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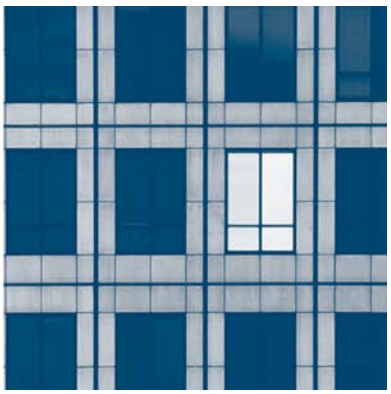

Health Advisory

March 24, 2014

The Centers for Medicare & Medicaid Services' Final Notice of Benefit and Payment Parameters for 2015 contains numerous alterations to premium stabilization programs, cost-sharing requirements and employee counting provisions to account for lower-than-anticipated enrollment through the Exchanges and the Obama Administration's decision to permit individuals to "keep their current plan" through 2016. All of these changes and the fluid regulatory environment create significant challenges for issuers, who must operationalize these changes, some of which are effective in 2014, and prepare for the 2015 benefit year.

2015 Notice of Benefit and Payment Parameters

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The Centers for Medicare & Medicaid Services (CMS or the agency) kicked off a flurry of springtime regulatory activity for health insurance issuers with publication of the final Notice of Benefit and Payment Parameters for 2015 (*Final Notice*), which can be found at http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf. The new requirements are primarily relevant for entities participating in the individual and small group health insurance markets, whether on or off an Exchange. Many of the more significant changes will have a direct effect on health insurance issuer revenue and federal funding levels.

Examples of changes that will affect issuer revenue are the modifications to the reinsurance and risk corridors programs that affect both 2015 and 2014 calendar year operations. These changes indicate that the agency is attempting to address the effects of the Administration's "transitional policy," which allows individuals to remain enrolled in plans that do not meet certain Affordable Care Act (ACA) requirements beyond 2014 (when they otherwise would be effective).

The Final Notice also implements changes affecting other aspects of ACA implementation, including the data validation process for the risk adjustment program. CMS borrowed many features of the data validation process from the Medicare Advantage (MA) risk adjustment context, reflecting the heavy influence of the agency's experience administering the MA risk adjustment process on the commercial insurance market regulations.

Finally, the Final Notice underscores how the regulatory landscape is developing and changing at the same time that issuers are implementing many of ACA's insurance market reforms. For example, CMS has finalized two different employee counting methodologies for the risk corridors and risk adjustment programs, respectively, adding to the distinct employee counting methodologies that already apply in the Small Business Health Options (SHOP) Exchanges and for purposes of ACA insurance market reforms. The agency suggests it may enact future rulemaking to streamline and standardize employee counting methodologies. In the meantime, issuers must operationalize all of these different employee counting methodologies, creating significant challenges and increasing the potential for error.

CMS Tweaks the Premium Stabilization Programs

The Final Notice makes a number of adjustments to both the risk corridors and reinsurance programs that are designed to ameliorate the potential effect of the Administration's transitional policy on the risk pool. Drafters of ACA recognized that, at least initially, the size and makeup of enrollee risk pools for individual and small group market coverage could be unpredictable with the implementation of significant insurance market reforms effective (*e.g.*, modified community rating and guaranteed issue) and the obligation for individuals to have minimum essential coverage beginning January 1, 2014. The temporary reinsurance and risk corridor programs are intended to provide mechanisms to facilitate issuer's management of this risk during the initial years.

CMS announced a transitional policy in November 2013 whereby states were encouraged to allow issuers to renew existing individual and small group market health insurance coverage between January 1, 2014, and September 30, 2014, without requiring compliance with certain ACA insurance market reforms

that otherwise would be mandatory. As a result, these renewed policies would not be part of the single risk pool that is used to develop rates under ACA's modified community rating standards that are otherwise effective for all non-grandfathered policies issued or renewed on or after January 1, 2014. By the time the transitional policy was announced in November 2013, issuers had already set their 2014 premium rates, believing that all non-grandfathered policies would be included in the single risk pool.

After CMS released the transitional policy, issuers immediately began expressing concern that excluding individuals on transitional policies from the single risk pool would result in higher utilization rates and costs from the individuals remaining in the risk pool than was anticipated when premium rates were set. This is due to the fact that less healthy individuals likely would benefit from the ACA modified community rating methodology, while healthier individuals would likely benefit from health status rating that is permitted for policies in effect prior to 2014; thus, individuals who are taking advantage of the transitional policy are expected to be disproportionately healthier individuals. The Final Notice includes adjustments to these premium stabilization programs that largely are designed to reduce the negative effects on the risk pool caused by the transitional policy.

