



VCU Medical Center

Office of Health Innovation

Final Rule - Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards

Description: This final rule outlines financial integrity and oversight standards with respect to Affordable Insurance Exchanges, qualified health plan (QHP) issuers in Federally-facilitated Exchanges (FEEs), and States with regard to the operation of risk adjustment and reinsurance programs. It also establishes additional standards for special enrollment periods, survey vendors that may conduct enrollee satisfaction surveys on behalf of QHP issuers, and issuer participation

Citation: 78 FR 65045 in an FFE, and makes certain amendments to definitions and standards
Publish Date: October 30, 2013 related to the market reform rules. These standards, which include financial
Comments Due: N/A integrity provisions and protections against fraud and abuse, are consistent
Effective Date: December 30, 2013 with Title I of the Affordable Care Act. This final rule also amends and adopts as final interim provisions set forth in the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, published in the Federal Register on March 11, 2013, related to risk corridors and cost-sharing reduction reconciliation.

Major Provisions

State Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

- State-operated reinsurance programs
 - States that establish a reinsurance program will 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.
 - The rule requires that states keep an accurate accounting for the programs, submit to HHS and make public reports on operations, and take other steps to ensure the soundness and transparency of the programs.
 - Use of Reinsurance Funds 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 will be required to carry over those funds to use for operating reinsurance in subsequent years.
- State-operated risk adjustment programs
 - 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.

- State-operated risk adjustment programs will be required to maintain program documents and records (paper, electronic, or another media) for each benefit year for at least ten years.

Health Insurance Issuer and Group Health Plan Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

- Reinsurance program
 - A health insurance issuer providing coverage under a group health plan will be required to make reinsurance contributions for lives under its health insurance 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.
 - 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.
 - 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, the issuer of the plan that provides the greatest portion of inpatient hospitalization is responsible for reinsurance contributions.
- Risk corridors program
 - Certain requirements for QHPs do not apply to stand-alone dental plans, 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.
- Risk adjustment program
 - Issuers that offer risk adjustment-covered plans to maintain documents and records sufficient to enable the evaluation of an issuer's compliance with applicable risk adjustment standards.
 - These documents and records must be available upon request.
 - Documents and records must be maintained for each benefit year and for at least ten years.

Program Integrity for Advance Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions

- Administration of APTC
 - If the Exchange does not reduce an enrollee's premium by the advanced premium tax credit (APTC), it will be required to refund any excess premium to the enrollee.
 - The Exchange may provide the refund to the enrollee by reducing the enrollee's portion of the premium on a monthly basis for the remainder of the period of enrollment, as long as the reduction is provided no later than 45 calendar days after the Exchange discovers the error.

Special Enrollment Periods

- 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.
- 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.

Program Integrity of State Marketplaces

- Oversight
 - State-based Exchanges (SBEs) must maintain an accounting of all receipts and expenditures, in accordance with generally accepted accounting principles.
 - SBEs will develop and implement a process for monitoring all Exchange-related activities for effectiveness, efficiency, integrity, transparency, and accountability.

Health Insurance Issuer Responsibilities with Respect to APTCs and CSRs

- Improper plan assignment and application of CSRs
 - If a QHP issuer failed to ensure that an individual assigned to a QHP plan variation received the required CSRs, the QHP must notify the enrollee of the improper CSR application and refund any excess cost sharing, no later than 45 calendar days after discovery of the error.
 - If a QHP issuer provided an enrollee assigned to a plan variation with greater CSRs than required under the applicable plan variation, the QHP issuer would not be eligible for reimbursement of any excess CSRs provided to the enrollee.
 - 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 45 calendar days after discovery of the error.
 - Refunds will be paid to the person or entity that paid the excess cost sharing, whether the enrollee or provider.
- Failure to reduce and enrollee's premium to account for APTC
 - 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 will refund to the enrollee any excess premium paid and notify the enrollee of the improper reduction no later than 45 calendar days after discovery.
 - 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.