

# Summary of Regulations

Presentation to the Minnesota Health Insurance Exchange Advisory Task Force



April Todd-Malmlov  
Exchange Director  
Friday, March 30, 2012

# Final Regulations Released

- ▶ HHS issued three regulations in March:
  - Exchange Regulation– March 13, 2012.
  - The Reinsurance, Risk Corridors and Risk Adjustment Rule–March 16, 2012.
  - Medicaid Eligibility Rule– March 16, 2012.
- ▶ High level summary and significant changes
- ▶ Most rules were final, some were “interim”
  - Exchange interim rules have a deadline to comment by May 11, 2012
  - Medicaid eligibility interim rules have a May 7, 2012 deadline to comment.

# Final Exchange Rules

# Covered in Exchange Rule

The Exchange final rule includes standards for:

- ▶ Establishment of an Exchange
- ▶ Federal Partnership Models
- ▶ Eligibility for Subsidy
- ▶ Verification Rules
- ▶ Qualified Health Plans
- ▶ Financing Options
- ▶ Navigators and Brokers
- ▶ Small Business Health Options Program (SHOP)

# Establishment

- ▶ A state's blueprint must be approved or conditionally approved by HHS no later than January 1, 2013.
- ▶ Approval is not modeled on the Medicaid State Plan process
- ▶ States not ready for 2014 may apply to operate Exchange for 2015 or subsequent year; Federal Exchange will operate in states not ready for 2014.
- ▶ Funding will be available for development through 2014

# Federal Partnership Models

- ▶ Partnership Exchanges must provide seamless consumer experience
- ▶ Regulation did not provide a complete list functions that a State could provide in a partnership, but stated that it would be extremely complicated to accommodate multiple state variations and options
- ▶ All Exchanges and impacted state agencies must enter into agreements delineating their responsibilities
- ▶ Partnership Exchanges are run by the federal government and are under federal authority

# Eligibility For the Tax Credit

- ▶ Who can file an application
  - Application filer including:
    - An applicant
    - An adult in applicant's house or family
    - Authorized representative
    - If applicant is minor or incapacitates, someone acting on their behalf
- ▶ How can an applicant file an application
  - Via internet website
  - By telephone
  - By mail
  - In person, with reasonable accommodations for those with disabilities
- ▶ Exchange application will be used for:
  - Enrollment in QHP
  - Advance payment of premium tax credit
  - Cost-sharing reductions
  - Medicaid, CHIP, BHP if applicable
- ▶ Exchange may use an alternate application approved by HHS as long as it captures all information necessary for required eligibility determinations.
- ▶ Exchange may use Federally managed services for determining eligibility for advance payment of premium tax credit and cost-sharing reductions.

# Verification for the Tax Credit

- ▶ Exchange must consider information that is “reasonably compatible” with the applicant’s/enrollees attestation
- ▶ If the applicant attests to income **increases** the Exchange must accept the attestation
- ▶ If the attestation reflects an income **decrease** of less than 10% of the IRS data, attestation is acceptable. More than 10%, exchange must use other data sources

# QHP Certification

- ▶ **Multistate Plans: Standards, processes, and oversight will be defined and implemented by OPM including:**
  - Standards for certification and decertification
  - Process for considering rate increases
  - Process for submitting rate and benefit data
  - Submission of transparency data
  - Accreditation timeline
- ▶ **Qualified health plans must meet minimum standards laid out both in the ACA and the final rule, but states have flexibility in setting specific certification requirements such as:**
  - Network Adequacy
    - Networks “Must maintain a sufficient number and type of providers including those specializing in mental health and substance abuse to assure availability of all services without unreasonable delay”
    - Networks must include a “sufficient number and geographic distribution of Essential Community Providers to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the QHP service areas”
  - Marketing Standards
  - Quality Accreditation
- ▶ **The Exchange also has flexibility in designing their certification, recertification, and decertification processes, including using existing regulatory entities in performing these functions**

# Financing Options

- ▶ Exchange can charge user fees of any issuer participating in a function of the Exchange
- ▶ Both State and Federal Exchange may charge user fees
- ▶ Appears to apply to Medicaid managed care plans and Basic Health Program contracted plans

