



# VCU Medical Center

## Office of Health Innovation

### Proposed Rule: Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards

**Description:** This proposed rule sets forth financial integrity and oversight standards with respect to Affordable Insurance Exchanges; Qualified Health Plan (QHP) issuers in Federally-facilitated Exchanges (FfEs); and States with regard to the operation of risk adjustment and reinsurance programs. It also proposes additional standards with respect to agents and brokers.

#### Major Provisions

##### Requirements Related to Health Insurance Coverage

- The proposed rule clarifies that coverage sold through associations to an employer-member is considered group coverage even if it includes an employer with one employee.
- HHS proposes definitions of small employer (employer with at least 1 but not more than 100 employees) and larger employer (employer with at least 101 employees), along with the state option to define small employers as at least 1 but not more than 50 employees until 2016.
- HHS also proposes changes to the definitions of “policy year” for the non-grandfathered individual market or in a State that has merged the individual and small group market to mean a calendar year.

##### Health Insurance Reform Requirements for the Group and Individual Insurance Markets

- **Fair Health Insurance Premiums** - HHS proposes to clarify that the rating area in the small group market is determined using the principal business address of the group policy holder, and in the individual market using the address of the primary policyholder, both inside and outside the Exchange.
- **Guaranteed Availability and Renewability of Coverage** - HHS proposes to clarify that the guaranteed availability and renewability requirements apply within the applicable market segment (individual, small group, and large group markets).
  - For example, 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 that are approved for sale only in the small group market, and vice versa.

##### Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

##### State Standards Related to the Reinsurance Program

- **Maintenance of Records** - HHS proposes to amend the maintenance of records requirement to require that the State maintain records for at least 10 years and make them available upon

request to HHS, the Office of the Inspector General (OIG), the Government Accountability Office (GAO), or their designees, and that the State ensure that contractors, subcontractors and agents also maintain such records.

- **General Oversight Requirements** - HHS proposes a set of general oversight requirements for State-operated reinsurance programs, including directing that an applicable reinsurance entity keep specified accounting records.
  - HHS also proposes that a State be required to:
    - Submit to HHS and make public a summary of its reinsurance program for each benefit year,
    - Engage an independent qualified auditing entity to perform an annual audit,
    - Provide HHS and the public the results of that audit,
    - Identify any material weakness or deficiency, and
    - Address how it intends to correct such deficiency.
- **Restrictions on Use of Reinsurance Funds for Administrative Expenses** - HHS proposes that a State must ensure that a state-directed reinsurance entity not use any funds for specified administrative expenses.

#### **State Standards Related to the Risk Adjustment Program**

- **Maintenance of Records** - HHS proposes to amend the maintenance of records requirement to require that the State maintain records for at least 10 years and make them available upon request to HHS, the Office of the Inspector General (OIG), the Government Accountability Office (GAO), or their designees, and that the State ensure that contractors, subcontractors and agents also maintain such records.
- **Interim Report and State Summary Report**
  - HHS proposes that a State be directed to provide to HHS an interim report on the first 10 months of operation in the first benefit year it operates a risk adjustment program, and notes that it intends to provide more information on this interim report in future guidance.
  - HHS proposes that, in order to obtain recertification of its risk adjustment program for each benefit year after the third benefit year, each State submit to HHS and make public a detailed summary of the program, including the results of an audit by an independent qualified auditing entity, identify any material weakness or deficiency, and address how it intends to correct such deficiency.
- **General Oversight Requirements** - HHS proposes that States must meet specified accounting requirements for their risk adjustment programs.

#### **Risk Adjustment Methodology**

- HHS proposes two changes in the risk adjustment payment transfer formula that would apply only to community-rated States that are using family tiering rating structures:
  - Billable members would be based on the number of children that implicitly count toward the premium under the State's family rating factors.

- The proposed rule would modify the allowable rating factor (ARF) formula that would be used for family tiering States. In such States, the ARF formula would be based on the family tiering factors in lieu of the allowable age rating factors used in all other States.

### **Health Insurance Issuer and Group Health Plan Standards Related to the Reinsurance Program**

- **Reinsurance Contribution Funds**
  - HHS proposes that a health insurance issuer must make contributions for reinsurance for lives covered even if the policy does not constitute major medical coverage if the situation is as follows:
    - The group health plan provides health insurance coverage 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 of the group health plan (except for self-insured coverage of excepted benefits).
  - In that situation, the reinsurance contribution be made by the issuer of health insurance coverage that represents the greatest percentage of the total health insurance coverage offered by the group health plan, determined based on average premium per covered life.
  - In the event that two policies offer the identical percentage of coverage, the issuer of the policy that covers the greatest portion of in-network hospitalization would be responsible for the reinsurance contribution.
- **Maintenance of Records** - HHS proposes to amend the maintenance of records requirement to require that the State maintain records for at least 10 years and make them available upon request to HHS, the Office of the Inspector General (OIG), the Government Accountability Office (GAO), or their designees, and that the State ensure that contractors, subcontractors and agents also maintain such records.

