



# VCU Medical Center

## Office of Health Innovation

### Final Rule: Benefit and Payment Parameters for 2014

**Description:** This final rule provides further detail and payment parameters related to: the risk adjustment, reinsurance, and risk corridors programs; cost-sharing reductions; user fees for a Federally-facilitated Exchange; advance payments of the premium tax credit; a Federally-facilitated Small Business Health Option Program; and the medical loss ratio program.

### Major Provisions

**Premium stabilization programs:** The Affordable Care Act establishes transitional reinsurance and temporary risk corridors programs, and a permanent risk adjustment program to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers. The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented.

**Risk Adjustment:** On an ongoing basis, the risk adjustment program is intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and reduce the incentives for issuers to avoid higher-risk enrollees.

### Regulatory Amendments

- States that operate their own exchanges can establish and operate their own risk adjustment programs with HHS approval.
- Beginning in 2015, state-operated risk adjustment programs will have to be certified by HHS, but given the short-time frame for 2014, HHS will instead engage in a consultative process with states that wish to run their own programs. States must submit the benefit and payment parameters for their own risk-adjustment and reinsurance programs within 30 days of the publication of the final rule.
- The risk adjustment methodology is developed by HHS and published in the applicable annual HHS notice of benefit and payment parameters; or an alternate risk adjustment methodology is submitted by a State, reviewed and certified by HHS, and published in the applicable annual HHS notice of benefit and payment parameters.
- An issuer of a risk adjustment covered plan in a State where HHS is operating risk adjustment on behalf of the State for the applicable benefit year must have an initial and second validation audit performed on its risk adjustment data.
  - o Based on these audits, HHS will extrapolate the error rate for an issuer and make payment adjustments for the next year. The issuer can appeal the findings of this

process. HHS will not make any payment adjustments for 2014 and 2015 to give issuers and auditors time to adjust to the program.

- The federal government will charge a user fee in states where it operates the risk-adjustment program. For 2014, the fee will be 8 cents per-member per-month for plans subject to the risk adjustment program.
- **Risk adjustment methodology:** The federal risk adjustment methodology includes five elements:
  1. Calculates a risk score for each insured individual in plans subject to risk adjustment based on that individual's recorded diagnoses, age and gender, metal plan level, geographic rating area, and other variables to calculate a risk score — a relative measure of how expensive that individual is likely to be.
  2. Calculates a plan-average risk score based on the average of the risk scores of all individuals in the plan.
  3. Uses these scores, as well as other plan-specific cost factors, to determine the funds that must be transferred among plans as charges or payments.
  4. HHS will use a distributed model to obtain the data to calculate determine these transfers. This means that HHS will not itself collect or maintain individual data, but rather will do the calculations on the insurers own servers using data in the possession of the plan.
  5. The rule contains a schedule for risk adjustment operations. Risk pooling will be done concurrently, that is based on actual reported risk experience, rather than prospectively, based on projected risks.

**Reinsurance:** The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting risk of high-cost enrollees. The program is expected to lower premiums in the individual market by an estimated 10 to 15 percent in 2014. The statute sets a fixed contribution amount for the reinsurance program.

#### Regulatory Amendments

- **Calculation:** The reinsurance contribution required from a contributing entity for its reinsurance contribution enrollees during a benefit year is calculated by multiplying
  - o The number of covered lives of reinsurance contribution enrollees during the applicable benefit year for all plans and coverage of the contributing entity; by
  - o The contribution rate for the applicable benefit year.
    - Entities subject to the contribution requirement must inform HHS of their average number of covered lives (using one of the counting methods specified in the rule) as of November 15 of any given year based on membership for the first nine months of the year.
    - By the later of December 15, or 30 days after the submission of the annual enrollment count, HHS must notify each contributing entity of its contribution

amount. The contributing entity must pay this amount within 30 days of the notice.

- States can also operate, or contract with non-profit entities to operate, their own reinsurance programs.
- If a State contracts with or establishes more than one applicable reinsurance entity, the State must ensure that each applicable reinsurance entity operates in a distinct geographic area with no overlap of jurisdiction with any other applicable reinsurance entity.
- If a State establishes a reinsurance program, HHS will collect all reinsurance contributions from all contributing entities for that State under the national contribution rate.
- HHS will allocate and disburse to each State operating reinsurance (and will distribute directly to issuers if HHS is operating reinsurance on behalf of a State), reinsurance contributions collected from contributing entities under the national contribution rate for reinsurance payments. The disbursed funds would be based on the total requests for reinsurance payments made under the national reinsurance payment parameters in all States.
- States may collect additional reinsurance contributions (or charges for administrative costs) and make additional reinsurance payments, but must publish a state notice of benefit and payment parameters if they wish to do so, and must do so within 30 days of the publication of the final rule if they plan to do so for 2014.
- Each contributing entity must make reinsurance contributions annually: at the national contribution rate for all reinsurance contribution enrollees, in a manner specified by HHS; and at the additional State supplemental contribution rate if the State has elected to collect additional contributions, in a manner specified by the State.