Risk Corridors Program

The risk corridors program is a temporary program in effect from 2014–2016, which allows issuers of plans offered on the Exchanges (known as qualified health plans, or QHPs) to share both potential losses exceeding a threshold amount and profits exceeding a certain margin with the federal government. The Final Notice contains several significant changes to the risk corridors program, including changes that will be in effect for calendar year (CY) 2014. For example, issuers will be required to report their risk corridors program amounts at the same time (July 31 of the year following the reporting year) and using the same forms as is used for medical loss ratio (MLR) reporting. Additional changes include:

- *Transitional Policy Adjustment*

  In response to issuer concerns, CMS will apply a state-specific adjustment to issuers' "allowable administrative costs" and "profits" recognized in assessing risk under the program in states that follow CMS's transitional policy. The adjustment should make it easier for issuers to qualify for risk corridor payments than would otherwise be the case. The actual state-specific adjustment will vary depending on the "percentage enrollment in these transitional plans in the State." Thus, in states where a larger percentage of the market is enrolled in transitional plans, the risk corridors adjustment will be greater. Any state-specific adjustment to account for the transitional policy will be excluded from an issuer's medical loss ratio calculation. No adjustment will be made for QHP issuers in states that do not follow the transitional policy.

  Adjustments will be applied only for 2014 and will not be applied in 2015 or 2016, as issuers are now aware of the transitional policy and can develop premium rates that reflect the policy. CMS left open the possibility, however, of making changes to the risk corridors formula to account for additional administrative costs related to implementing the transitional policy. For example, in a subsequently released *proposed rule*, found at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf, the agency formally proposed to increase, for CY 2015, the allowable administrative cost ceiling from 20 to 22 percent and the profit margin floor from 3 to 5 percent to "stabilize the market as it continues to transition to full compliance with Affordable Care Act provisions."

- *Budget Neutrality for Risk Corridors*

  In the preamble to the Final Notice, when discussing the risk corridors program, the agency indicated for the first time that it "intend[s] to implement this program in a budget neutral manner, and may make future adjustments ... to the extent necessary to achieve this goal." (79 Fed. Reg. 13744, 13787 and 13829 (Mar. 11, 2014)) This is a change from the agency's prior policy reflected in the following statement: "Regardless of the balance of payments and receipts, [the U.S. Department of Health and Human Services] will remit payments as required under section 1342 of the Affordable Care Act." (78 Fed. Reg. 15410, 15473 (Mar. 11, 2013)) Furthermore, the statute does not appear to require the program to be budget neutral—budget neutrality is not reflected in the regulation itself—and the agency previously stated that "the risk corridors program is not required to be budget neutral." (78 Fed. Reg. at 15473) This apparent shift in policy may be a response to the scrutiny that has been generated over the possibility of the federal government paying more to issuers under the program than it receives in risk corridor contributions. The agency does not, however, explain what is driving this change.

  The Final Notice does not specify how CMS intends to implement budget neutrality. For example, the agency does not state whether it intends to achieve budget neutrality each year during the three-year program or in the aggregate across all three years. The preamble states that the changes to the program for 2014 are meant to result in budget neutrality for 2014, so this could indicate that the agency is seeking budget neutrality in each year of the program. The agency also indicates that when budget neutrality is not achieved in a given year, it will make "future adjustments" to the risk corridor program parameters to achieve neutrality. It is not clear whether the "future adjustments" could be applied

retroactively to a prior year's experience, if such a change is necessary to ensure budget neutrality is achieved in a given year. It is possible to interpret the agency's statements as indicating that if the current risk corridor parameters do not achieve budget neutrality in a given year, then the agency would still pay out more than it takes in for that year, but would make future adjustments to the program to achieve budget neutrality in future years.

Transitional Reinsurance Program

The transitional reinsurance program is the other temporary program in effect from 2014–2016, which is designed to protect issuers enrolling individuals who incur particularly high claims during a given benefit year. CMS will reinsure issuers for a certain percentage of an enrollee's costs (the coinsurance rate) between the attachment point and the reinsurance cap.

