Insight

In Latest Attempt to Save the ACA, CMS Issues New Rules Without Public Comment

TARA O'NEILL HAYES | MAY 12, 2016

On Friday, May 6, shortly after 5:00 p.m., the Centers for Medicare and Medicaid Services (CMS) released an interim final rule making regulatory changes affecting Special Enrollment Periods on the health insurance exchanges. The regulation also impacts the governance and financing rules of the Consumer Operated and Oriented Plans (CO-OPs) created by the Affordable Care Act (ACA).

This rule will be published in the Federal Register on May 11, and the provisions regarding the CO-OPs will be immediately effective; the Special Enrollment Period provisions will take effect 60 days later. CMS has decided to waive the requirements which typically dictate the issuance of a proposed rule and comment period, though comments will be accepted. Comments relating to the Special Enrollment Period changes are due by July 5, 2016, only three business days before those changes go into effect. Essentially, these regulatory changes are being made without any consideration of public feedback.

Changes to the CO-OPs' Governance and Finance Regulations

The CO-OPs were created by the ACA to provide alternative options from the larger, established insurers for individuals buying insurance through the Exchanges. These CO-OPs were funded with loans from the federal government and had many restrictions regarding their governance structure and financing options. These requirements were intended to protect the federal taxpayers who financed the loans and the plans' enrollees by preventing conflicts of interest among the directors of the CO-OPs' boards. Unfortunately, over half of these plans have already failed, the federal government will lose billions of dollars, and enrollees in states across the country have had to scramble to find new insurance plans.

The regulatory changes being implemented in this latest rule are an attempt to try and salvage the few remaining CO-OPs. Currently, CO-OPs are required to immediately begin repaying their loans if they fail to meet the requirement that "substantially all" (two-thirds) of its plans are qualified health plans sold in the individual and small group markets. CMS will waive this requirement if the CO-OP is offering silver and gold plans in each Small Business Health Options Program (SHOP) exchange that serves the geographic regions in which the CO-OP offers coverage; the CO-OP "has a specific plan and timetable to meet the two-thirds requirement, and acts with demonstrable diligence and good faith"; and comes back into compliance in "future years." There is no explanation as to what constitutes a reasonable timetable, demonstrable diligence and good faith, or how many years into the future would be acceptable to meet these requirements. It is also not clear that allowing the CO-OPs to expand into other insurance markets, given their dismal record of success, is in any way a good idea.

Recognizing that more CO-OPs are likely to fail, CMS will also allow changes to the loan terms. Because the CO-OPs are required to be non-profit organizations, they were prohibited from converting or selling policies to a for-profit or non-consumer operated entity (insurer). CMS has decided to provide leniency here such that, in the event that a CO-OP is winding down and would otherwise become insolvent, a CO-OP may convert or sell

its policies to such an insurer in order to prevent the loss of coverage for the plan's enrollees as has repeatedly happened as CO-OPs have failed over the last year. The rule does note that certain rights would become available to CMS, such as requiring accelerated repayment or even termination of the loan, if a CO-OP took such an action. However, this may be a moot point given that the CO-OP will cease to exist after the sale and presumably has limited funds available to repay the loan anyway; otherwise, it would likely not be going out of business.

Lastly, CMS will loosen current restrictions regarding the composition of the boards of directors for the CO-OPs. Some believe the current restrictions—which banned individuals who are "representatives" of a Federal, State, or local government or another health insurance issuer from serving on the board of directors—are partially to blame for the CO-OPs' many failures, as this led to governance by a group of individuals with limited knowledge about the health insurance business or navigating the governmental bureaucracy. In an attempt to resolve this, CMS will limit this restriction to those who are "officers", "directors", "trustees", "senior executives", or "high level representatives." All of a board's directors will also no longer be required to be members of the CO-OPs; such a requirement is typically fundamental to the governance of a CO-OP, which by definition is consumer operated.

Changes to Special Enrollment Periods

Many insurers have complained that the numerous categories rendering people eligible for special enrollment periods—and the seemingly lax verification protocols—were allowing individuals to take advantage of the system, undermining and destabilizing the market. Insurers found that individuals who enrolled during special enrollment periods had much higher medical claims, some as much as 55 percent higher, than those who enrolled during the open enrollment period preceding the coverage period. Too much flexibility for special enrollment periods may allow individuals to wait until they are sick to enroll in coverage, undermining the insurance market, and ultimately resulting in higher premiums the following year to compensate.

Now that evidence of this problem has surfaced, CMS is now agreeing to tighten restrictions for special enrollment periods. Specifically, in order for individuals to be eligible for a special enrollment period as a result of a permanent move, an individual must have been enrolled in minimum essential coverage for at least one day in the 60 days preceding the date of the move.

Conclusion

CMS knows the individual marketplaces are in trouble, and is taking action to try to save them. While many agree changes are needed, few likely agree that such changes should be made via regulation without a public comment period. These regulatory changes, particularly those regarding the CO-OPs, are vague and undermine the purpose and nature of the organizations.