

MEMO

DATE: July 20, 2011
TO: Clients & Friends
FROM: John Gorman and Jean LeMasurier
SUBJECT: Notice of Proposed Rule Making on Establishment of Exchanges and Qualified Health Plans and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

On July 11, 2011, the Center for Medicare and Medicaid Services (CMS) released two proposed rules to implement provisions of the Affordable Care Act (ACA) which authorize competitive marketplaces known as Affordable Insurance Exchanges, or “Exchanges,” where individuals and small employer groups can compare private health insurance options on the basis of price and quality, enroll in qualified health plans and receive federal subsidies (or determine eligibility for other health programs such as Medicaid and CHIP). The Exchanges are effective beginning January 1, 2014.

- CMS-9989-P - Establishment of Exchanges and Qualified Health Plans
http://www.ofr.gov/OFRUpload/OFRData/2011-17610_PI.pdf
- CMS-9975-P - Standards Related to Reinsurance, Risk Corridors and Risk Adjustment
http://www.ofr.gov/OFRUpload/OFRData/2011-17609_PI.pdf
- In addition, CMS issued a preliminary impact analysis:
<http://cciio.cms.gov/resources/files/cms-9989-p2.pdf>

Comments are due 75 days after publication in the Federal Register. Additional proposed rules will provide further guidance on the establishment and operation of Exchanges.

CMS-9989-P: ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS

The proposed rule establishes the requirements for state run exchanges that facilitate purchase of health insurance coverage, establishes minimum requirements for health insurance issuers to offer qualified health plans (QHPs) in the exchanges, and establishes basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP).

Under the Affordable Care Act (ACA), states have the option of establishing their own Exchange or deferring to a Federally-facilitated Exchange which the Department of Health and Human Services (HHS) will operate directly or through agreement with a not-for-profit entity. States may offer a statewide Exchange or may offer subsidiary Exchanges within a state that serve geographically distinct areas at least as large as rating areas to assure non-discriminatory premiums. A state may also participate in a regional Exchange serving two or more states (which the NPRM proposed do not have to be contiguous).

The preamble discusses a partnership model that would combine state-designed and operated business functions with Federally-designed and operated business functions in an Exchange. The Department of Health and Human Services (HHS) indicated that they are exploring different models that would meet the needs of states and Exchanges.

Under the ACA, a state has the option of combining the individual exchange and small business exchange into a single exchange.

In addition to purchasing Quality Health Plans (QHPs) from an Exchange, certain individuals (and a small subset of individuals eligible for employer sponsored plans) are eligible for advance payments of the premium tax credit and reduction of cost sharing. In addition, some employers will qualify for a small business tax credit for up to 50% of the employer's premium contribution if purchased through the SHOP. The NPRM does not address these subsidies in detail since additional regulations will be issued by the Department of Treasury.

APPROVAL

The Exchanges must be approved by HHS no later than January 1, 2013 in order to begin offering qualified health plans on January 1, 2014. The proposed rule allows states to be conditionally approved or seek approval later than January 2013 as discussed below.

In order to be approved the state must submit an Exchange Plan and demonstrate operational readiness to meet the following standards:

- Be capable of carrying out the functions of the Exchange, including minimum Exchange functions, enrollment, operation of a SHOP and certification of QHPs;
- Be capable of carrying out the information requirements with respect to advance payments of the premium tax credit;
- The State must operate a qualified reinsurance program;
- The entire geographic area of the state is covered by one or more Exchange.

For regional Exchanges, the preamble recommends submission of a single Plan and consideration of issues of coordination among multiple state departments of insurance, consistent levels of consumer protection, financing, and procedures for withdrawal.

The HHS will conduct an operational readiness assessment to assure that the state is ready to implement its plan. The NPRM does not provide details other than to say that the assessment may involve phone calls, meetings and/or on-site visits. The HHS will provide written notice of approval of the Exchange Plan by January 1, 2013. Conditional approval will be provided when there are necessary systems development or contracting activities in 2013. Written approval must also be provided when states are planning significant changes in their Exchange (e.g. governance, enrollment, QHP certification). In the preamble, CMS requests comments on a process to review the Plan and changes that would be similar to the Medicaid/CHIP state plan and amendment process.

If a state elects to delay the operation of an Exchange after 2014, they must have in effect an approved or conditionally approved Exchange plan and operational readiness assessment at least 12 months prior to the first effective date of coverage. They must also develop a plan jointly with HHS to facilitate the transition from a Federally-facilitated Exchange to a state Exchange.

ELIGIBLE EXCHANGE ENTITIES

States have the option to establish an Exchange as a government agency or a non-profit entity. The Exchange may enter into agreements with an eligible entity to carry out one or more functions of the Exchange provided the entity is incorporated and subject to the laws of the State, demonstrates experience on a state or regional basis in benefits coverage in the individual and small group health insurance markets, is the state Medicaid agency and is not a health insurance issuer. The preamble notes that the state Medicaid agency may determine eligibility on behalf of the Exchange.

The Exchange must have Governance principles that address ethics, conflict of interest standards, accountability and transparency standards and disclosure of financial interests.

