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Overview of October 24, 2013 Final Rule on Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards

November 1, 2013

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Introduction

On October 24, 2013, the U.S. Department of Health and Human Services (HHS) issued a final rule on *Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014* (http://www.gpo.gov/fdsys/pkg/FR-2013-10-30/pdf/2013-25326.pdf). This final rule outlines financial integrity and oversight standards for Exchanges and qualified health plan (QHP) issuers, and the operation of state risk adjustment and reinsurance programs. In addition, this final rule clarifies standards for special enrollment periods, survey vendors that conduct enrollee satisfaction surveys on behalf of QHP issuers, and issuer participation in the federally-facilitated Exchange (FFE).

This document provides a high-level summary of these rules and highlights key changes to the regulation since the issuance of the proposed rule.

Part 144 – Requirements Relating to Health Insurance Coverage

Subpart A – General Provisions

Scope and Applicability (45 CFR §144.102(c))

In this section, HHS proposed a technical amendment deleting the reference that defines a "group health plan that has fewer than two participants who are current employees on the first day of the plan year" as individual coverage. This revision is to align with the Affordable Care Act (ACA) amendments that define a small employer to include groups consisting of only one common law employee.

HHS finalized this section as proposed.

Definitions (45 CFR §144.103)

In this section, HHS proposed several amendments to definitions of terms that are used throughout Part 146 (group market requirements), Part 148 (individual market requirements), and Part 150 (enforcement). These included definitions of "group market," "individual market," "large employer," "policy year," and "small employer." Unless otherwise provided, the definitions in §144.103 also apply to Part 147 (group and individual market insurance reform requirements).

HHS finalized these provisions as proposed, with minor modifications for consistency and clarity, including:

- In defining "policy year," replace the reference to January 1, 2015, with the phrase, "for coverage issued or renewed beginning January 1, 2014," to clarify the definition's applicability to calendar year plans
- Remove the exception for certain small group health plans to conform to the amendments of this final rule

Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

Guaranteed Availability and Renewability of Coverage (45 CFR §147.104, §147.106)

In this section, HHS proposed to clarify language to ensure that the guaranteed availability and renewability requirements apply to the individual, small group, and large group markets. The clarification would ensure, for example, that a health insurance issuer must offer to a large employer all products that are approved for sale in the large group market, but not those products approved for sale only in the small group market, and vice versa. HHS proposed similar amendments for guaranteed renewability within the large and small group markets. Under the guaranteed renewability provisions, an issuer could elect to discontinue all products in one segment of the group market (e.g., the small group market) without being required to discontinue all products in the other segment of the group market (e.g., the large group market).

HHS proposed a clarification stating that, as of January 1, 2015, all non-grandfathered coverage must be offered on a calendar year basis. HHS noted that this provision would apply to coverage in the individual market and to markets in which a state has merged the individual and small group markets. HHS noted that, for purposes of new enrollment effective on any date other than January 1, the first policy year following such enrollment may comprise a prorated policy year, ending on December 31.

HHS finalized these provisions as proposed, with technical corrections.

Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the ACA

Subpart A – General Provisions (45 CFR §153.20)

In this section, HHS proposed to amend the definition of "contributing entity" to clarify that, when a group health plan is partially self-insured and partially insured, it is a contributing entity

for purposes of reinsurance contributions, but only when the insured coverage is not major medical coverage (e.g., prescription drug benefits).

In the final rule, HHS finalized this provision as proposed, and explained that a specific definition of "major medical coverage" will be added to the 2015 Notice of Benefit and Payment Parameters.

Subpart C – State Standards Related to the Reinsurance Program

Maintenance of Records (45 CFR §153.240(c))

HHS proposed to amend the existing language of §153.240(c) to specify that, if a state establishes a reinsurance program, the state would be directed to maintain documents and records relating to the program (whether paper, electronic, or in another media) for each benefit year for at least ten years, and to make such documents available upon request to HHS, the Office of the Inspector General (OIG), and the Comptroller General. HHS would require states to ensure that their contractors, subcontractors, and agents similarly maintain and produce relevant documents and records upon request. HHS noted that a state may satisfy this standard through archiving and ensuring that the records are accessible if needed for investigation, audit, and other review.

HHS finalized this provision as proposed.

