

# Overview of Recently Published Proposed Federal Rules

Presentation to Exchange Advisory Task Force  
December 11, 2012



# Recently Proposed Federal Rules

Rules	Date Published	Comments Due By
Market Rules and Rate Review	November 26, 2012	December 26, 2012
Essential Health Benefits, Actuarial Value, and Accreditation	November 26, 2012	December 26, 2012
Payment Notice on Risk Sharing and Other Provisions	November 30, 2012	December 31, 2012
Multi-State Plan Program	November 30, 2012	January 4, 2013

# Essential Health Benefits

- Proposed rule preserves many components of guidance issued in December 2011 which has framed discussion in Minnesota
- States are required to choose a benchmark plan from one of ten options
- If a State does not choose a benchmark by December 26, it will default into the largest plan by enrollment in the small group market

# EHB Benefit Substitution

- Actuarially equivalent benefits may be substituted within each EHB category, but not across EHB categories
- Benefit substitution policy is not available for prescription drug benefits
- States have option to enforce stricter standard on benefit substitution or prohibit it completely

# EHB and Prescription Drugs

- A plan must cover the greater of:
  - 1) one drug in every category and class;  
or
  - 2) the same number of drugs in each category and class as the EHB benchmark plan

# Other Key EHB Provisions

- Pediatric services recommended to extend to at least age 19, with state option to extend age range for pediatric beyond that level
- Certain services may NOT be considered EHB:
  - Non-pediatric dental services
  - Non-pediatric eye exams
  - Cosmetic orthodontia
  - Long-term/custodial nursing home benefits

# EHB Rules Define Cost Sharing

- "Any expenditure required by or on behalf of an enrollee with respect to EHB. The term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services."
- Cost-sharing requirements for benefits from a provider outside of a plan's network do not count towards the annual limitation on cost sharing.

# Stand-Alone Dental Plans

- Annual limitation on cost sharing for stand alone dental is separate and in addition to cost sharing for QHP
- No dollar limits are established; cost sharing must be “reasonable”
- Two levels of AV unique to stand-alone dental:
  - “Low” AV at 75%
  - “High” AV at 85%

# Actuarial Value

- Coverage in the individual and small group market will need to meet specified AV levels – bronze, silver, gold, platinum
- Defined as “the percentage that represents the total allowed costs of benefits paid by the health plan, based on the provision of EHB as defined for that plan”.

# Actuarial Value Calculator

- Goal is to have a uniform method for calculating AV across issuers
- Developed with a standardized population using a national claims data set
- States may substitute a state-specific standard population data set beginning in 2015 for use in the AV calculator

# Other Key Provisions

- Only in network utilization is considered in calculating AV
- Calculator does not accommodate all potential plan designs. Proposed rule has provisions for certifying AV of non-standard plan design
- Annual employer contributions to HSAs and newly made available under HRAs for current year should count toward AV
- AV levels may vary by a de minimus level of +/- 2 percentage points
  - For example, a silver plan can have an AV of 68-72 percent

# Measuring “minimum value” for employer coverage

- Employers meet “minimum value” requirements if they provide coverage with at least 60 percent AV.
- Employers will be able to use a “minimum value” calculator
  - Similar in design to AV calculator
  - Based on standard population of typical self-insured employer plans
  - Safe harbor provisions established

# Accreditation

- Preserves approach outlined in final rule issued this summer with one exception
- Additional entities will be allowed to seek approval to serve as accrediting entities

# Proposed Rules on Market Reforms and Rate Review

# Market Reforms and Rate Review

- State laws that are stricter than federal requirements are not superseded by federal law
- Carriers have to maintain a single risk pool respectively for individual and small group market inside and outside the Exchange

# Allowable Rating Factors

- Issuers may vary premium rates only according to four factors
  - Whether coverage is for individual or family
  - Rating area
  - Age, limited to variation of 3:1
  - Tobacco use, limited to variation of 1.5:1
- Any premium variation for age and tobacco must be applied to portion of premium attributable to each family member

# Rating Methodologies

- Rule proposes to standardize rating methodologies
  - Age rating
  - Family rating
- Goal is to enhance transparency, predictability, and accuracy of risk adjustment
- Facilitates key functions of an Exchange, such as consistent identification of a silver plan

# Family Rating

- Rates of no more than the three oldest family members who are under age 21 would be taken into account in computing family premium
- CMS seeks comments on whether it should establish minimum categories of family members that issuers must include in rating (e.g. spouse, biological or adopted children, stepchildren, etc.) and who should be included on policy

# Rating for Geography

- A State may establish no more than seven rating areas within a state
- A State may select one of the standards below or propose its own for approval:
  - 1) one rating area for state
  - 2) rating areas based on counties or zip codes
  - 3) rating areas based on metropolitan statistical areas or non-MSAs

# Rating for Age

- Rates may vary within a ratio of 3:1 for adults age 21 and older
- Age factors and bands must be determined based on enrollees' age at time of policy issuance
- Rule establishes standard age bands and a uniform age rating curve

# Guaranteed Availability

- Establishes an open enrollment period for individual market coverage purchased outside the Exchange
- Rule also has provisions for narrow circumstances under which issuers may refuse to offer coverage
- Issuers must offer coverage to individuals even if they have history of non-payment

# Risk Pooling

- States intending to merge individual and small group market pools in 2014 must inform CMS by no later than 30 days after publication of final rule
- Claims experience of all enrollees within a state's individual or small group market be combined when setting premiums

# Premium Increases

- Issuer required to set an index (average) rate to be used for all plans in a given market sold by that issuer
- Premium rates may vary from index for
  - AV and cost sharing design
  - Provider network and utilization management
  - Plan benefits in addition to EHB
  - Expected impact of eligibility categories for catastrophic plans

# **Multi-State Program Plan Proposed Rule**

# Scope of Proposed Rule

- Establishes standards for:
  - 1) Issuers seeking to contract with OPM to participate in multi-state plan program
  - 2) Issuers appealing decisions by OPM either to non-renew or terminate their MSPP contract
  - 3) Enrollees in an MSP to appeal denials of payment or services by an MSPP issuer.