### **Failure to Comply with HHS-operated Risk Adjustment and Reinsurance Data Requirements**

- HHS proposes that HHS may impose civil money penalties (CMPs) against an issuer in a State where HHS operates the reinsurance or risk adjustment program if the issuer fails to meet established regulatory standards for those programs.
  - HHS would take into account the totality of the issuer's circumstances, including factors such as the issuer's previous record, the frequency and level of the violation, and any aggravating or mitigating circumstances.
- HHS proposes that it would assess a default risk adjustment charge on an issuer of a risk adjustment covered plan if the issuer fails to establish a dedicated distributed data environment or fails to provide HHS with access to risk adjustment data in that environment by April 30th of the year following the applicable benefit year in accordance with existing regulatory standards.

### **Exchange Establishment Standards and Other Related Standards under the Affordable Care Act**

#### **Definitions**

- HHS proposes to modify the regulatory definition of Exchange to allow a State to elect to operate a SHOP even if it does not operate the individual market Exchange.
- HHS further clarifies that there must be an individual market Exchange and a SHOP in each State.
- HHS proposes to add a new regulatory definition of customer service representative to mean an employee, contractor, or agent of a QHP issuer that provides assistance to applicants and enrollees but is not licensed as an agent, broker, or producer under State law.
- HHS also proposes to clarify that a plan sold to consumers outside the Exchange would be subject to the risk corridors program only if it is the same as a QHP actually offered by the issuer on the Exchange.

#### **General Standards Related to the Establishment of an Exchange**

- HHS proposes to permit a State to operate a State-based SHOP while the individual market Exchange is operated as an FFE.
  - HHS notes that it decided not to allow a State to operate an individual market Exchange but not the SHOP, with the federal government operating a federally-facilitated SHOP.

#### **Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers or Qualified Employees Enrolling in QHPs**

- **Web-broker policies and procedures** - CMS proposes changes to limit the Web-broker's obligation to disclosure and display of QHP information that is provided by the Exchange or directly by QHP issuers, and to display a Web link to the Exchange Web site.
  - Web-brokers should display all information that is provided by the Exchange or an issuer in a manner that is as consistent as possible with the broader disclosure requirements.
  - HHS proposes to require a Web-broker's Internet site in an FFE to prominently display a notice for consumers stating:
    - That the Web site is not the Exchange Web site,
    - That it might not display all QHP data available on the Exchange Web site, and
    - That the Web-broker has entered into an agreement with HHS.
  - HHS proposes to require that any Web-broker that enters into an agreement to make its Web site available to other agents or brokers must require as a condition of that agreement that the agents and brokers comply with the above standards
    - The Web-broker must provide a list to the FFE of the agents and brokers who are entering into an agreement to use the Web-broker's Web site.
- **Agent and broker policies and procedures on privacy and security** - HHS proposes to require agents and brokers assisting or enrolling consumers in the individual market FFE to establish policies and procedures implementing the privacy and security requirements in current federal regulations.
  - HHS proposes to implement training with regard to those policies and procedures on a periodic basis; and to ensure that their employees, representatives, contractors and agents comply with those policies and procedures.

- **Standards for Agent and Broker Agreement Termination in an FFE** - HHS proposes to require agents and brokers who wish to terminate their agreement with an FFE to send HHS a 30-day advance notice of the intent to terminate. HHS has the option to set a date that would be no less than 30 days from the date of the notice.
  - HHS proposes standards for termination of an agent or broker from the FFE for cause if, in HHS' determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe.
    - HHS proposes a process of notification to the agent or broker and may terminate the agreement for cause after 30 days, which it describes as an opportunity to cure, if the matter is not resolved to HHS' satisfaction.
    - HHS proposes that an agent or broker may request reconsideration from an appropriate HHS-designated reconsideration entity within 30 days of the HHS notice.
    - The HHS reconsideration entity will provide the agent or broker a written notice of the reconsideration decision within 30 calendar days of the date it receives the request. That decision will constitute HHS' final determination.