General Oversight Requirements for State-Operated Reinsurance Programs (45 CFR §153.260)

HHS proposed that states that establish a reinsurance program would be required to ensure that such reinsurance entity keep an accounting of the following for each benefit year: (1) all reinsurance funds received from HHS for reinsurance payments and administrative expenses, (2) all claims for reinsurance payments received from issuers of reinsurance-eligible plans, (3) all reinsurance payments made to issuers of reinsurance-eligible plans, and (4) all administrative expenses incurred for the reinsurance program. HHS noted that such accounting must be conducted in accordance with generally accepted accounting principles.

HHS also proposed that states that establish a reinsurance program would be directed to submit to HHS and make public a summary report on program operations for each benefit year, in the manner and timeframe specified by HHS. HHS further proposed that states that establish a reinsurance program must engage an independent, qualified auditing entity to perform a financial and programmatic audit of the program. States must ensure that the auditing process addresses the prohibition on the improper use of reinsurance funds for administrative expenses. An audit must be conducted for each benefit year in accordance with generally accepted auditing standards, and the qualified auditing entity may be a government entity. HHS proposed that states submit the results of the independent external audit for each benefit year and make public a summary of the results of the audit.

HHS finalized these provisions as proposed, with one modification: Public audit reports must include information on how the state intends to take corrective action for each weakness or deficiency identified by the audit.

Restrictions on Use of Reinsurance Funds for Administrative Expenses (§153.265)

HHS proposed that states operating reinsurance programs would be required to keep an accurate account of reinsurance funds received from HHS for administrative expenses. If a state incurs fewer operating expenses for a benefit year than are allocated to it under the national reinsurance contribution rate, the state would be required to carry over those funds to use for operating reinsurance in subsequent years. The standards for Exchanges that prohibit the improper use of funds allocated for administrative and operational expenses must be applied to state-operated reinsurance programs. The applicable Exchange-related prohibitions include staff retreats, promotional giveaways, excessive executive compensation, and promotion of federal and state legislative and regulatory modifications.

HHS finalized this provision as proposed.

Subpart D – State Standards Related to the Risk Adjustment Program

HHS explained that, in the first Program Integrity Rule (78 FR 54070), it solicited comment on whether a state that elects to run only a state-based small business health options program (SHOP) Exchange should be allowed to establish a risk adjustment program. In response to comments, HHS finalized policy on this issue as follows: for 2015 and later years, HHS will allow states operating only a state-based SHOP Exchange to propose an alternate risk adjustment methodology that covers both the individual and small group markets, and to apply for approval of running a risk adjustment program in both markets.

Maintenance of Records (§153.310(c)(4))

HHS proposed that state-operated risk adjustment programs would be required to maintain program documents and records (whether paper, electronic, or in another media) for each benefit year for at least ten years. HHS noted that states may satisfy this standard through archiving and ensuring that records are accessible if needed for investigation, audit, and other review.

HHS finalized this provision as proposed.

Interim Report and State Summary Report (§153.310(d))

HHS proposed that states provide interim and summary reports in order to obtain recertification from HHS to operate risk adjustment programs for a third benefit year.

- An interim report must include a detailed summary of the risk adjustment activities in the first ten months of the benefit year. This report would be due no later than December 31of the first benefit year in which the state operated a risk adjustment program. Because the process of certification begins more than one year before the applicable benefit year, the first year for which an interim report based on the year's operations could be used for certification purposes is the third benefit year.
- A summary report to HHS detailing risk adjustment program operations for the most recent benefit year for which operations were completed would also be required. HHS proposed that the detailed summary include the results of a programmatic and financial audit, any material weaknesses and significant deficiencies identified in such audit, and an explanation of how the state intends to take corrective action. The timeframe and manner of the detailed summary would be specified by HHS.

HHS finalized this provision as proposed, adding that the audits must also be made public.

General Oversight Requirements for State-Operated Risk Adjustment Programs (§153.365)

HHS proposed that states operating risk adjustment programs should be required to keep an account of all receipts and expenditures related to risk adjustment payments and charges, and the administration of risk adjustment-related functions and activities for each benefit year.

HHS finalized this provision as proposed.