- *Reinsurance Contribution Requirements*

  Under ACA, issuers and "third party administrators on behalf of group health plans" are required to make contributions that fund the transitional reinsurance program. For 2015, the per capita annual contribution rate is set at $44 (compared to $63 for CY 2014). This reduction is tied to the statutory reduction in reinsurance funds from $10 billion in CY 2014 to $6 billion in CY 2015. Policies renewed under CMS's transitional policy are required to make reinsurance contributions, even though these policies are not eligible to receive reinsurance payments because they are not subject to the modified community rating requirements and other insurance market reforms.

  CMS describes the effect of this exclusion on the per capita contribution rate for CY 2015 as "small," but does not indicate the exact monetary effect on the contribution rate. (79 Fed. Reg. at 13775)

- *Reinsurance Payment Parameters for CY 2014 and 2015*

  The Final Notice lowers the transitional reinsurance program attachment point from $60,000 to $45,000 for CY 2014 to reduce the adverse risk pool effects from the transitional policy. The agency does not expect that this change will cause the $10 billion in available reinsurance amounts to be exhausted, in part due to the lower than projected enrollment in Exchange plans. This lower attachment point, while ostensibly designed to counterbalance the transitional policy, will apply to coverage offered in states that do not adopt CMS's transitional policy.

  For CY 2015, CMS adopted a $70,000 attachment point, a coinsurance rate of 50 percent and a $250,000 reinsurance cap. This higher attachment point and lower coinsurance rate reflect the decrease in available reinsurance amounts from $10 billion to $6 billion.

Permanent Risk Adjustment Program

The permanent risk adjustment program transfers funds from issuers whose individual and small group market enrollees have lower health risks to those whose enrollees have greater health risks. Each enrollee receives a risk score based on the medical conditions reflected in his or her medical records, and this contributes to an issuer's overall risk score. The agency finalized a number of details regarding the enrollee risk score validation process.

- *Risk Adjustment Data Validation Process*

  The agency finalized the data validation process that will be used to verify the information submitted by issuers to determine enrollee risk scores. The Final Notice largely adopts the data validation process reflected in CMS's June 22, 2013, *white paper* (the White Paper) outlining how the agency will collect and verify risk adjustment data. This can be found at https://www.regtap.info/uploads/library/ACA_HHS_OperatedRADVWhitePaper_062213_5CR_062213.pdf. First, CMS will take a sample of 200 of an issuer's aggregated number of enrollees, stratified by age and health status, using methods comparable to the data validation process for MA organizations. Second, the issuer will engage a third party to conduct an initial validation audit on the data from the sample. CMS reaffirmed that it will eventually expect initial auditors to achieve inter-rater reliability of 95 percent. But in contrast to the proposed notice, the agency will only require reviewers to reach 85 percent in 2014 and 2015, giving auditors and issuers more time to improve data validation before 2016. This is also significant because it appears to recognize a 15-percent discrepancy rate as reflective of the ambiguity and differences of interpretation inherent in coding.

  Issuers will be required to attest, following a reasonable investigation, that the initial auditor (or the members of the audit team, owners, directors, officers or employees) has no conflicts of interests with the issuer (or its owners, directors, officers or employees), and the issuer must also obtain such a representation from the initial auditor. Issuer agreements with initial auditors should account for potential conflicts by requiring the auditor to attest that no conflicts of interest exist and establish procedures for the auditor to notify the issuer should any conflicts subsequently arise.

  Following the initial audit, CMS will conduct a second validation audit on a subset of the original 200 enrollees to verify the work of the initial auditor. Based on the initial and second validation audits, CMS will derive an issuer-level risk score adjustment, which will be the basis for a corrected risk

score for the enrollee population that will be used to determine risk adjustment transfer payments. CMS confirms it will implement the data validation process in 2015 for the CY 2014 benefit year, but it will not adjust transfer payments in the risk adjustment program until CY 2016 risk score data.

The risk adjustment data validation process will have substantial differences from the audit standards in MA, including the fact that there will be a self-audit and risk score errors may result in transfer payments among issuers.

- *Risk Adjustment Data Sources*

The Final Notice also defines the "medical record documentation" that would be a permissible source of health status data: "clinical documentation of hospital inpatient or outpatient treatment or professional medical treatment from which enrollee health status is documented and related to accepted risk adjustment services that occurred during a specified period of time." Similar to the MA program, diagnostic radiology, durable medical equipment and pathology/laboratory would not be acceptable sources of medical record documentation, but physicians, physician assistants and nurse practitioners would be acceptable sources.