# Navigators and Brokers

- ▶ Exchanges cannot require all navigators to be licensed brokers or to carry E & O insurance
- ▶ Exchanges must have at least two types of entities serving as navigators – one must be a community or consumer-focused nonprofit
- ▶ Navigators may not receive compensation from insurers for enrolling individuals or employers inside or outside the Exchange
- ▶ Exchanges may allow agents and brokers to enroll individuals in Exchange coverage under specified conditions– relationship to navigators is unclear, we are discussing with HHS
- ▶ In order to assist individuals in applying for premium tax credits, agents/brokers must register with the exchange, receive training, use the streamlined application, and comply with privacy and security standards

# Web-Based Agents and Brokers

- ▶ The rule allows agents and brokers to use their own websites to provide information about QHPs
- ▶ Only the Exchange can determine eligibility and enroll the consumer in a QHP
- ▶ The agent/broker website must:
  - Provide consumers the ability to view all QHPs offered through the Exchange
  - Not provide financial incentives, such as rebates or giveaways
  - Display all QHP data provided by the Exchange
  - Maintain audit trails and records in an electronic format for a minimum of ten years
  - Provide consumers with the ability to withdraw from the process and use the Exchange Web site at any time

# Small Employer Exchange Provisions

- ▶ Exchanges must give employers the option to select a metal level, within which employees may select any QHP
- ▶ Exchanges may choose to allow choice across metal levels, or permit an employer to offer only a single plan
- ▶ Unless the Exchange merges the markets, employees may only select from the group QHPs – we are discussing impact on multiemployer, multi-contribution, and portability with HHS
- ▶ Insurers do not need to participate in both the small group and individual markets, but an Exchange can choose to implement such a participation requirement
- ▶ States may decide whether to implement a group employee participation rule, but if states choose to do so it must be at the Exchange, not QHP or insurer level
- ▶ Sole proprietors are not eligible for small employer Exchange participation, only individual Exchange participation