Risk Adjustment Methodology

HHS proposed two changes to the risk adjustment payment transfer formula used when HHS operates risk adjustment on a state's behalf: First, in the case of family tiering states, the number of billable members would be based on the number of children who implicitly count toward the premium under a state's family rating factors. Second, a modification to the allowable rating factor formula would be used for family tiering states. HHS noted that, aside from these proposed changes, payment transfers in family tiering states will be calculated using the formulas provided in the Payment Notice: 78 FR at 1543-34. HHS also noted that the proposed changes would not apply to community rated states that do not implement family tiering rating factors.

HHS finalized the two proposed modifications, with a technical correction.

Subpart E – Health Insurance Issuer and Group Health Plan Standards Related to the Reinsurance Program

Reinsurance Contribution Funds (§153.400)

HHS proposed that a health insurance issuer providing coverage under a group health plan would be required to make reinsurance contributions for lives under its health insurance coverage—even when such coverage does not constitute major medical coverage—if:

- The group health plan provides health insurance coverage for the same covered lives through more than one insurance policy that, in combination, constitute major medical coverage, but individually do not
- The lives are not covered by self-insured coverage within the group health plan (except for self-insured coverage limited to excepted benefits)
- The health insurance coverage under the policy offered by the health insurance issuer represents a percentage of the total health insurance coverage under the policy offered in combination by the group health plan that is greater than the percentage offered under any of the other policies

HHS proposed that the percentage of coverage offered under various policies would be based on the average premium per covered life for those policies. When the percentage of coverage for two or more insurance policies is equal, the policy issuer that provides the greatest portion of in-network hospitalization benefits would be responsible for reinsurance contributions. HHS acknowledged that an issuer of group health insurance coverage that does not, by itself, constitute major medical coverage may not be aware of the existence of, or premium for, other health insurance coverage obtained by a plan sponsor covering the same lives under a group health plan.

In the case of a group health plan under which some benefit options for employees are insured by the issuer, and others offer benefits without the involvement of an issuer (because the group health plan or some non-issuer entity assumes the risk for that coverage option), HHS proposed that, when a coverage option is insured by an issuer, the issuer would be responsible for the reinsurance contribution associated with that coverage option. Additionally, if an employee coverage option under such group health plan is not insured, the group health plan would be responsible for the reinsurance contribution associated with that coverage option.

HHS finalized the reinsurance contribution provision as proposed, with a modification to the percentage of coverage provision, explaining that the issuer of a plan that provides the greatest portion of inpatient hospitalization is responsible for reinsurance contributions.

Maintenance of Records (§153.405(h) and §153.410(c))

HHS proposed that a contributing entity would be required to maintain documents and records (whether paper, electronic, or in another media) sufficient to substantiate the enrollment count submitted pursuant to that section for at least ten years. HHS also proposed that an issuer of a reinsurance-eligible plan in a state in which HHS operates reinsurance would be required to maintain documents and records (whether paper, electronic, or in another media) sufficient to substantiate the requests for reinsurance payments made pursuant to that section for at least ten years.

HHS finalized the reinsurance contribution provision as proposed, clarifying that "documents and records" must be made available to federal agencies upon request.

Subpart F – Health Insurance Issuer Standards Related to the Risk Corridors Program

In this section, HHS noted that certain requirements for QHPs do not apply to stand-alone dental plans. HHS explained that it would not be appropriate to subject stand-alone dental plans to the risk corridors program, because such plans are excepted benefits and not subject to the federal prohibition on underwriting premiums or the requirement to base pricing on the single risk pool. States have the option to prohibit underwriting for excepted benefit plans. HHS noted that stand-alone dental plans are also excepted from the reinsurance and risk adjustment programs, and stand-alone dental claims would not be pooled with an issuer's other claims for purposes of determining "allowable costs" in the risk corridors calculations.

HHS finalized this provision as proposed, adding that QHP issuers are not subject to the risk corridor provisions under this subpart with regard to a stand-alone dental plan.

Subpart G – Health Insurance Issuer Standards Related to the Risk Adjustment Program

HHS proposed to require issuers that offer risk adjustment-covered plans to maintain documents and records (whether paper, electronic, or in another media) sufficient to enable the evaluation of an issuer's compliance with applicable risk adjustment standards. This standard would require issuers of risk adjustment-covered plans to retain additional records—not only those pertaining to data validation—to substantiate compliance with risk adjustment standards, regardless of whether risk adjustment is operated by HHS or the state. HHS explained that it anticipates that the bulk of the record maintenance obligations will relate to data validation.