The Governing Board must:

- Be administered under a formal, publicly-adopted operating charter or by-laws;
- Hold regular public meetings announced in advance;
- Represent consumer interests and assure that the majority of voting members are not representatives of health insurance issuers or agents or brokers or others licensed to sell health insurance, and
- Ensure that a majority of voting members have relevant experience in health benefits administration, health finance, health purchasing, health delivery administration, public health or health policy related to the small group and individual markets and the uninsured.

A state may elect to operate its Exchange and SHOP under single governance and administrative structure provided it has adequate resources to assist individuals and small employers. A separate SHOP must coordinate and share relevant information between the two Exchange bodies. The preamble recommends that regional or subsidiary exchange should combine the individual and small group exchanges but if a SHOP is operated through a separate governance structure, it is recommended that the geographic areas be the same.

The regulation defines a “qualified employer” as a small employer with at least one but not more than 100 employees, although states have the option to limit small employers to no more than 50 employees until 2016. The NPRM includes a provision that beginning in 2017 states will have the option of allowing issuers to offer QHPs in the large group market through a Small Business Health Options Program (SHOP).

The proposed rule includes the ACA provisions that state laws that do not interfere with the federal requirements for Exchanges are not pre-empted, that states must comply with applicable nondiscrimination and noninterference statutes.

The NPRM provides a transition process for Exchanges that were in existence before January 2010 and insure a percentage of the population projected under the ACA (described in the preamble as the projected number insured in 2016). These Exchanges are assumed to be compliant or work with HHS on areas of non-compliance.

STAKEHOLDER CONSULTATION

The Exchange must consult regularly with the following stakeholders:

- Educated health consumers who are enrollees of QHPs (the preamble recommends including individuals with disabilities)
- Individuals and entities with experience in facilitating enrollment in health coverage
- Advocates for enrolling hard-to-reach populations including individuals with mental health or substance abuse disorders
- Small business and self-employed individuals
- State Medicaid and CHIP agencies
- Federally recognized Tribes
- Public health experts
- Health care providers
- Large employers
- Health insurance issuers
- Agents and brokers

FUNDING FOR ONGOING OPERATIONS

No Federal funds may be used for Exchange operations after January 1, 2015. States must assure sufficient funding to support the on-going operations of the Exchange through:

- Assessment or user fees on participating users, e.g. a percentage of premium or per capita amount (announced in advance of the plan year), or
- Other funding generated by the state

FUNCTIONS OF AN EXCHANGE

The NPRM includes general and minimum functions of an Exchange . General functions include consumer assistance, Navigator grants, notices and payment of premium discussed below. Minimum functions include:

- Required functions in the individual and small group market exchanges discussed below;
- Certification of QHPs;

- Eligibility Determinations (including a streamlined and coordinated eligibility and enrollment process for enrollment in a QHP, advance payment of premium tax credits or cost-sharing reductions, Medicaid and CHIP eligibility and operation of an appeals process);
- Issue Certificates of Exemption from individual responsibility and payment
- Enrollment in QHPs
- Certification of QHPs
- Perform oversight and financial integrity
- Perform quality improvement activities including implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosure, and data reporting strategies (to be defined in future rulemaking)

CONSUMER ASSISTANCE

The Exchanges must offer consumer assistance tools and programs including:

- Toll-free call center - The preamble notes that the states have wide flexibility to structure the call center but it is expected that the call center will provide assistance on a broad array of issues including types of QHPs offered with premiums, benefits, cost-sharing and quality ratings, categories of assistance available such as advance payment of premium tax credits and cost-sharing reductions and Medicaid and CHIP eligibility and the application process for enrollment through the Exchange and other programs such as Medicaid).
- Internet website that provides:
 - Comparative information on each QHP including premium and cost-sharing information; summary of benefits and level of coverage (bronze, silver, gold, platinum, catastrophic); enrollee satisfaction survey results; quality ratings; MLR; coverage measures, provider directory
 - Accessible to people with disabilities and limited English proficiency (LEP)
 - Financial information including average cost of licensing, regulatory fees, other Exchange fees; administrative costs, FWA losses
 - Information on Navigators and other consumer assistance services.
 - Ability to determine eligibility
 - Enrollment in coverage
- Exchange calculator with ability to compare QHPs after application of premium tax credits and cost-sharing reductions
- Outreach and education

NAVIGATOR PROGRAM

Navigators are entities that conduct public education in both the individual market and SHOP to raise awareness about the Exchanges and assist consumers by maintaining expertise in eligibility, enrollment and program specifications to facilitate enrollment in QHPs in an impartial manner. For example, Navigators could provide referrals to agencies for grievances (e.g. SHIPs, Ombudsman, or other state agencies) and provide information in accessible formats (e.g. ADA, CLASS, LEP).

The Exchange must award grants with non-Federal funds to eligible public and private entities that have (or could readily establish) relationships with employers and employees, consumers or self-employed individuals and meet any licensing or certification standards without conflict of interest during the term of the Navigator.

The Exchange must provide grants to at least *two* of the following:

- Community and consumer-focused non-profit groups (CMS is seeking comments on whether they should require this category as one of the required two);
- Trade, industry and professional associations;
- Commercial fishing industry organizations, ranching and farming organizations;
- Chambers of commerce;
- Unions;
- Resource partners of the Small Business Administration;
- Licensed agents and brokers, or
- Others that meet requirements including Indian tribal organizations and state or local human service agencies.