# Final Medicaid Eligibility Rules

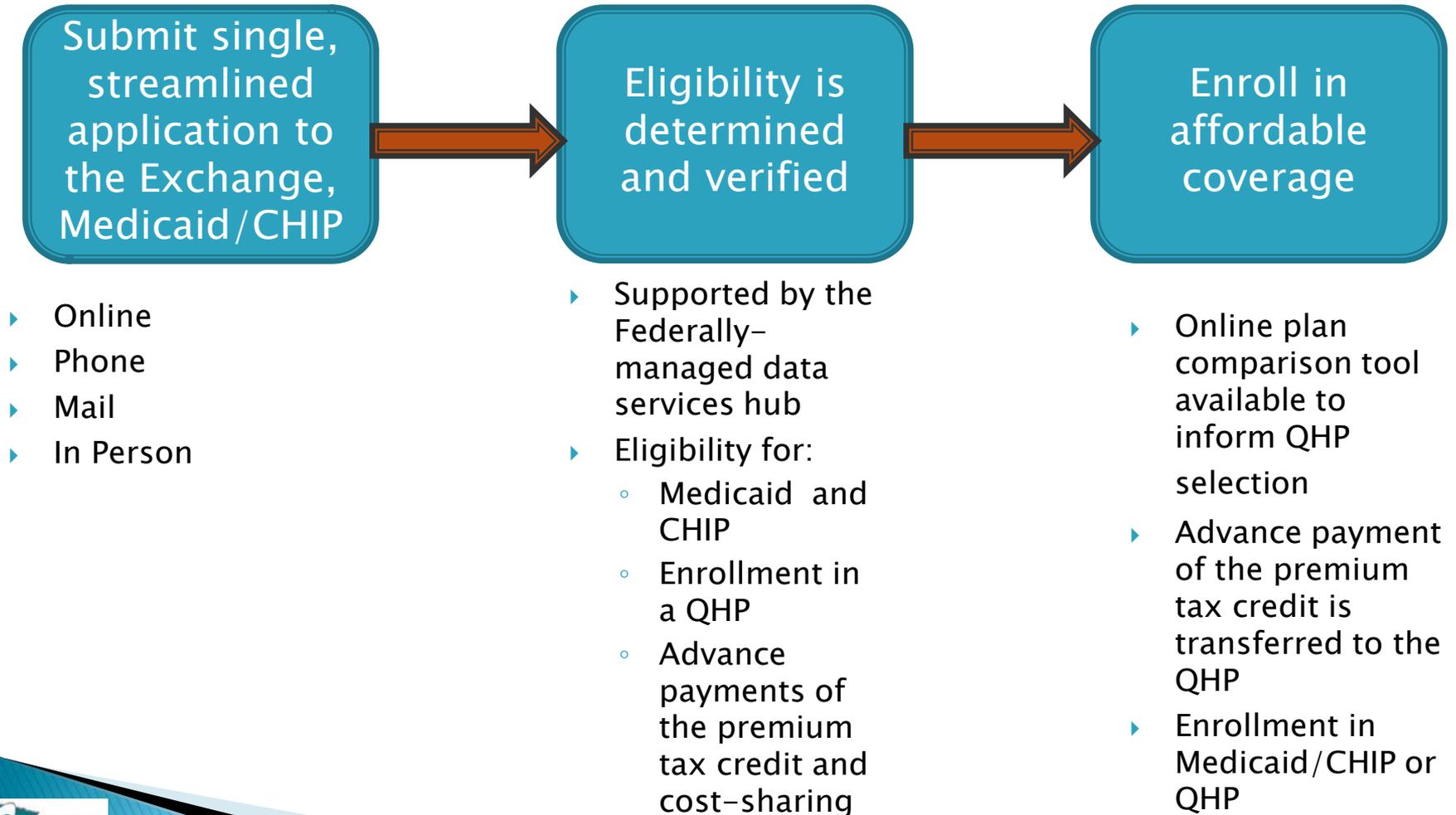
# Covered in Medicaid Rule

- ▶ Seamless / Coordinated Eligibility Determinations
- ▶ Timeliness
- ▶ Verification
- ▶ Eligibility Determinations of Non-MAGI applicants
- ▶ Budget Periods

# Coordination of Eligibility Determinations

- ▶ Eligibility determination must be seamless for Medicaid and Exchange to ensure simple, highly-coordinated, timely, and accurate determinations
  - Information may not be duplicated
  - Must use single, streamlined application
- ▶ Medicaid agency can now make Medicaid eligibility determination based on initial Exchange assessment

# Seamless System of Coverage



# Timeliness

- ▶ Establishes performance standards for efficient and accurate eligibility determinations
  - ▶ The majority of eligibility determinations should be made in real time – but the rule preserves a 45 day outer limit for eligibility determination for non-disabled applicants
- ▶ Medicaid agencies must set “timeliness standards” for maximum amount of time allowed for eligibility determinations and communicate to individuals

# Verification for Medicaid

- Use of documentation is limited. States may only require documentation when electronic data is not reasonably compatible with information provided by an applicant or is not available.
- Rule requires states to use electronic financial information available through the federal hub for eligibility determination.
- Requires that when information provided by an individual through self-attestation is reasonably compatible with electronic data that the information must be used for determining Medicaid eligibility
  - Reasonably compatible policy application is being evaluated
- New language requires states to develop a verification plan describing verification policies and procedures adopted by the State agency.
  - Must describe usefulness of financial data from other state agencies and federal programs as it relates to program integrity efforts such as Payment Error Rate Measurement (PERM) reviews

# Eligibility of Non-MAGI

- ▶ States have the option to use supplemental or separate forms for approval of eligibility under a non-MAGI category
- ▶ Any application or supplemental form used by a State for determining eligibility on bases other than the applicable MAGI standard must meet Secretarial guidelines
- ▶ HHS model application will try to incorporate non-MAGI criteria
- ▶ Until non-MAGI eligibility is determined, applicants are not precluded from enrolling in MAGI Medicaid