#### **Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs**

- **Eligibility Processes** - HHS proposes to establish a standardized process for handling applications that are submitted without information necessary for determining eligibility for enrollment in a QHP and, if requested, qualification for an advance payment premium tax credit and cost-sharing subsidy.
  - The Exchange must:
    - Provide notice to the applicant specifying the missing information and providing instructions on how to provide it;
    - Provide a period of no less than 15 and no more than 90 days to provide the information needed; and
    - Not proceed with eligibility during this period, unless the application filer has provided sufficient information for enrollment in a QHP.
- **Verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan** - HHS proposes to clarify that HHS would provide information to Exchanges for purposes of verification of an applicant's enrollment in minimum essential coverage other than through an employer-sponsored plan, Medicaid, CHIP or the Basic Health Program.
  - This may include information on programs such as Veterans Health, TRICARE, and Medicare.
  - HHS proposes to add a new paragraph specifying that a health plan that is a government program providing public benefits is expressly authorized to disclose protected information that relates to eligibility for or enrollment in the health plan to HHS for verification of applicant eligibility.

- **Administration of Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions -** HHS proposes that if the Exchange discovers that it did not reduce an enrollee's premiums by the amount of the advance payment premium tax credit, it must notify the enrollee within 30 calendar days of discovery and refund to the enrollee any excess payments.
  - If the issuer provides the refund by reducing the enrollee's portion of the premium in the following month, and the amount of the repayment required exceeds the enrollee's share of the premium, the issuer must refund the excess within the 30 day window.

#### **Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans**

- **Allowing issuer customer service representatives to assist with eligibility applications -** HHS proposes to add, at the option of an Exchange and to the extent permitted under State law, issuer customer service representatives who do not meet the definition of an agent or broker to assist individuals in the individual market with application for eligibility.
  - HHS notes that it would interpret non-Exchange entities to include, but not be limited to, individuals and entities that are authorized by the Exchanges to assist with enrollment in QHPs, such as Navigators, non-Navigator consumer assistance personnel, certified application counselors, agents or brokers, issuer customer service representatives, and QHPs conducting direct enrollment.
- **Special Enrollment Periods -** HHS proposes to add a new paragraph calling for a special enrollment period when an Exchange determines that a consumer has been incorrectly or inappropriately enrolled in coverage due to misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

#### **Exchange Functions: Small Business Health Options Program (SHOP)**

- **Standards for the establishment of a SHOP -** HHS proposes to define a "SHOP application filer" as an applicant, authorized representative, agent or broker, or employer filing for its employees. This permits entities that have traditionally assisted employees in filing applications to provide that assistance.
- **Functions of a SHOP**
  - HHS proposes that a SHOP require all QHP issuers to make any change in rates at a uniform time that is no more frequent than quarterly.
  - HHS proposes, for the FFE-SHOP, that rates may be updated quarterly with effective dates of January 1, April 1, July 1 or October 1, beginning with rate updates effective no sooner than July 1, 2014.
    - The rates must be submitted to HHS at least 60 days in advance of the effective date.
  - HHS proposes that a SHOP must provide data related to eligibility and enrollment of a qualified employee to the individual market Exchange unless the SHOP is operated as a State operated SHOP in a State that opts not to also operate the individual market Exchange.

- HHS also proposes to provide additional flexibility to States in operating the Navigator program in States that have elected to operate only a SHOP and not an individual market Exchange.
- **Application Standards for SHOP** - HHS proposes to permit a SHOP, if it chooses, to accept applications only via an Internet Web Site.
- **Termination of Coverage** - HHS proposes that each SHOP be required to develop uniform standards for the termination of coverage in a QHP.
  - HHS proposes that the SHOP must determine the timing, form and manner in which coverage in a QHP may be terminated, including:
    - Policies for advance notice of termination required from an employer group requesting termination.
    - Policies for termination of an employer group for non-payment of premiums.
    - Policies for termination of employee or dependent coverage in the following circumstances:
      - The employee or dependent is no longer eligible under the employer's plan;
      - The employee requests termination of the coverage;
      - The QHP in which the employee is enrolled terminates or is decertified;
      - The enrollee changes from one QHP to another during annual or special open enrollment; or
      - The enrollee's coverage is rescinded in accordance with the regulations.
- **Maintenance of Records** - HHS proposes maintenance of records requirements, consistent with the requirements above for State reinsurance and risk adjustment programs, to require that a State Exchange and its contractors, maintain specified records for at least 10 years and to make them available upon request to HHS, the OIG, the GAO, or their designees.