Navigators may not be health insurance issuers or receive any direct or indirect consideration from an issuer in connection with enrollment. The preamble states that a Navigator is not precluded from receiving compensation in connection with non-QHPs.

AGENTS AND BROKERS

States may permit agents and brokers to assist in enrollment in QHPs and to apply for premium tax credits and cost-sharing reductions. The Exchange may elect to provide information on agents and brokers on their website.

EXCHANGE NOTICES

Notices must be in writing and include contact information for customer service resources, appeals rights and regulatory citations. Applications and notices must be in plain language and meet the needs of diverse populations. Exchanges must re-evaluate annually the appropriateness of notices and applications. CMS anticipates developing model notices that may be used by Exchanges.

PAYMENT OF PREMIUMS

The preamble notes that in the individual market, the Exchange has the option to not pay premiums, to facilitate payment of premiums through an electronic pass-through or to collect premiums from enrollees and pay an aggregated sum to QHP issuers. The NPRM includes the mandatory option that the Exchange must allow a qualified individual to pay the premium owed by the individual directly to the issuer.

In a SHOP, the Exchange must accept payment of an aggregate premium. The Exchange may facilitate this payment through electronic means, either as a pass through or where the Exchange collects and distributes premiums to QHP issuers. The Exchange must establish administrative protocols to ensure the financial integrity of collection and payment of premiums but the Exchange is not liable for payment.

PRIVACY AND SECURITY

The Exchanges must follow laws and appropriate policies regarding privacy protection and security of personally identifiable information. While HIPAA must be followed, the NPRM includes additional requirements for data matching arrangements for Medicaid and CHIP eligibility and privacy and security protections to protect tax return information.

TERMINATION OF AN EXCHANGE

States must notify HHS at least 12 months prior to ceasing to operate a state-run exchange and develop a joint transition plan with HHS.

ELECTRONIC TRANSACTIONS

The Exchanges must use standards, specifications and code sets consistent with HIPAA, HIT enrollment and other policies adopted by HHS.

INDIVIDUAL MARKET: ENROLLMENT IN QUALIFIED HEALTH PLANS

The Exchange must accept a QHP selection from an eligible applicant, notify the issuer of the applicant selection and transmit information to the QHP issuer to enroll the applicant. The Exchange must develop a process by which QHP issuers can verify receipt of enrollment information.

The Exchange must use a single streamlined application to determine eligibility and collect information necessary for enrollment in QHPs and to determine advance payments of the premium tax credit and cost-sharing reduction, and eligibility for Medicaid, CHIP and BHP (Basic Health Program). The HHS plans to create the application, but the Exchange can use an alternative application if approved by HHS. The application may be submitted by the individual or an authorized individual and may be filed via Internet portal, mail, or in person.

Applications must be submitted during an initial or annual open enrollment or special enrollment periods.

- The initial open enrollment period is October 1, 2013 - February 28, 2014. Coverage is effective January 1, 2014 for applications submitted on or before December 22, 2013. For subsequent months during the initial open enrollment period, for applications submitted between the 1st and 22nd day, coverage is effective the first day of the following month. For applications received between the 23rd to 31st of any month between December 2013 and February 28, 2014 the effective date is either the first day of the following month or the first day of the second following month.
- Beginning with January 2015, the annual open enrollment period is October 15 to December 7 of the previous year. Coverage is effective the first day of the following benefit year. (In the preamble, CMS asks for comments on an alternative longer open enrollment period of November 1 - December 15).
- Special enrollment periods (SEP) allow individuals to enroll or change from one QHP to another QHP at the same level of coverage under the following circumstances. The NPRM proposes a SEP of 60 days from the triggering event:
 - Qualified individual or dependent loses minimum essential coverage;
 - Qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption;
 - Qualified individual's enrollment or non-enrollment results from error, misrepresentation or inaction;
 - QHP violates a material provision of its contract;
 - Change in eligibility for advance payments of the premium tax credit or cost-sharing; reductions, including affordability of an employer's upcoming plan year

- Permanent move;
- A member of an Indian tribe may enroll or change a QHP one time per month;
- Other exceptional circumstances as the Exchange or HHS may provide.

The Exchange must transmit eligibility and enrollment information timely to the issuer for enrollment. The QHP must accept enrollment information in electronic format and provide the individual an enrollment information package and notification of the effective date of coverage. If an individual initiates enrollment directly with the issuer, the QHP issuer submits information to the Exchange and enrolls the individual only after receiving confirmation that the individual is eligible for enrollment.

The Exchange must maintain records including QHP issuer verification of the enrollment. Enrollment information must be submitted to HHS and reconciled on a monthly basis.

TERMINATION OF COVERAGE

The Exchange must determine the form and manner in which coverage in a QHP may be terminated.

An enrollee may terminate coverage from a QHP with appropriate notice and a QHP may terminate an enrollee's coverage (e.g. if the enrollee is no longer eligible or becomes eligible for other minimum essential benefits or fails to pay premiums after a grace period). The QHP provides the enrollee and the Exchange with a notice of termination. The Exchange must require QHPs to track terminations and provide reasonable accommodations for enrollees with mental or cognitive conditions and submit the number of terminations to HHS on a monthly basis. Different effective dates apply depending on the circumstance of the termination.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

The state must establish a SHOP that assists qualified employers and facilitates enrollment of qualified employees into QHPs. The SHOP may be combined with the Exchange serving the individual market. If combined, employees may enroll in any QHP that meets the requirements of the small group market for maximum deductible and levels of coverage.