HHS finalized this provision as proposed, with two corrections. First, "documents and records" must be available upon request. Second, documents and records must be maintained for each benefit year and at least for ten years.

Subpart H – Distributed Data Collection for HHS-Operated Programs

Failure to Comply with HHS-Operated Risk Adjustment and Reinsurance Data Requirements (§153.740)

HHS proposed that it be permitted to pursue an enforcement action for civil money penalties against an issuer in a state in which HHS operates reinsurance or risk adjustment. HHS had noted that it will pursue enforcement if an issuer fails to: (1) establish a secure, dedicated distributed data environment; (2) provide HHS with access to enrollee-level plan enrollment information, enrollee claims data, or enrollee encounter data through its dedicated distributed data environment; (3) otherwise comply with the requirements related to a secure, dedicated distributed data environment; (4) adhere to the reinsurance data submission requirements; or (5) adhere to the risk adjustment data submission and data storage requirements.

Risk Adjustment

HHS proposed to apply the standards for imposing civil monetary penalties to risk adjustment-covered plans. HHS noted that it intends to work collaboratively with issuers to address any problems in establishing dedicated distributed data environments in 2014. HHS also proposed to assess the default risk adjustment charge. However, HHS noted that it may pursue civil monetary penalties in conjunction with the imposition of the default risk adjustment charge if an issuer fails to comply with applicable data security or privacy standards, putting the interests of third parties at risk.

Reinsurance

HHS proposed that an issuer of a reinsurance-eligible plan may be subject to civil monetary penalties for failure to comply. HHS noted that it would reserve the right to pursue these penalties regardless of whether or not an issuer becomes ineligible for reinsurance payment as a result of failing to comply.

HHS finalized these provisions as proposed, adding regulatory language to clarify non-enforcement of civil money penalties for good faith.

Default Risk Adjustment Charge (45 CFR §153.740(b))

In this section, HHS proposed to assess a default risk adjustment charge if a risk adjustment-covered plan fails to:

- Establish a dedicated distributed data environment
- Provide HHS with access to risk adjustment data in such environment by April 30 of the year following the applicable benefit year, such that HHS cannot apply its federally

certified risk adjustment methodology to calculate the plan's risk adjustment payment transfer amount in a timely fashion

HHS noted that delaying the calculation of risk adjustment payment transfers in a market in a state until all risk adjustment-covered plans submit complete risk adjustment data would weaken the integrity of the April 30 data submission deadline and related deadlines for the risk corridors and medical loss ratio (MLR) programs.

HHS is considering two methods for calculating the default risk adjustment charge. The first option would be to use the highest per member per month (PMPM) charge among the risk adjustment-covered plans in a risk pool in the market within the plan's geographic rating area. The second option would be to use a PMPM default charge that is two standard deviations above the mean charge in the market within the plan's geographic rating area.

HHS finalized these provisions as proposed, with the exception of the approach for determining the PMPM to calculate the default risk charge. HHS will propose that methodology in future rulemaking.

Part 155 – Exchange Establishment Standards and Other Related Standards under the ACA

Subpart D – Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions (45 CFR §155.340)

In this section, HHS proposed additional requirements that apply when an Exchange facilitates the collection and payment of premiums to QHP issuers and stand-alone dental plans. If the Exchange did not reduce an enrollee's premium by the advanced premium tax credit (APTC), it would be required to refund any excess premium to the enrollee. The Exchange would also be required to notify the enrollee of the improper application of the APTC no later than 30 calendar days after the Exchange discovers the error. The Exchange may provide the refund to the enrollee by reducing the enrollee's portion of the premium in the following month, as long as the reduction is provided no later than 30 calendar days after the Exchange discovers the error.

HHS finalized these provisions as proposed, with the following modifications:

- The time period for notifying the enrollee of the improper application of the APTC and the associated refund is changed from *30 days to 45 days*.

- The Exchange may issue the refund by applying the total excess premium to the enrollee's portion of the premium on a monthly basis for the remainder of the period of enrollment or benefit year until the excess premium is completely refunded. However, the Exchange must refund any remaining excess premium within 45 days of the request (by or for the enrollee) or the end of the enrollment period or benefit year.