Medical records used to support an enrollee's risk score must use valid industry standards for coding (*e.g.*, International Classification of Diseases codes) and "must be generated under a face-to-face or telehealth visit documented and authenticated by a permitted provider of services." The agency also indicated that in the "initial years of the data validation program it "plan[s] to accept certain supplemental documentation, such as health assessments, to support the risk adjustment diagnosis." (79 Fed. Reg. at 13760) This is significant, as many MA organizations perform home assessments and use these visits to identify and document diagnoses for risk adjustment purposes, and CMS has proposed to limit the use of such assessments in the MA program.

Cost-Sharing Limits During CY 2015

For CY 2015, CMS announced that the annual maximum out-of-pocket limitation on cost sharing for CY 2015 would be increased to $6,600 for self-only coverage and $13,200 for family coverage, whether it is an individual or group market policy. CMS also announced that the small group maximum deductible is $2,050 for self-only coverage and $4,100 for family coverage for CY 2015.

In addition, CMS finalized the reduced maximum limitations on cost sharing that apply to individuals who are eligible for cost-sharing reductions. Set forth in Table 1 (see below) are the various reduced annual maximum limitations that apply for individuals with qualifying incomes. Each of these cost-sharing caps reflects a roughly 4-percent increase from the 2014 cap, below the projected 6-percent increase projected in the proposed notice of benefit and payment parameters for CY 2015 released December 2, 2013.

Recent guidance from the Office of Management and Budget (OMB) released just before publication of the Final Notice might also affect cost-sharing subsidy levels in 2015 and beyond. In its annual report specifying reductions in federal appropriations resulting from the Budget Control Act of 2011 (popularly known as sequestration), and located at http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/sequestration_order_report_march2014.pdf, the OMB exempted cost-sharing subsidies for low-income enrollees purchasing QHPs on the Exchanges from sequestration cuts. This guidance reverses the OMB's previous determination that funding for cost-sharing subsidies was in fact subject to sequestration.

Table 1: Cost-Sharing Limits For the Individual Market During CY2015

Annual Income as a Percentage of the Federal Poverty Line (FPL)	Annual Cost-Sharing Limit for Self-Only Plans ($)	Annual Cost-Sharing Limit for Plans Other than Self-Only Plans (*i.e.*, Families) ($)
100–150	2,250	4,500
150–200	2,250	4,500
200–250	5,200	10,400
> 250	6,600	13,200

Employee Counting Requirements

The Final Notice also addresses the employee counting methodologies that must be applied when determining whether an employer is a small employer for purposes of the risk corridor and risk adjustment programs. The employee counting methodology is critical because it can affect whether an employer qualifies for the small or large group market. For example, more employers would be considered small employers if part-time employees are excluded from the employee count.

For the risk corridors program, a state's employee counting methodology will be utilized to determine which coverage is included in the risk corridors program. (79 Fed. Reg. at 13786) For the risk adjustment program, the state counting methodology applies "unless the State counting method does not take into account employees that are non-full-time." (79 Fed. Reg. at

13755) If the state's employee counting methodology does not take non-full-time employees into account, then the employee counting methodology under 26 U.S.C. § 4980H(c)(2) will apply in the risk adjustment program because it takes into account part-time employees by using a full-time equivalent (FTE) methodology.

One issue raised by commenters is the lack of a uniform employee counting methodology under ACA that applies when determining whether an employer is a small employer or large employer. CMS responded that it "agree[s] that consistency in counting methods across the Affordable Care Act programs is important, and we plan to collaborate with other Federal agencies to develop a streamlined counting method in future rulemaking." (78 Fed. Reg. at 13744) Until such rulemaking is released, however, there is considerable variation in employee counting methods, depending on which ACA requirement is at issue. The chart below summarizes the employee counting methodologies that apply to various ACA requirements.

The practical implication of these disparate standards is that an employer could qualify as a small employer with respect to certain requirements while qualifying as a large employer for other standards. This will likely create administrative complexities for the issuer and possible confusion for employers that could be either a small or large employer depending on what methodology is being used.