### **Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges**

#### **Single Risk Pool**

- HHS proposes to clarify when issuers may modify rates, to align with previously issued rules on rate setting schedules in the Exchange and SHOP.
  - HHS proposes that issuers in individual markets or markets in which individual and small group markets are merged be permitted to make rating changes annually.
  - HHS proposes that issuers in the small group market generally would be permitted to make such rating changes quarterly, beginning in the third quarter of 2014, applying to both new and renewing business for the entire plan year.

#### **Federally-Facilitated Exchange Qualified Health Plan Issuer Standards**

- **Changes of Ownership of Issuers of Qualified Health Plans in the Federally-Facilitated Exchange** - HHS proposes notification requirements when an issuer in the FFE undergoes a

change of ownership, and that the new owner must agree to adhere to all applicable statutes and regulations.

- **Standards for Downstream and Delegated Entities** - HHS proposes that an issuer maintains responsibility for compliance of any of its delegated or downstream entities.
  - HHS proposes specifications for any such delegation agreements, including specificity of the delegated activity and reporting requirements, compliance with all applicable standards and regulations, and access by the Secretary and the OIG or their designees to books and records.

### **Health Insurance Issuer Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions**

- **Improper Plan Assignment and Application of Cost-Sharing Reductions** - HHS proposes setting out requirements for issuers in cases in which it does not provide the appropriate cost-sharing reduction or does not assign an individual to an appropriate plan variation.
  - **Improper cost-sharing reductions:** HHS proposes that, if an issuer fails to ensure that an individual receive the cost-sharing reductions required under the applicable plan in which they are enrolled, the issuer must refund any resulting excess cost-sharing reduction within 30 days after discovery and notify the enrollee
  - **Improper plan assignment:** HHS proposes that, if an issuer does not assign an individual to the applicable plan variation, based on the eligibility and enrollment information or the information provided by an Exchange, then the issuer must, no later than 30 days after discovery of the improper assignment, reassign the enrollee to the applicable plan variation and notify the enrollee.
    - If the issuer reassigns an enrollee from a more generous variation to a less generous variation, the issuer is not eligible for and may not seek from the enrollee or provider reimbursement for excess cost-sharing reductions provided.
    - If the issuer reassigns an enrollee from a less generous variation to a more generous variation, the issuer must recalculate the individual's liability for cost-sharing paid between the effective date of eligibility and the date the reassignment is effective. The issuer must refund any excess cost sharing paid.
- **Failure to Reduce an Enrollee's Premium to Account for Advance Payments of the Premium Tax Credit** - HHS proposes specifying that if an issuer discovers that it did not reduce an enrollee's premium by the amount of the advance payment of the premium tax credit, it would be required to refund to the enrollee any excess premium and notify the enrollee within 30 days of the discovery.
- **Oversight of the Administration of Cost-sharing Reductions and Advance Payments of the Premium Tax Credit Programs** - HHS proposes general provisions related to the oversight of QHP issuers in relation to cost-sharing reductions and advance payments of the premium tax credits.



## Oversight & Financial Integrity Requirements for Issuers of Qualified Health Plans in Federally-Facilitated Exchanges

- **Maintenance of Records for the Federally-facilitated Exchanges** - HHS proposes maintenance of records requirements necessary for HHS to periodically audit and conduct compliance reviews, including record retention for 10 years, and record availability to HHS, the OIG, the GAO, or their designees.
- **Compliance Reviews of QHP Issuers in Federally-facilitated Exchanges** - HHS proposes that issuers in a FFE be subject to compliance reviews by HHS, and that issuers must make available to HHS records that pertain to activities within the FFE, and specifies the types of records that may be included.

## Enforcement Remedies in Federally-Facilitated Exchanges

- **Available Remedies** - HHS proposes that it may impose the following types of sanctions on QHP issuers for noncompliance with standards for such issuers in the FFE: civil money penalties or decertification of a QHP offered by the non-compliant QHP issuer.
- **Bases and Process for Imposing Civil Money Penalties in Federally-facilitated Exchanges** - HHS proposes grounds for imposition of CMPs on QHP issuers in the FFE:
  - Misconduct in the FFE or substantial non-compliance with Exchange standards;
  - Limiting enrollee access to medically necessary items and services;
  - Imposing premiums in excess of the monthly premiums permitted by Federal standards;
  - Engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment by qualified individuals whose medical history indicates the potential for a future need of significant items or services;
  - Intentionally or recklessly misrepresenting or falsifying information;
  - Failure to remit required user fees;
  - Failure to comply with cost-sharing reductions and advance payment premium tax credits.
- HHS proposes that the maximum penalty imposed for each violation be \$100 per day for each QHP issuer for each individual adversely affected by the issuer's non-compliance.
- **Bases and Process for Decertification of a QHP Offered by an Issuer through the Federally-facilitated Exchanges** - HHS proposes bases for decertification of a QHP offered by an issuer in the FFE:
  - Substantial failure to comply with federal laws and regulations, and a list of specified program requirements for issuers in the FFE;
  - Operating in the FFE in a manner that hinders the efficient and effective administration of the Exchange;
  - No longer meeting the certification criteria;
  - Based on credible evidence, the issuer has committed or participated in fraudulent or abusive activities, including the submission of false or fraudulent data;