Subpart E – Exchange Functions in the Individual Market: Enrollment in QHPs

Special Enrollment Periods (45 CFR §155.420)

In this section, HHS clarified that special enrollment will be available when an Exchange determines that a consumer has been incorrectly or inappropriately enrolled in coverage due to misconduct of a non-Exchange entity. This special enrollment would include cases in which individuals are not enrolled in QHP coverage as desired, are not enrolled in their selected QHP, or have been determined eligible for, but are not receiving, APTCs and cost-sharing reductions (CSRs). Non-Exchange entities include Navigators, non-Navigator consumer assistance personnel, certified application counselors, agents or brokers, issuer customer service representatives, and QHPs that conduct direct enrollment.

HHS finalized these provisions as proposed, with technical corrections and a modification to extend a special enrollment period to SHOPs.

Subpart H – Exchange Functions: SHOP

Enrollment Periods under SHOP (45 CFR §155.725)

In this section, HHS made a conforming amendment that extends to SHOP the new special enrollment period that is made available when the Exchange determines that a consumer has been incorrectly or inappropriately enrolled in coverage due to misconduct on the part of a non-Exchange entity.

HHS finalized this provision as proposed.

Subpart M – Oversight and Program Integrity Standards for State Exchanges

General Program Integrity and Oversight Requirements (45 CFR §155.1200)

In this section, HHS proposed that state-based Exchanges (SBEs) maintain an accounting of all receipts and expenditures, in accordance with generally accepted accounting principles. SBEs would develop and implement a process for monitoring all Exchange-related activities for effectiveness, efficiency, integrity, transparency, and accountability. SBEs would submit several types of reports to HHS, including:

- Annual report to allow for transparency of SBE activities; due to HHS by April 1and including a financial statement
- Eligibility and enrollment reports in a form and manner to be specified by HHS
- Performance monitoring data that includes financial sustainability, operational efficiency, and consumer satisfaction
- An independent audit conducted by an independent, qualified auditing entity (whether governmental or private). The SBE would be required to submit the results of the audit, and proposals for how to remedy any material weakness or significant deficiencies.

HHS proposed that the external audits and annual reports required under federal law address SBE processes and procedures to comply with the standards for Exchanges regarding APTCs and CSRs. Such standards include requirements that specify eligibility determinations, such as requirements regarding the confidentiality, disclosure, maintenance, and use of information. HHS also proposed that such audits and annual reports assess whether an SBE has processes and procedures in place to prevent improper eligibility determinations and enrollment transactions.

HHS finalized these provisions as proposed, with the following modifications:

- Requires the Exchange to annually report if it did not reduce an enrollee's premium by the amount of the APTC
- Requires that the state make public a summary of the results of the external financial audit

Maintenance of Records (45 CFR §155.1210)

In this section, HHS proposed that SBEs and their contractors, subcontractors, and agents maintain records for ten years, including documents, records (whether paper, electronic, or another media) and other evidence of accounting procedures and practices of the SBE to prepare for targeted audits. HHS noted that targeted audits will be conducted based on information from the external audit, annual report, prospective measurement programs of improper payments, consumer complaints, and other data sources. SBEs must make all records of this section available to HHS, the OIG, and the Comptroller General or other designee.

HHS finalized these provisions as proposed, noting that the ten-year record retention requirement begins when the record is created.

Part 156 – Health Insurance Issuer Standards under the ACA, Including Standards Related to Exchanges

Subpart A – General Provisions

Definitions (45 CFR §156.20)

In this section, HHS proposed to add the following definitions:

- Enrollee satisfaction survey vendor: An organization that has relevant survey administrative experience, organizational survey capacity, and quality control procedures for survey administration
- Registered user of the survey data warehouse: Enrollee satisfaction survey vendors, QHP issuers, and Exchanges authorized to access the Centers for Medicare & Medicaid Services' secure data warehouse

HHS finalized these provisions as proposed, with minor technical corrections.

Single Risk Pool (45 CFR §156.80)

In this section, HHS proposed that issuers in individual and merged markets would be permitted to make changes to their market wide adjusted index rate and plan-specific pricing on an annual basis. Issuers in the small group market would be permitted to make these changes on a quarterly basis, beginning with the rates effective for the third quarter of 2014. Issuers in the federally-facilitated SHOP (FF-SHOP) would be required to set rates for non-grandfathered plans in the small group market on an annual basis until the FF-SHOP is capable of processing quarterly rates.