If the SHOP is a separate Exchange, the SHOP must perform most of the functions and must meet specified requirements of the Individual Exchange with the exception of functions unique to the individual market such as individual eligibility determinations (including advance premium tax credits or cost-sharing reductions), premium tax credit calculator, certification of exemptions from individual coverage, special enrollment for change in citizenship, and premium payment. There are also additional Exchange functions unique to the small group employer market.

- **Employer Eligibility:** The SHOP must assure that the employer is a small employer, i.e. no more than 100 employees unless a state limits employers to no more than 50 employees until January 2016. The employer can attest to the size of its workforce or the SHOP can require a more stringent determination. A small employer can elect to cover all employees through the SHOP serving the employer's principle business address. An employer with worksites in different SHOP service areas can elect to cover each employee through the SHOP serving the employee's principal worksite.
- **Application:** The SHOP must accept a single application from an employer which includes a list of qualified employees with SSNs. The SHOP must also use a single application from

an employee that includes eligibility and enrollment information and QHP selection. The SHOP must verify information to support the employer's application and assure that the employee is identified by the employer as eligible for employer coverage. Notice of approval or denial of eligibility must be sent to the employer and employee. The SHOP must also process employee applications into applicable QHP issuers before the effective date of coverage and notify employees of the effective date of coverage.

- **Plan Year:** The employer's plan year is a 12-month period beginning with the employer's effective date of coverage. The employer may change its participation for the next plan year prior to the completion of the plan year and before the next open enrollment period.
- **Employer Choice of QHPs:** Employers must select certified QHPs. The employer may select a level of coverage of QHPs (ranging from a single QHP to all QHPs in a single level or any QHP at any level).
- **Enrollment:** QHPs must enroll qualified employees according to the employer's annual open enrollment period. Employees hired outside an initial or annual open enrollment period are covered in a QHP the first day of employment.
- **Premium Aggregation:** The SHOP must bill employers on a monthly basis the total amount due for all QHPs and make payments to QHP issuers for all qualified enrollees. The preamble notes that most SHOPS will include the employer and the employee contribution for the selected QHP.
- **Premium Rates:** The rule proposes that the SHOP require QHPs to make changes to rates either quarterly, monthly or annually to accommodate different plan years. However rates for an individual employer may not vary during the plan year.
- **Reconciliation:** The SHOP must reconcile enrollment information and employer participation information with the QHPs on a monthly basis including notification to the employer if an employee terminates coverage from a QHP.

CERTIFICATION OF QHPs

The Exchange must only offer QHPs that are certified as a QHP and that the Exchange determines are in the interest of individuals and employers. The Exchange may not exclude plans on the basis that it is a FFS plan, through the imposition of price controls, or end-of-life treatment costs. Multi-state QHPs offered by an issuer and approved by OPM with a uniform benefit package in each state are deemed to be certified. Each Exchange must offer at least two multi-state QHPs.

Exchanges must monitor QHPs for ongoing compliance with certification standards and establish a process to decertify a QHP that does not meet minimum requirements. QHPs must be recertified on or before September 15 of the applicable calendar year based on the frequency determined by the Exchange.

MINIMUM CERTIFICATION REQUIREMENTS FOR QHPs

Each QHP must:

- Be certified or recognized by the Exchange;
- Comply with Exchange processes, procedures and requirements (e.g. submission of justified rates, transparent coverage information, enrollment periods);
- Comply with benefit design standards, including offering at least one silver level and one gold level plan and a child-only plan at the same premium rate inside and outside the Exchange;
- Be licensed and in good standing to offer health insurance coverage in each state and comply with state provisions on an Exchange. QHPs must comply with state laws and regulations including state requirements regarding marketing by health insurance issuers and marketing practices that discourage enrollment of individuals with significant health needs. Comments are sought on the need for a broad prohibition against unfair or deceptive marketing practices by all issuers and their agents;
- Report on quality improvement strategies, outcomes and enrollee satisfaction surveys;
- Pay applicable user fees;
- Comply with the risk adjustment program;
- Comply with network adequacy requirements including essential community providers. The QHP must provide a provider directory to the Exchange for on-line publication that identifies providers that are not accepting new patients and in hard copy to potential enrollees upon request. QHPs may provide coverage through direct primary care medical homes that meet HHS criteria provided that services are coordinated with the QHP issuer.

If a QHP elects not to seek recertification, the QHP issuer must provide benefits through the end of the plan year, provide notice and terminate beneficiaries according to requirements. The Exchange will implement procedures for decertification of health plans as QHPs and establish an appeals process.

ACCREDITATION OF ISSUERS

A QHP issuer must be accredited within the timeframes established by the Exchange on the basis of local performance of its QHPs by an accrediting organization recognized by HHS in the following areas:

- Clinical quality measures such as HEDIS
- Patient experience ratings on a standardized CAHPS survey
- Consumer access
- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and
- Patient information programs.

The QHP must authorize the accrediting agency to release accreditation information to the Exchange and HHS.

