notices that consumers will receive with the list of documents that people enrolling through a Special Enrollment Period will need to prove their eligibility for their SEP. Consumers should provide the appropriate documents by the deadline listed in their notice to confirm eligibility for a Special Enrollment Period to avoid any disruptions to their coverage.

Reducing the Impact of Data Matching Issues

CMS takes very seriously its obligation to ensure that access to coverage and financial assistance are limited to those individuals who are indeed eligible. The Marketplace verifies eligibility for most consumers through electronic trusted data sources, but if consumers' data cannot be matched electronically we generate a data matching issue to request additional information from enrollees. Consumers who do not provide the necessary information will have their coverage or financial assistance ended or modified.

Unfortunately, eligible individuals sometimes lose coverage or financial assistance through the Marketplace during the year because they have trouble finding documents or navigating the data matching process. In addition to the direct impact on consumers, avoidable terminations due to data-matching issues also negatively impact the risk pool, since younger, healthier individuals appear to be less likely to persevere through the data matching process. In fact, in 2015, younger open enrollment consumers who experienced a data matching issue were about a quarter less likely to resolve their problem than older consumers.

This year, CMS made a range of improvements to the data matching process to help consumers avoid generating data matching issues in the first place and to help them resolve these issues once generated. More recently, we have also intensified our outreach, and partnered with issuers so that they are reaching out to consumers about data-matching issues as well. These efforts are beginning to pay off, with a sharp reduction in total data-matching issues generated and an almost 40 percent year-over-year increase in the number of documents consumers have submitted to resolve these issues. Continued progress in this area should benefit both directly affected consumers and other consumers who will benefit from a stronger risk pool.

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