HHS finalized these provisions as proposed, with the following modifications:

- Specified that an index rate must be established and effective for a state market (individual, small group, or merged market) by January 1 of each calendar year
- Clarified that an issuer is prohibited from making index rate and plan-level adjustments on any basis other than annually, except in the small group market once quarterly rate changes are permitted
- Clarified the effective dates of quarterly rate updates in the small group market

Subpart B – Standards for Essential Health Benefits, Actuarial Value, and Cost Sharing

Enrollment in Catastrophic Plans (45 CFR §156.155)

In this section, HHS made technical corrections to clarify that a catastrophic plan provides "no benefits" for any plan year (with the exception of coverage for at least three primary care visits and preventive health services) until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation on cost sharing that is in effect.

HHS finalized these provisions as proposed.

Subpart D – QHP Minimum Certification Standards

Changes of Ownership of Issuers of QHPs in FFEs (45 CFR §156.330)

In this section, HHS proposed that, when a QHP issuer in the FFE undergoes a change in ownership, it must notify HHS of the change at least 30 days prior to the date of the change, as well as provide the legal name and taxpayer identification number of the new owner. In addition, the new owner must list the effective date of the change and agree to adhere to applicable statutes and regulations.

HHS finalized these provisions proposed.

Subpart E – Health Insurance Issuer Responsibilities with Respect to APTCs and CSRs

Definitions (45 CFR §156.400)

In this section, HHS clarified that the definitions of "least generous" and "less generous" plan variations are opposite those of "most generous" and "more generous" plan variations, respectively. Between two plan variations (or a plan variation and a standard plan without CSRs), the plan variation or standard plan without CSRs designed for the category of individuals would be considered the less generous one. The term "less generous" was used to address the circumstance in which a QHP issuer would reassign an enrollee from a more generous plan variation to a less generous plan variation (or a standard plan without CSRs).

HHS finalized these provisions as proposed.

Improper Plan Assignment and Application of CSRs (45 CFR §156.410(c)-(d))

In this section, HHS identified the actions a QHP issuer would take if it did not provide the appropriate CSRs to an individual or assign an individual to the appropriate plan variation (or

standard plan without CSRs). If a QHP issuer failed to ensure that an individual assigned to a QHP plan variation received the required CSRs, the QHP would notify the enrollee of the improper CSR application and refund any excess cost sharing, no later than 30 calendar days after discovery of the error. This refund would be paid to the person or entity that paid the excess cost sharing, whether the enrollee or provider.

If a QHP issuer provided an enrollee assigned to a plan variation with greater CSRs than required under the applicable plan variation (taking into account the continuity of deductibles and out-of-pocket amounts, if applicable), the QHP issuer would not be eligible for reimbursement of any excess CSRs provided to the enrollee, and would not be able to seek reimbursement from the enrollee or provider for any of the excess CSRs. HHS stipulates that the QHP issuer should not be allowed to recoup overpayments of CSRs that resulted from the QHP issuer's own errors.

If a QHP issuer improperly assigned an enrollee to a plan variation (or standard plan without CSRs), or did not change the enrollee's assignment due to a change in eligibility, in each case, based on the eligibility and enrollment information or notification provided by the Exchange, the QHP issuer would reassign the enrollee to the applicable plan variation (or standard plan without CSRs) and notify the enrollee of the improper assignment, no later than 30 calendar days after discovery of the error.

If a QHP issuer reassigned an enrollee from a less generous plan variation (or a standard plan without CSRs) to a more generous QHP plan variation to correct an improper assignment on the part of the issuer, the QHP issuer would recalculate the individual's liability for cost sharing paid between the effective date of eligibility required by the Exchange and the date on which the issuer effectuated the change. The QHP issuer would refund any excess cost sharing paid by or for the enrollee during such period, no later than 30 calendar days after discovery of the error. This refund would be paid to the person or entity that paid the excess cost sharing, whether the enrollee or provider.

HHS finalized these provisions as proposed, with the following modifications:

- HHS amended language to increase the time period for issuing refunds from 30 days to 45 days after discovery of the error.
- The Exchange may issue the refund by applying the total excess premium to the enrollee's portion of the premium on a monthly basis for the remainder of the period of enrollment or benefit year until the excess premium is completely refunded. However, the Exchange must refund any remaining excess premium within 45 days of the request (by or for the enrollee) or the end of the enrollment period or benefit year.
- HHS restructured language to establish a timeframe for effectuating a reassignment to the correct plan variation.