ANNUAL BENEFIT AND RATES

QHP issuers must set rates for an entire benefit year (or plan year for SHOPs) and provide annual notices of rates, covered benefits and cost sharing requirements. A QHP may vary premiums by geographic rating area (as specified in the PHS Act) and must cover all of the following groups using some combination of the following categories: individual; two-adult families; one-adult families with a child or children; all other families. A QHP must charge the same premium rate for a plan offered in or out of an Exchange and without regard to whether the plan is offered directly from the issuer or through an agent.

Rate increases must be submitted to the Exchange prior to implementation and must be posted on the QHP website. The Exchange must consider the rate increases including a recommendation by the state and any excess rate of growth outside the Exchange compared to inside the Exchange. Cost sharing information must be transparent and made available in a timely manner at the request of an individual.

NETWORK ADEQUACY

The Exchange must ensure that QHPs have a sufficient network. The preamble seeks comments on the need for more specific standards, e.g. standards included in the NAIC Managed Care Plan Network Adequacy Model Act.

SERVICE AREA

The Exchange must assure that the QHP service area meets minimal requirements including an entire county or group of counties defined by the Exchange (unless a smaller area is non-discriminatory and in the best interest of individuals and employers). The service area must be established without regard to racial, ethnic, language or health status factors.

DENTAL PLANS

The Exchange must offer a limited-scope dental plan as a stand-alone plan or in conjunction with a QHP if it meets PHS requirements and covers essential pediatric dental health benefits.

PRESCRIPTION DRUG REPORTING

The QHP must provide information on drug coverage as specified by HHS including the percentage provided through retail and mail order pharmacies, percentage of generic drugs, percentage dispensed by type of pharmacy (e.g. independent, supermarket); drug costs (e.g. aggregate amount, rebates), and the difference between the amount paid by the QHP issuer to the PBM and the amount the PBM pays pharmacies.

STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT (CMS-9975-P)

The proposed rule issues standards for states and health insurance issuers related to reinsurance, risk corridors and risk adjustment starting in 2014. There are three separate programs, mandated by the ACA, to mitigate potential adverse risk selection and stabilize premiums in the individual and small group markets:

- Transitional state-based reinsurance program which makes payment for high cost cases in the individual market during the first three years of Exchange operation (2014-16). Non-grandfathered plans in and out of the Exchange are eligible for payments. States have the option of extending this program to State high-risk pools.

- Temporary Federally-administered risk corridor program which limits QHP losses or gains in the individual and small group markets for the first three years of the Exchange. Under the program, a QHP issuer must remit gains greater than 3 percent of projections to HHS, while HHS makes payment to issuers who incur losses greater than 3 percent.
- Permanent State-based risk adjustment program to provide adequate payments to issuers who enroll high-risk populations such as individual with chronic conditions. This program applies to all non-grandfathered plans in the individual and small group market both inside and outside the Exchange. The program begins after the end of the 2014 benefit year.

Under the ACA legislation, HHS may implement reinsurance and risk adjustment in states that have not done so.

STATE NOTICE OF INSURANCE BENEFIT & PAYMENT PARAMETERS

The Federal government plans to issue an annual notice of benefit and payment parameters that will be used to specify factors for payment such as the national reinsurance contribution rate and the federally-certified risk adjustment model. The NPRM proposes that a state also issue an annual notice describing any reinsurance or risk adjustment parameters that differ from the federal parameters. The state notice should be provided one year in advance of the benefit year or no later than early March in the calendar year before the effective date (i.e. beginning in 2013 for CY 2014). If the state does not publish a notice, the NPRM provides that the federal parameters will apply.

For the reinsurance program, the state notice should specify the data requirements and the data collection frequency for health issuers to receive reinsurance payments. The data elements will include the state specified attachment point, reinsurance cap and coinsurance rate. If the state uses more than one reinsurance entity, the state must describe the geographic boundaries of each entity, and estimated number of enrollees in fully insured and self-insured group plans, amount of reinsurance payments made to issuers and premiums for each region.

For the risk adjustment program, the state notice should describe the modifications from the federal notice including: methodology for determining average actuarial risk, inclusion of risk pools, and the data validation methodology.

STATE STANDARDS FOR THE TRANSITIONAL REINSURANCE PROGRAM FOR THE INDIVIDUAL MARKET

All health insurance issuers and third-party administrators of self-insured group plans must make contributions to a not-for-profit reinsurance entity to support reinsurance payments to individual market issuers. These payments cover high-cost individuals except for high-cost individuals in grandfathered individual market plans. The reinsurance program will operate 2014-2016.

Under the NPRM, states are given flexibility to operate a reinsurance program without operating an Exchange or to allow HHS to establish the reinsurance program that performs all of the reinsurance functions for the state.

A state that operates its own reinsurance program must enter into a contract with an existing reinsurance entity or establish a reinsurance entity to administer the program. States may choose more than one entity and the geographic divisions of the entities must be distinct and not overlap with any other reinsurance entity and cover the entire individual market in the state. The reinsurance entities may subcontract administrative functions subject to state approval. The reinsurance contracts must provide for payment activities after 2016 however may not extend past

December 31, 2018. If a reinsurance entity contracts with more than one state, they must maintain separate risk pools for each state's reinsurance programs.