# Multi-State Plan Program Phase In

- An issuer may phase in coverage across all Exchanges over four years, but must offer MSPs in all Exchanges in all states by the fourth year of the issuer's participation
- An issuer may initially cover only certain service areas in a state and phase in to statewide coverage over four years
- Issuers may phase in to coverage on SHOP

# Multi-State Plan Program

- Issuers must apply to participate in program
- OPM anticipates beginning to accept applicants in January 2013
- Participating issuers must offer coverage in at least 31 states in the first year of their participation

# Multi-State Plan Program

- At least one issuer must be a non-profit
- OPM is interpreting ACA to require them to contract with at least two issuers
- Contract terms are for at least one year
- OPM is reserving its authority to assess a user fee on MSPP issuers

# Requirements for MSPs

- OPM will certify multi-state plans
  - State Exchanges have no role in certifying multi-state plans
  - Multi-state plans must be licensed in each state in which it offers coverage
  - Multi-state plans must comply with state laws “not inconsistent” with relevant provisions of ACA

# Level Playing Field

- “If an MSP... is not subject to any Federal or State law related to one of the 13 categories listed in section 1324(b) [of the ACA], then neither shall any health insurance coverage offered by a private health insurance issuer be subject to such law.”

# 13 Categories of Section 1324(b)

- Guaranteed renewal
- Rating
- Preexisting conditions
- Non-discrimination
- Quality improvement and reporting
- Fraud and abuse
- Solvency
- Market conduct
- Prompt payment
- Appeals and grievances
- Privacy/confidentiality
- Licensure
- Benefit plan material or information

# Level Playing Field

- OPM says multi-state plans will be required to comply with requirements in all 13 areas
- OPM reserves authority to adopt standards or requirements for MSPP that differ from requirements applicable to QHPs under either State or Federal law

# Level Playing Field

- Proposed rule establishes a dispute resolution process to resolve future potential disputes about applicability of State laws to the MSPP

## Three Areas of Special Interest

- **Appeals:** OPM proposes to use its own process for resolving appeals of disputed claims
- **Rating:** OPM will conduct its own rate review and share analysis with State; MSP issuers must comply with State rating factors
- **Benefit plan material:** does not include policy form or contract, which must meet state requirements

# MSPs and Essential Health Benefits

- Benefits package must be substantially equal to either:
  - 1) Each State's EHB-benchmark plan in each State in which it operates; or
  - 2) Any EHB-benchmark plan selected by OPM
    - Three largest FEHBP plan options by enrollment
    - State mandates in effect prior to 12/30/2011 would also be included as EHB in initial years

# Potential Challenges with MSP

- Network adequacy
- Quality reporting
- Accreditation timeframe
- Issuers may market that OPM has certified it as an MSP
- Medical Loss Ratios
- Coverage periods
- Escrow accounts to facilitate financial incentives
- Different processes for consumers to file appeals

# Payment Notice

# Risk Adjustment

- HHS will use a concurrent model (current year diagnostic information affects current year payments)
- States may propose their own model and must obtain approval to use it
- Funds will begin to be transferred between issuers approximately 18 months after beginning of a coverage year

# Risk Adjustment

- HHS will access risk adjustment data on carrier servers
- HHS will test carrier servers between March and October 2013
- HHS is proposing a user fee of less than \$1/year per enrollee to fund administrative costs for risk adjustment

# Reinsurance

- Reinsurance payments would be determined based on the total pool of all reinsurance contributions collected and total paid eligible claims nationally.
- Contributions would be collected once annually each benefit year beginning in late 2014.
- Reinsurance payments would be made once annually for each benefit year, based on a uniform coinsurance rate, attachment point, and reinsurance cap.

# Reinsurance

- The proposed 2014 national, uniform contribution rate is \$5.25 per enrollee per month.
- A contributing entity would submit its enrollment count based on an allowable permitted method by November 15.
- Certain coverage and plans would be exempted from making reinsurance contributions if they:
  - Are not considered “commercial books of business”;
  - Would not be “major medical products”; or
  - Would not be health insurance coverage that is not issued and approved by a State department of insurance.

# Reinsurance Payments

- Payment parameters that would apply to all States:
  - \$60,000 attachment point
  - \$250,000 reinsurance cap
  - 80 percent coinsurance rate
- Payments would be made using the total contributions pool collected under the national rate, and would be adjusted uniformly if payment requests exceed total contributions.
- Payments would be made annually.

# Risk Corridors

- Proposed rule would permit a QHP to include profits and taxes within its allowable administrative costs.
- Proposed schedule:
  - June 30: the notification date to QHP issuers concerning reinsurance and risk adjustment payments and charges.
  - July 31: the risk corridors reporting deadline
    - QHP issuers must submit required information to HHS by this date.