**Risk Corridors:** The temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 through 2016. The risk corridors program will protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains. The rule finalizes additional technical details on how issuers will account for profits and taxes in their risk corridors calculations, which align this program with the medical loss ratio program (see below).

#### Regulatory Amendments

- The risk corridor program requires QHPs whose ratio of allowable costs to their target amount falls below a certain percentage to remit to HHS a contribution from which HHS can compensate QHPs whose ratio of allowable costs to their target amount exceeds a certain percentage.
- Allowable costs are claims costs plus allowable quality improvement and technology expenses, reduced for reinsurance, risk-adjustment, or cost-sharing reduction payments received.
- The target amount for a QHP is earned premiums minus taxes and minus administrative costs and profits (the sum of which cannot exceed 20 percent).
- HHS is finalizing a change to the risk corridors calculation in which reinsurance contributions will be treated as a regulatory fee instead of an adjustment to allowable costs, and is replacing the term "taxes" in their proposed definition of taxes with the term "taxes and regulatory fees."

- A QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in a manner specified by HHS.
- The preamble clarifies that unlike the risk adjustment or reinsurance programs, the risk corridor program is not required to be budget neutral. HHS can either make or lose money on the program.

**Advanced payments of the premium tax credit and cost-sharing reductions:** This final rule establishes standards for advanced payments of the premium tax credit and for cost-sharing reductions. These programs assist low- and moderate-income Americans in affording health insurance on an Exchange.

An Exchange makes an advance determination of tax credit eligibility for individuals who enroll in QHP coverage through the Exchange and seek financial assistance. Using information available at the time of enrollment, the Exchange determines whether the individual meets the income and other requirements for advance payments and the amount of the advance payments that can be used to pay premiums. If an enrollee receiving premium tax credits reports a change of income to an exchange during the course of a year, the exchange must account for any advance premium tax credit payments already made on behalf of the enrollee in that year to minimize, to the extent possible, over- or under-payments at the end of the year.

Advance premium tax credits only cover the essential health benefits, thus each QHP must provide annually for each metal level health plan an allocation of its expected allowed claims costs to EHB and to other benefits, accompanied by an actuarial memorandum supporting the allocation.

Section 1402 of the Affordable Care Act directs issuers to reduce cost sharing for essential health benefits for individuals with household incomes between 100 and 400 percent of the Federal poverty level (FPL) who are enrolled in a silver level QHP through an individual market Exchange and are eligible for advance payments of the premium tax credit. The final rule requires QHP issuers to offer variations of their standard plans reflecting these various levels of cost-sharing. The silver plan variations designed to accommodate reduced cost sharing may not vary more than 1 percentage point from the target reduced actuarial value.

**Federally-facilitated Exchange user fees:** Section 1311(d)(5)(A) of the Affordable Care Act contemplates an Exchange charging assessments or user fees to participating issuers to generate funding to support its operations. As the operator of a Federally-facilitated Exchange, HHS has the authority, under this section of the statute, to collect and spend such user fees. This final rule establishes a user fee, calculated as a percentage of the premium for a QHP, applicable to issuers participating in a Federally-facilitated Exchange.

As proposed in the earlier notice of proposed rulemaking, HHS is setting the user fee for the federally-facilitated exchange at 3.5 percent of monthly premium charges. HHS acknowledges that this fee may not cover the full cost of the exchange, but notes that it is trying to encourage enrollment and align the cost with that of state-based exchanges. The user fee will be spread across the entire individual or small-group risk pool of a QHP issuer.

**Small Business Health Options Program (SHOP):** Section 1311(b)(1)(B) of the Affordable Care Act directs each State that chooses to operate an Exchange to establish a Small Business Health Options Program (SHOP) that provides health insurance options for small businesses. The Exchange Establishment Rule sets forth standards for the administration of SHOP Exchanges. In this final rule, HHS clarifies and expands upon the standards established in that final rule.

Each SHOP exchange may determine the method by which it will allow employers to contribute toward premiums to cover their employees. In the FF-SHOP, an employer may either pay a percentage of the premiums of a reference plan or, if the employer requests it or the state requires it, a premium based on a composite premium charged all employees for a reference plan. Insurers that participate in the individual exchange will only be required to participate in the SHOP exchange if they (or a related issuer in an issuer group) already participate in the SHOP exchange or have at least a 20 percent in the small group market.

**Medical loss ratio (MLR) program:** Public Health Service (PHS) Act section 2718 requires health insurance issuers to submit an annual MLR report to HHS and provide rebates to consumers if they do not achieve specified MLRs. This ratio is calculated as the sum of health care claims costs and amounts spent on quality improvement activities divided by premium revenue, excluding taxes and regulatory fees, and after accounting for the premium stabilization programs.

This final rule amends the regulations to specify how issuers are to account for payments or receipts for risk adjustment, reinsurance, and risk corridors programs, and to change the timing of the annual MLR report and distribution of rebates required of issuers to account for the premium stabilization programs. HHS is extending the annual medical loss ratio reporting deadline from June 1 to July 31, and the rebate disbursement deadline from August 1 to September 30. This final rule also amends the regulations to revise the treatment of community benefit expenditures in the MLR calculation for issuers exempt from Federal income tax.