Reinsurance entities will collect contribution funds from all health insurance issuers and third-party administrators on behalf of self-insured plans to cover all reinsurance payments and administrative costs incurred by the reinsurance entity. The ACA specifies that aggregate funds are \$10 billion in 2014, \$6 billion in 2015 and \$4 billion in 2015 and may only be used for the purpose of the reinsurance payments and administrative costs. The reinsurance entity will also collect additional contribution funds for deposit in the general fund of the U.S. Treasury as an offset for the costs of administering the Early Retiree Reinsurance program. These are set at \$2billion in 2014 and 2015 and \$1billion in 2016.

Under the NPRM, HHS will use a national uniform contribution rate to set contribution levels based on a percent of premium applied to all contributing entities. All contribution funds collected by a state will stay in that state to make valid reinsurance claims. States may collect more than its amount collected in the national rate if the state believes the amount would be insufficient to cover payments and administrative costs. Comments are requested on the frequency to collect reinsurance contribution funds for reinsurance payments and payments to the Treasury.

CALCULATION OF REINSURANCE PAYMENTS

Under the NPRM, reinsurance payments are based on items and services within the essential health benefits for an individual enrollee that exceed an attachment point. Because the temporary reinsurance program does not replace commercial reinsurance or internal risk mitigation strategies, the NPRM proposes establishing a reinsurance cap set at the attachment cap of traditional reinsurance. The reinsurance payment would be a percentage above the attachment point and below a reinsurance cap (representing the product of the coinsurance rate times all health issuer costs for the individual's essential health benefits).

REINSURANCE PAYMENTS

The NRPM proposes to identify reinsurance-eligible individuals based on medical costs to the health issuer for covered benefits. This focuses on all high-cost enrollees without regard to the conditions that caused the increased cost. The preamble discusses the lower administrative burden of this approach compared to alternative condition-specific options identified by the American Academy of Actuaries and requests comments.

The NPRM proposes to calculate payments for costs incurred above an attachment point since this approach aligns compensation with costs, is an administratively simple to operationalize and is consistent with reinsurance in the Early Retiree Reinsurance program and market overall. Payments to the U.S. Treasury will be addressed in the Federal annual notice of benefits and payment parameters.

States may modify the attachment point, reinsurance cap (including elimination of the cap) and coinsurance rate to ensure that contributions are sufficient to meet obligations for payment and are described in the annual state notice.

DISBURSEMENT OF REINSURANCE PAYMENTS

States must specify the data requirements and data collection frequency for issuers to report medical cost data to calculate reinsurance payments in the annual notice. States may reduce payments on a pro rata basis to match the amount of contributions in a given year.

Reinsurance payments must be made after receiving a valid claim and the regulation seeks comment on whether the timeframe for submitting claims should be six months after the end of the coverage year (consistent with Part D. The preamble notes that MLR rebates and risk corridor calculations rely on information from the final reinsurance payments.

The NPRM proposes that states maintain reinsurance records for ten years consistent with the requirement under the False Claims Act.

COORDINATION WITH HIGH RISK POOLS

The state should eliminate or modify the high risk pools to the extent necessary to carry out the reinsurance program.

State Standards Related to Risk Adjustment Program: The ACA establishes a permanent risk adjustment program that applies to all non-grandfathered plans in the individual and small group market both inside and outside the Exchange. Plans that experience lower than average actuarial risk compared to the state average will be assessed charges and the state will make payments to plans that have higher than average actuarial risk. The risk adjustment program will level premiums inside and outside of the Exchange.

Under the NPRM the risk pools must be aggregated at the state level even if the state uses regional Exchanges. If multiple states contract with a single entity to administer risk adjustment, risk may not be combined across state lines.

The state may elect an entity other than the Exchange to operate a state risk adjustment program provided the entity meets the eligibility criteria. HHS will operate a risk adjustment program for states that do not operate an Exchange or for states that operate an Exchange and choose not to administer a risk adjustment program.

The NPRM proposes that payment calculations begin with the 2014 benefit year. HHS seeks comments on the deadline for completion of risk adjustment (e.g. by June 30 of the year following the benefit year). The preamble notes that risk adjustment must be coordinated with reinsurance and risk corridors to assure the viability of the Exchanges.

The NPRM also seeks comments on the timeframe for states to begin risk adjustment payments recognizing that the state must receive payments from low actuarial risk plans before making payments to high actuarial risk plans. The NPRM requires states to submit a summary report of risk adjustment activities for each benefit year in the year following the calendar year covered in the report. The report should include the average actuarial risk score for each plan, corresponding charges or payments and other information requested by HHS.

FEDERALLY CERTIFIED RISK ADJUSTMENT METHODOLOGY

Under the proposed rule HHS will establish a baseline methodology to be used by a state or HHS on behalf of a state however a state alternative risk adjustment methodology that offers similar or better performance may become federally certified. The Federal and certified state methodologies will be fully described in the respective annual notices including demographic and utilization factors, qualifying criteria for an individual to be eligible for a specific factor, weights, data required to support the model, deadlines for data submission and schedule for risk adjustment factor determination. The risk adjustment methodology will also describe adjustments used in calculating the premiums (e.g. age, tobacco use, geographic rating area, family size) so appropriate adjustments can be made in the risk adjustment methodology.