Payment for CSRs (45 CFR §156.430)

In previous guidance, HHS established an approach for providing monthly advance payments to issuers to cover projected CSR amounts, and then reconciling those advance payments at the end of the benefit year. QHP issuers must submit data to HHS on the amount of cost sharing enrollees paid in each plan variation, as well as the amount the enrollees would have paid under the standard plan. QHP issuers have two options for calculating the amount that enrollees would have paid under the standard plan: The first option is "standard methodology," in which QHP issuers apply the cost-sharing requirements for the standard plan to the allowed costs for each plan variation policy. The second option is "simplified methodology," in which QHP issuers calculate the amount of cost sharing that enrollees would have paid under the standard plan using certain summary cost-sharing parameters. QHP issuers that select the simplified methodology must apply it to all plan variations offered within the Exchange during that plan year. QHP issuers may not select the simplified methodology if they did not select the simplified methodology for the prior plan year.

In this final rule, HHS made the following changes:

- Added a new requirement that QHP issuers may only use the simplified methodology for benefit years 2014 through 2016
- Modified §156.430(c)(4) to address unique benefit structures and potential biases in the formulas, including edits to Formulas B and C
- Clarified how QHP issuers should calculate the effective cost-sharing parameters for self-only coverage, other than self-only coverage, medical services, and pharmaceutical services

Failure to Reduce an Enrollee's Premium to Account for APTC (45 CFR §156.460(c))

In the proposed rule, HHS required a QHP issuer that discovers it did not reduce the portion of the premium charged to or for an enrollee by the amount of the APTC to refund to the enrollee any excess premium paid and notify the enrollee of the improper reduction no later than 30 calendar days after discovery. The QHP issuer may provide the refund by reducing the enrollee's portion of the premium in the following month, as long as the reduction is provided no later than 30 calendar days after discovery.

In the final rule, HHS extended the refund time period to 45 days after discovery of the error. In the final rule, HHS also gave QHP issuers another option for issuing refunds. If an enrollee requests the refund, the QHP issuer must refund the excess premium within 45 days of discovery. If the enrollee *does not* request a refund, the QHP issuer may apply the excess premium paid to the enrollee's portion of the premium each month for the remainder of the enrollment period or benefit year. If any excess premium paid remains at the end of the enrollment period or benefit year, the QHP issuer must refund the excess amount within 45 days.

HHS had requested comment on whether it should impose quarterly reporting requirements detailing the occurrence of improper application of APTCs. In the final rule, HHS did not adopt a quarterly reporting standard; instead, issuers are required to report this information as part of their annual reporting requirements.

Oversight of the Administration of CSRs and APTCs (45 CFR §156.480)

The proposed rule specified that HHS must oversee QHP issuer compliance in the areas of APTCs and CSRs. In this section, HHS:

- Extends the standards set forth in §156.705 concerning maintenance of records to a QHP issuer in the individual market on a state Exchange in relation to CSRs and APTCs.
- Requires QHP issuers to ensure that any delegated and downstream entities adhere to these requirements, in parallel with the proposed standards for QHP issuers in the FFE. HHS notes that a QHP issuer and its delegated and downstream entities may satisfy this standard by maintaining the relevant records for a period of ten years and ensuring that they are accessible if needed for an investigation or audit.
- Subjects QHP issuers that participate in state Exchanges and the FFE to reporting and oversight requirements that are intended to help monitor a QHP issuer's compliance with federal standards regarding APTCs and CSRs.
- Requires QHP issuers in the individual market through a state Exchange or an FFE to report annual summary statistics on the administration of APTCs and CSRs, including:
    - The total amount of cost sharing paid under each plan variation, including the amount paid by the individual and the amount reduced by CSRs.
    - An annual error rate of the misapplication of the APTCs and CSRs by plan variation.
    - The total number of enrollees who received refunds and the total and average refunds made to enrollees and providers resulting from underpayments, by plan variation.
- May audit an issuer that offers a QHP in the individual market through a state Exchange or the FFE to assess its compliance with responsibilities regarding APTCs and CSRs.

