United States Senate
WASHINGTON, DC 20510

March 1, 2016

The Honorable Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave, S.W.
Washington, D.C. 20201

Dear Mr. Slavitt,

As Chairmen of the Senate Finance Committee and Republican Policy Committee, we are conducting oversight of Affordable Care Act (ACA) implementation and continue to have concerns over the cost and availability of insurance coverage offered in the Federally Facilitated Marketplace (FFM). Specifically, we are concerned with possible negligent administration of the enrollment process and the potential that creates for abuse that threaten the viability of state insurance markets.

Special Enrollment Periods have a long and established history within both private health insurance markets and public programs. When implemented properly, SEPs allow consumers with significant life events to access insurance coverage outside of the normal enrollment window. This is an important consumer protection when implemented in a thoughtful and responsible manner.

The Centers for Medicare & Medicaid Services, through Federal regulations and sub-regulatory guidance, has required thirty-four categories of SEPs with varying degrees of documentation and oversight. Many of these SEPs are not shared by Medicare, ERISA or the Federal Employee Health Benefits Program. This fact alone calls into question the proliferation of SEPs under the ACA.

The proliferation potentially allows individuals to game the Affordable Care Act's poorly-designed rules by waiting until they need medical services before enrolling in insurance plans – and dropping coverage after receiving care. This abuse weakens the model that makes health insurance possible by threatening the viability of the risk pool. The deterioration of the risk pool impacts both products sold on and off the exchange, meaning even individuals who made a conscience choice to avoid the ACA exchanges face higher premiums as a result these policies.

Early last month, you admitted as much at a conference hosted by JP Morgan, stating that there "are some [special enrollment periods] that we need to clarify because they're subject frankly to abuse."[1] Later in February, CMS moved to eliminate several SEP categories and further clarify CEP eligibility. While we are pleased to see that you recognize the problem, we write today seeking details of what the agency will do about it. Specifically, we ask that you provide the following information:

[1] http://blog.cms.gov/2016/01/12/comments-of-cms-acting-administrator-andy-slavitt-at-the-j-p-morgan-annual-health-care-conference-jan-11-2016/

1. Describe the process by which CMS established the SEPs, including:
    a. Which office(s) is/are responsible for regulations and sub-regulatory guidance?
    b. What nongovernmental organizations have met with CMS officials regarding expanding existing or establishing new SEPs?
2. Detail CMS's plans to eliminate unnecessary SEPs and clarify remaining SEPs in ways that will prevent abuse.
3. Detail CMS's oversight of brokers and what efforts the agency takes to identify bad actors and inappropriate enrollment practices.
4. What steps does CMS take to verify the qualifications of individuals enrolling in the FFM under a SEP?
5. Does the FFM require and review documentation before granting eligibility for SEPs? What documents are used to substantiate eligibility under each SEP? (In responding, please list the documents and verification process for each SEP).\
6. When the FFM grants eligibility for an SEP, does it inform the insurance plan of the SEP under which enrollment was allowed? If there has been a change in SEP coding policy, describe that change and when it occurred.
7. Insurance plans have claimed that between one quarter and one third of last year's enrollments were through SEPs. Does FFM data support this? How do these numbers compare to Medicare and the Federal Employees Health Benefits Program?
8. Provide the total number of FFM enrollments through each of the 34 SEPs for 2015.
    a. For those who enrolled due to a loss in Minimum Essential Coverage (MEC):
        i. How many claimed this SEP after losing coverage due to failure to pay premiums?
        ii. Does CMS allow individuals who lost MEC due to failing to pay premiums to re-enroll under this SEP?
        iii. If not, what steps does CMS or the FFM take to prevent it?
        iv. Does CMS maintain data on the types of coverage these individuals lost?
    b. For those enrolling because their "enrollment or non-enrollment in a [qualified health plan] is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS...."[2] When enrollees use this SEP, what steps does CMS or the FFM take to follow up on the officer, employee, or agent's error, misrepresentation, or inaction? Has CMS or the FFM taken steps to counsel or discipline those who cause this SEP enrollment to be necessary?
    c. For those enrolling under §155.420(d)(10), which allows for an SEP when an individual is not enrolled "as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities." After enrollment under this provision, what steps does CMS take against those entities that caused the enrollment to be necessary?

[2] §155.420(d)(4)

d. For those enrolling due to a permanent move and with no prior coverage, does FFM allow enrollment by those using a PO Box, provider clinic, or some other non-residential address?

Thank you for your prompt attention to this matter and we would appreciate your response by March 25, 2016. If y
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Sincerely,

Orrin G. Hatch
Chairman
Senate Committee on Finance

John Barrasso
Chairman
Republican Policy Committee