When seeking approval for an alternative state risk adjustment methodology, the state request must include details outlined in the regulation including: a description of the specific risk pools to which the methodology will be applied, factors (e.g. demographic diagnostic and utilization), qualifying criteria to establish that an individual is eligible for a factor, weights assigned to factors, calibration methodology and any adjustments to determine average actuarial risk. States should submit data to substantiate that: their methodology accurately explains cost variation within a given population, chosen risk factors are meaningful to providers, favorable behavior is encouraged, data is complete and timely, risk scores are stable over time and across plans and administrative burden is minimized.

In calculating premiums and charges, States using alternative methodologies should address situations when gross plan payments are greater than gross plan charges e.g. states may normalize the plan premium for actuarial value of their benefits or adjust for the specific premiums collected by each plan. States may also choose the Federal methodology with State-specific weights. The NPRM proposes that states submit alternative risk adjustment methodologies no later than November in the calendar year two years before the effective date. If HHS approves an alternative risk adjustment methodology it could be implemented not only in the state that proposed it but any other state that elects to implement an Exchange.

DATA COLLECTION

The NPRM proposes that the state (or HHS on behalf of a state) is responsible for collecting the data used in determining individual risk scores. The rule proposes national standards to protect consumer privacy, standard HIPAA claims and enrollment and demographic data submission formats and the NCPDP claims transaction standard for prescription drug claims and encounter data. States must accept any valid transaction that contains the minimum data required by the state. States with all payer claims databases operational before January 1, 2013 may request an exception from the minimum standards for data collection when they submit their alternative risk adjustment methodology with technical specifications.

States must also make certain claims and encounter data collected under risk adjustment is available to support other activities including recalibrating federally-certified risk adjustment models, verifying risk corridor submissions and auditing reinsurance claims.

VALIDATION STANDARDS

States must have a reliable data validation process to assure a credible risk adjustment process. The state (or HHS on behalf of the state) must validate a statistically valid sample of all issuers that submit data for risk adjustment every year. Based on the validation, adjustments may be made in the average actuarial risk for each plan based on the error rate found in the validation. The state may also adjust payment and charges to average actuarial risk. HHS is considering a three year deadline for completing data validation. Either the state or HHS must provide an appeals process for issuers.

Issuer Standards Related to the Transitional Reinsurance Program: Under the proposed rule, all contributing entities make contributions to the applicable reinsurance entity in the state. The frequency and manner will be determined at a later date. If any state establishes multiple reinsurance entities, the contributing entities must contribute according to the formula established by the state based on data submitted by the contributing entities. In the insured markets data will be submitted on enrollment and premiums and in the self-insured markets data will be submitted on covered lives and total medical expenses.

REQUESTS FOR REINSURANCE PAYMENTS

Reinsurance-eligible plans must submit a request for reinsurance payment to the applicable reinsurance entity. Comments are sought on the frequency and deadline and how to handle late claims.

Issuer Standards Related to the Temporary Risk Corridor Program: The ACA creates a program for the first three years of the Exchanges beginning in 2014 to stabilize the market and limit adverse selection. Risk corridors share risk between the federal government and QHP issuers. HHS will administer the risk corridor program.

- QHP issuers with costs less than 97 percent of their cost projections (or target amount) will remit charges for a percentage of these savings to HHS while issuers with costs greater than 103 percent of cost projections will receive payments from HHS to offset a percentage of these losses.
- A QHP issuer whose allowed costs are between 97 percent and 103 percent of the target amount will not receive or make payments for risk corridors.
- For a QHP with allowable costs of 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer 50 percent of the amount in excess of 103 percent.
- For QHPs that have allowable costs that exceed 108 percent of the target amount, HHS will pay the issuer 2.5 percent of the target amount plus 80 percent of the amount in excess of 108 percent of the target amount.
- For QHP issuers with allowable costs less than 97 percent of the target amount but greater than 92 percent of the target amount, HHS will charge the issuer an amount equal to 50 percent of the difference between 97 percent of the target amount and the actual value of allowable costs.
- For QHPs with allowable costs below 92 percent of the target amount, the issuer will remit charges to HHS equal to 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the actual value of allowable costs.

The NPRM defines risk corridor as a payment adjustment system based on the ratio of allowed costs of a plan to the plan's target amount. The target amount equals the total premiums incurred by the QHP including any premium tax credit or financial assistance from any governmental program (including cost-sharing reductions) reduced by the allowable administrative costs of the issuer. Allowable costs include total medical costs, including clinical costs, excluding administrative costs, paid by the issuer in providing benefits covered by the QHP. Allowable costs must be net of direct and indirect remuneration. Comments are requested on whether HHS should allow costs for activities that improve health care quality consistent with MLR policy in the ACA and whether administrative costs should be limited to 20 percent consistent with the MLR.

Risk corridor provisions apply to all QHPs offered in the Exchange. HHS will include risk corridor guidance on the reporting and administration of payments and charges which will be plan specific and not issuer specific in the federal annual notice of benefits and payment parameters for QHPs. The NPRM does not include deadlines, but the preamble seeks comments on a requirement that issuers remit charges within 30 days of receiving a notice from HHS and HHS make payments to issuers within 30 days after HHS determines that risk corridor payments should be made.