HHS finalized this section as proposed, with a modification to paragraph (b), specifying that the annual report must contain summary statistics on the application of APTCs and CSRs, including any failure to adhere to standards. In response to comments, HHS noted that it will provide future detailed guidance and seek comment on the audit processes.

Subpart H – Oversight and Financial Integrity Requirements for QHP Issuers in the FFE

Maintenance of Records for the FFE (45 CFR §156.705)

In this section, HHS requires issuers offering QHPs in an FFE to maintain all documents and records (whether paper, electronic, or another media) and other evidence of accounting procedures and practices for ten years. Activities necessary to safeguard the financial and programmatic integrity of the FFEs include periodic auditing of the QHP issuer's financial records and reviews, and other monitoring of a QHP issuer's compliance. These standards only pertain to Exchange-specific areas of concern (e.g., matters pertaining to APTCs and CSRs) within the FFE, as HHS would expect states to oversee the maintenance of records pertaining to other aspects of QHP issuer operations, as required under state law.

HHS finalized this section as proposed.

Compliance Reviews of QHP Issuers in the FFE (45 CFR §156.715)

HHS specifies that issuers offering QHPs in an FFE be subject to compliance reviews, and that findings from compliance reviews may be used in conjunction with other findings related to the QHP issuer's compliance with certification standards. HHS will have the discretion to conduct either an onsite or desk review.

HHS finalized this section as proposed, with correction of a minor typographical error.

Subpart J – Administrative Review of QHP Issuer Sanctions in the FFE

Administrative Review in the FFE (45 CFR §§156.901-156.963)

This section specifies the administrative hearing process for QHP issuers against which an enforcement action has been taken.

HHS finalized this section as proposed, with only a minor technical correction. HHS did not finalize §156.949.

Subpart L – Quality Standards

Establishment of Standards for HHS-Approved Enrollee Satisfaction Survey Vendors for Use by QHP Issuers in Exchanges (45 CFR §156.1105)

Under §1311(c)(4) of the ACA, the Secretary of HHS must develop an enrollee satisfaction survey for each QHP offered through an Exchange that had more than 500 enrollees during the previous year. The results of the evaluation must be publicly available on the Exchange's

internet portal "in a manner that allows easy comparison." In this section, HHS outlines the processes for approving and overseeing enrollee satisfaction survey vendors that administer the surveys. The application and approval standards for survey vendors include:

- Submit an application form
- Ensure that appropriate staff members participate in HHS survey vendor training
- Ensure and attest to the accuracy of the vendor's data collection, calculation, and submission processes
- Execute a standard data use agreement with HHS
- Adhere to the enrollee satisfaction survey protocols and technical specifications, as specified by HHS.
- Develop and submit to HHS a quality assurance plan
- Adhere to privacy and security standards under the Exchange regulations
- Comply with all federal and state laws
- Become a registered user of the enrollee satisfaction data warehouse to submit files to HHS on behalf of the QHP issuers working with the vendor
- Participate in and cooperate with HHS oversight for quality-related activities
- Comply with minimum business criteria established by HHS

Vendors will be approved for one-year terms and must be approved by mid-2014 to allow for issuers to contract in a timely manner. HHS indicates that it will, through future rulemaking, direct QHP issuers to contract with HHS-approved vendors and require surveys to be modeled on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan survey. Further, HHS intends to promulgate additional quality reporting standards for QHP issuers and Exchanges.

HHS finalized this section as proposed.

Subpart M – QHP Issuer Responsibilities

Confirmation of HHS Payment and Collections Reports (45 CFR §156.1210)

HHS intends to send each issuer a monthly payment and collections report that will specify the payments HHS owes to the issuer, and vice versa. For 2014, this report should include APTCs and CSRs that HHS is paying to the issuer for each policy, as well as any applicable FFE user fees. Issuers are required to review these reports and, within 15 calendar days of the date of the report, either confirm that the report is accurate or identify any inaccuracies. HHS will work with issuers to resolve discrepancies.

HHS finalized this section as proposed, with a minor technical correction and added a new paragraph stating that HHS will work with issuers to resolve discrepancies reported by the issuer after the 15-day deadline. HHS is considering establishing a final deadline, after which discrepancies cannot be reported in future rulemaking. HHS also notes that it intends to publish a companion guide to the HIX 820 payment and collections report in the fall of 2013.

The Hilltop Institute

University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854
www.hilltopinstitute.org