Table 2: Employee Counting Methodologies

Requirement	Employee Counting Methodology
Public Health Service (PHS) Act Insurance Market Reforms (42 U.S.C. § 300gg et seq.)	▪ An employee is "any individual employed by an employer." (42 U.S.C. § 300gg-91(d)(5) (cross-referencing 29 U.S.C. § 1002(6)) ▪ "[O]nce it has been determined that there is an employer-employee relationship with respect to a particular individual, the question of whether the employee is, for example, full-time or part-time becomes irrelevant for purposes of determining employer size under the PHS Act." (CMS, Insurance Standards Bulletin, "Group Size Issues under Title XXVII of the Public Health Service Act" (Sept. 1999)) ▪ Inconsistent state employee counting methodologies would be preempted to the extent they "prevent the application" of the Federal standard. (42 U.S.C. § 300gg-23(a)(1)) HHS has not provided clear guidance regarding whether an inconsistent state counting methodology would be preempted for these purposes.
MLR	▪ An employee is "any individual employed by an employer." (42 U.S.C. § 300gg-91(d)(5) (cross-referencing 29 U.S.C. § 1002(6)) ▪ An "employee" is defined as including "each full-time, part-time and seasonal employee." (CMS, Insurance Standards Bulletin Series, "Questions and Answers Regarding the Medical Loss Ratio Interim Final Notice" (July 18, 2011) (citing 42 U.S.C. § 300gg-91(d)(5))
State-based SHOPs	▪ For 2014 and 2015, state-based SHOPs may apply "State methods of determining group size and status as a full-time employee." (78 Fed. Reg. 15410, 15504) ▪ HHS is exercising its enforcement discretion to permit this.
Federally Facilitated SHOPs	▪ HHS will use the FTE method of determining group size that takes into account part-time employees consistent with 26 U.S.C. § 4980H(c)(2)(E). (45 C.F.R. § 155.20)
Risk Corridor	▪ The state employee counting methodology will apply. (79 Fed. Reg. at 13786)
Risk Adjustment	▪ The state counting method would apply "unless the State counting method does not take into account employees that are non-full-time. In that circumstance, we will apply the counting method described in section 4980H(c)(2) of the Code and any implementing regulations." (79 Fed. Reg. at 13755)

Additional Provisions

In addition to those described above, CMS finalized a number of other notable changes in the Final Notice. These include:

- *Open Enrollment Period Extended One Month*: The agency originally proposed that the open enrollment period for CY 2015 would be from November 15, 2014, to January 15, 2015. The Final Notice extends the open enrollment period an additional month. The open enrollment period for CY 2015 will be November 15, 2014, to February 15, 2015, to allow individuals additional time to enroll in coverage.

- *Small Group Composite Premiums Allowed*: The Final Notice clarifies that issuers may offer small group health plans "composite premiums" as long as the group's total premium amount is derived from per-member rating consistent with the modified community rating standards under 45 C.F.R. § 147.102. The composite premium that is calculated at the beginning of the plan year cannot be adjusted throughout the year, so any new enrollees must be charged the composite premium amount calculated at the beginning of the plan year. Also, if an issuer offers composite premiums, it must do so for all its small employer groups enrolled in that product. Finally, for plan years beginning on or after January 1, 2015, issuers will be required to use a two-tiered composite premium structure if they choose to offer composite premiums. Under this two-tiered system, issuers must calculate two composite premium amounts for individuals age 21 years or older and one for those under 21 years. The choice of composite premiums or per-member premiums only affects how premiums are allocated amongst the small group's enrollees but, does not affect the total amount of premiums paid by the small group.

- *Privacy and Security Requirements*: CMS is finalizing its proposed revisions to the privacy and security standards that apply to "non-Exchange entities." A broad range of entities are non-Exchange entities, including QHP issuers. Under the Final Notice, each Exchange must establish data privacy and security requirements for non-Exchange entities that, among other requirements, are at least as protective as the privacy and security standards that apply to the Exchange. CMS leaves it to each Exchange to determine whether a QHP issuer's compliance with Health Insurance Portability and Accountability Act (HIPAA) privacy and security standards is sufficient to meet this standard. With respect to Federally Facilitated Exchanges, CMS did not make a determination, but stated that it will issue future guidance "that will address in greater detail the applicability of the HIPAA Privacy, Security, and Breach Notification Notices and the additional limitations on disclosure of PII in section 1411(g) of the Affordable Care Act." Section 1411(g) establishes requirements regarding the confidentiality of information obtained from applicants for Exchange coverage. A QHP issuer, as a non-Exchange entity, should carefully consider Exchange-specific privacy and security requirements, as these may exceed or be distinct from those required under HIPAA and they may also vary from Exchange to Exchange.

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