Issuers must submit data related to actual premium amounts collected by QHP issuers including premium amounts paid by parties other than enrollees in the QHP (including advance premium tax credits paid by the government). Premium amounts will be increased by the amounts paid to the issuer for risk adjustment and reinsurance and reduced for risk adjustment charges and reinsurance contributions and user fees the issuer pays on behalf of the plan. Reinsurance claims will count based on the date the reinsurance claim was submitted, e.g. if submitted on or before the deadline for a benefit year the issuer would attribute the claim to the risk corridor calculation for the benefit year in which costs were accrued and if submitted after the deadline for a benefit year, the claim would count toward the risk corridor calculations for the following year.

Allowable costs submitted for risk corridors must be reduced by any direct or indirect remuneration and any cost-sharing reduction received from HHS. Comments are sought on the deadline for issuers to complete submission of all risk corridor data and how to prevent duplicative data submission (e.g. similar data collected for MLR).

ISSUER STANDARDS RELATED TO THE RISK ADJUSTMENT PROGRAM

Issuers must submit risk adjustment data according to the timetable and format prescribed by the state or HHS on behalf of the state. Data will include enrollment and demographic data, encounter data for items and services and prescription drug utilization data. Issuers may include contract provisions with providers that address submission of complete and accurate risk adjustment data and include financial penalties for failure to comply.

Comments are sought on the timeframes considered include submission of claims and encounter data every 30 days and no later than the end of 180 days following the date of service; enrollment and demographic information by the end of the month following enrollment; issuer rate setting rules by the end of the month they are effective, and prescription drug utilization data every 30 days and no later than the end of 90 days following date of service.

After calculating all payments and charges, the state or HHS will determine a net value of payments and charges for each risk adjustment covered plan and issuers who owe a net balance will be assessed the net charge. HHS is considering requiring payment of net charges within 30 days. Issuers in multiple states must settle with each state individually.

Risk adjustment covered plan issuers must provide documentation in response to HHS or state validation programs and retain records to substantiate risk adjustment data for audit purposes.

PRELIMINARY REGULATORY IMPACT ANALYSIS (CMS-9989-P2)

The Preliminary Regulatory Impact Analysis primarily uses the Congressional Budget Office (CBO) assumptions and concludes that the NPRM will not substantially alter CBO's estimates of the budget impact of the Exchanges or enrollment.

ENROLLMENT

The analysis estimates nearly 22 million people will be enrolled in the Exchanges by 2016 and that there will be 32 million fewer uninsured due to the ACA.

	2014	2015	2016
Total Exchange Enrollment	9	14	22
Enrollees with Tax Credits	8	12	18
Employment Coverage	3	2	3
Change in Uninsured	-21	-26	-32

ADMINISTRATIVE COSTS FOR START-UP & INITIAL IMPLEMENTATION OF AN EXCHANGE

The Impact Analysis assumes that administrative costs for start-up and initial implementation of an Exchange are covered by the \$2 billion that HHS approved for State Planning and Establishment grants. The analysis assumes that the development of the Exchange Plan will also be covered by these grants.

EXCHANGE OPERATIONAL COSTS

After 2015, states will assess user fees to cover the ongoing operations of the Exchanges. For example, these fees may be a percentage of premium or a per capita fee. Operational costs will vary widely by states given the flexibility provided in the NPRM. Thus the impact analysis did not estimate most administrative costs and emphasized that automated and web resources will be lower cost than more labor-intensive administrative processes.

In addition the analysis points out that the Exchanges will lower the distribution costs of health insurance in general.

Operational costs include:

- Information Technology Infrastructure: Based on experience of Innovator IT Exchange grants, the analysis estimates \$6-48 million per state, except that \$6 million is expected to be too low.
- Consumer Assistance Tools (e.g. website, call center): States will be responsible for maintenance costs.
- Navigators: Grants are fully state funded, however estimates were not provided.
- Notifications: Based on the cost of Part D, 13 notices are estimated to cost \$11,000 for each Exchange.
- Enrollment Standards: Coordination of processes and data sharing may require significant resources initially and will need to include coordination with Pre-Existing Condition

Insurance Plans to support transition of enrollees into the Exchange without lapse in coverage.

- Eligibility Process: use of model applications will reduce administrative costs. SHOPs will have a dual role of interacting with employers and employees, however, integration with the individual Exchange will reduce administrative costs.
- Certification of QHPs: There will be wide variation since Exchanges have flexibility to determine certification standards and to engage in selective contracting.

ISSUER OPERATIONAL COSTS

The analysis characterizes QHP issuer costs such as QHP certification, issuer accreditation, and meeting network adequacy standards as an investment since Exchanges will be an important distribution channel for QHPs. The analysis also characterizes the new premium rating rules as improving the risk pool and preventing adverse selection.

REINSURANCE, RISK CORRIDORS & RISK ADJUSTMENT

The estimated Federal cost of reinsurance and risk adjustment are offset by reinsurance and risk adjustment program receipts. Risk Adjustment payments and collections are equal in the aggregate but payments lag revenues one quarter.

Reinsurance is also estimated to be budget neutral. The impact of risk corridors assumes collections would equal payments to plans in the aggregate.

	2014	2015	2016
Est. Outlays Reinsurance and Risk Adjustment Program Payments	11	18	18
Est. Receipts Reinsurance and Risk Adjustment Program Payments	12	16	18

Should you have specific questions about the information presented here, please contact us at 202.364.8283 or via e-mail at ghg@gormanhealthgroup.com.