# Budget Periods

- ▶ States can use current or projected annual income methods for current Medicaid beneficiaries
- ▶ Can take into account reasonably predictable income changes for both new and current enrollees
- ▶ Must default to the IRS MAGI projected annual income methodology for individuals who appear Medicaid ineligible based on Medicaid methods, but have income below 100% FPL based on tax credit methods

# Risk Adjustment, Reinsurance, and Risk Corridors

# Covered in Rule

- ▶ **Permanent Risk Adjustment** program transfers funds from lower risk plans to higher risk plans
- ▶ **Temporary Reinsurance** program provides funding to issuers that incur high claims costs for enrollees
- ▶ **Temporary Risk Corridors** program limits issuer losses and gains

# Risk Adjustment– Approach

- ▶ HHS will not collect claims data for risk adjustment and instead will require carriers to calculate risk scores on siloed carrier-specific data sets under a distributed approach
- ▶ As a result, prospective risk adjustment no longer possible under federal model
- ▶ States operating their own risk adjustment programs may choose whether to use a centralized claims data or distributed approach
- ▶ States operating their own risk adjustment program must limit data collection to information reasonably necessary to operate the risk adjustment program

# Risk Adjustment (cont)

- ▶ States wanting to run their own program must submit a risk adjustment methodology in November 2012 to HHS
- ▶ States operating their own programs must publish its methodology and data validation processes by March 1 of the calendar year prior to the first benefit year for which the notice applies
- ▶ If a state does not publish this notice, it must use HHS methods.
- ▶ “Risk adjustment process” must conclude by June 30 of each year following the benefit year.
- ▶ Insurers must pay risk adjustment charges within 30 days of invoice.

# Reinsurance

- ▶ States do not have to administer their own reinsurance programs and may choose to have HHS administer it
- ▶ States with their own programs must publish notice if they intend to modify data requirements for reinsurance payments, collect reinsurance contributions, use more than one applicable reinsurance entity, or modify reinsurance parameters
- ▶ If a State fails to do this by March 1 of the calendar year prior to the benefit year for which the notice applies, it can only use HHS standards
- ▶ States that elect to collect additional reinsurance contributions must describe the purpose of the additional collection and additional contribution rate
- ▶ Reinsurance payments are no longer linked only to essential health benefits
- ▶ HHS clarified which contributing entities must make reinsurance contributions. These will include State and local employee group health plans and high risk pools
- ▶ HHS will collect contributions from self-insured plans, while the State may choose to collect from fully insured plans

# Risk Corridors and Misc.

- ▶ Risk corridors will be administered by HHS.
- ▶ Most changes in final rule are primarily related to adding and refining definitions to better align with Medical Loss Ratio provisions.
- ▶ The final rule specifies that reinsurance payments and contributions and risk adjustment payments and charges be allocated to the benefit year for which they apply.

# Interim Rules

# Interim Final Rules

- ▶ Exchange Interim Final Rules
  - §155.220(a)(3) – State option to permit agents and brokers to assist individuals in applying for tax credits and cost-sharing reductions
  - §155.300(b) – Related to Medicaid and CHIP regulations
  - §155.302 – Related to options for conducting eligibility determinations
  - §155.305(g) – Related to eligibility standards for cost-sharing reductions
  - §155.310(e) – Related to timeliness standards for Exchange eligibility determinations
  - §155.315(g) – Related to verification for applicants with special circumstances
  - §155.340(d) – Related to timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions
  - §155.345(a) and §155.345(g) – Related to agreements between agencies administering insurance affordability programs.
- ▶ Medicaid Eligibility Interim Final Rules
  - §431.300(c)(1) and (d)– Basis and Purpose
  - §431.305(b)(6)– Types of information to be safeguarded
  - §435.912– Timely determination of eligibility
  - §435.1200– Medicaid Agency responsibilities
  - §457.340(d)– Application for and enrollment in CHIP: Timely determination of eligibility
  - §457.348– Determinations of Children’s Health Insurance Program eligibility by other insurance affordability programs
  - §457.350(a), (b), (c), (f), (i),(j), and (k)– Eligibility screening and enrollment in other insurance affordability programs