- The State recommends that the QHP should no longer be available in the FFE.
- HHS proposes two processes for decertification actions:
  - A standard decertification process, when the basis for decertification does not put the QHP enrollees' ability to access necessary medical items or services at risk, or substantially compromise the integrity of FFEs.
  - An expedited decertification process, when the basis for decertification is credible evidence of fraudulent or abusive activities, failure to meet standards related to network adequacy requirements or inclusion of essential community providers, or failure to comply with standards related to internal claims and appeals and external review.

### **Administrative Review of QHP Issuer Sanctions in a Federally-facilitated Exchange**

- HHS proposes to model the administrative hearing process for CMPs and for decertification on the existing process spelled out under HIPAA in §150.401 through §150.463, which it says is also similar to State appeals processes.
- HHS proposes requirements for resolving cases forwarded by HHS to a QHP issuer operating in an FFE.
  - A case is a communication brought by a complainant that expresses dissatisfaction with a specific person or entity subject to State or Federal laws regulating insurance, concerning activities related to the offering of insurance, other than with respect to an adverse benefit determination.
- HHS proposes that cases may be forwarded through a casework tracking system developed by HHS or through other means, and QHP issuers in the FFE must investigate and resolve such cases, as appropriate.
- HHS proposes that, for cases received from HHS, an urgent case is one in which there is an immediate need for health services because the non-urgent standard could jeopardize the enrollee's or potential enrollee's life, health or ability to attain, maintain or regain maximum function.
- HHS proposes that, for cases received from HHS, issuers notify complainants regarding disposition of a case as soon as possible, but no later than seven days after the resolution.

### **Qualified Health Plan Issuer Responsibilities**

- **Confirmation of HHS Payment and Collections Reports** - HHS proposes that each issuer must, within 15 days of the date of receiving its monthly payment and collections report, confirm the amounts or describe any inaccuracy it identifies.
- **Direct Enrollment With the QHP Issuer in a Manner Considered to be Through the Exchange** - HHS proposes that QHP issuers may, at the option of the Exchange, enroll applicants who initiate enrollment in a manner that is considered enrollment through the Exchange so long as the issuer follows the enrollment process for qualified individuals, and the issuer's Website provides the ability to view QHPs offered by the issuer, with required data elements, distinguish between QHPs for which the individual is eligible from other non-QHPs that the issuer may

offer, and indicate that advance payment premium tax credits and cost-sharing subsidies apply only in QHPs offered through the Exchange.

- The QHP issuer must also inform applicants of the availability of other QHP products offered through the Exchange, including the Web link or a description of how to access the Exchange Web site; and allow an applicant to select and attest to an advance payment premium tax credit amount, if applicable, in accordance with the regulations.
- HHS proposes that, if permitted by the Exchange and by State law, a QHP issuer may enter into an agreement with an Exchange to permit its customer service representatives who do not meet the definition of agent or broker to assist qualified individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange for insurance affordability programs, facilitating selection of a QHP offered by the issuer.
  - In such cases, the issuer customer service representatives must comply with terms of an agreement between the Exchange and the issuer under which the representative at least:
    - Receives training on QHP options and insurance affordability programs, eligibility and benefits;
    - Complies with the Exchange's privacy and security standards;
    - Complies with applicable State law related to: the sale, solicitation and negotiation of health insurance products, including those related to agent, broker, and producer licensure; confidentiality; and conflicts of interest.
- HHS proposes that an issuer must assure that premiums are accurate after accounting for any advance payment premium tax credit, that it will retroactively correct any incorrect amounts collected not later than 30 days after discovery of an incorrect amount collected from an enrollee.
- **Enrollment Process for Qualified Individuals** - HHS proposes to require that QHP issuers, at a minimum, accept a variety of payment formats, including but not limited to paper checks, cashier's checks, money orders, and replenishable pre-paid debit cards.
  - Issuers may also offer electronic funds transfer and automatic deduction from a credit or debit card.

**Sections of this document were borrowed from the summary prepared for the American Hospital Association by Health Policy Alternatives, Inc.**