Proposed HHS Notice of Benefit and Payment Parameters for 2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS for MEDICARE and MEDICAID SERVICES

Center for Consumer Information and Insurance Oversight

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Outline

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Payment Notice Overview

Ensuring that every American has access to high-quality, affordable health insurance

- In March 2012, the Premium Stabilization Rule provided a regulatory framework for the permanent risk adjustment program, the transitional reinsurance program, and the temporary risk corridors program.
- The proposed Payment Notice expands upon these standards and proposes payment parameters for these programs.
- Additionally, standards are proposed regarding Federally-facilitated Exchange user fees, Cost-sharing Reductions (CSRs), Advance Payments of the Premium Tax Credit (APTCs), the Small Business Health Options Program (SHOP), and the Medical Loss Ratio Program (MLR).

Risk Adjustment Program

Protects against potential effects of adverse selection

- Section 1343 of the Affordable Care Act provides for a permanent risk adjustment program.
  - Applies to non-grandfathered individual and small group plans inside and outside Exchanges.
- Provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions).
- Transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against potential effects of adverse selection.

Risk Adjustment Program: Overview

In the proposed Payment Notice, HHS proposes:

- An approval process for State-operated risk adjustment programs.
- The risk adjustment methodology HHS will use when operating risk adjustment on behalf of a State.
- The criteria for the evaluation of State-submitted alternate risk adjustment methodologies.
- The data validation approach HHS will use when operating risk adjustment on behalf of a State.
- A user fee to support HHS operation of risk adjustment programs.

Risk Adjustment Program: State Requirements

- We propose an approval process for State operation of risk adjustment programs, beginning in 2015.
  - The process would ensure that States and their risk adjustment entities are operationally ready to administer the federally certified risk adjustment methodology they choose for their program.
  - We request that States planning to operate risk adjustment in 2014 consult with HHS to determine their capacity to operate risk adjustment in 2014.
- We propose criteria for the evaluation of State-submitted alternate risk adjustment methodologies.
  - In addition to the elements outlined in the Premium Stabilization Rule, we propose to evaluate whether the:
    - Methodology complies with subpart D of the Premium Stabilization Rule;
    - Methodology accounts for risk selection across metal levels; and
    - Components of the methodology are aligned with each other.

Risk Adjustment Methodology: Models' Features

HHS is proposing to use risk adjustment models that predict plan liability for each combination of metal level (platinum, gold, silver, bronze, catastrophic) and age group (adults, children, infants).

The risk adjustment models HHS would use:

- Are developed on commercial claims data for a population similar to the expected population to be risk adjusted;
- Employ the hierarchical condition category ("HCC") grouping logic used in the Medicare population, with HCCs refined and selected to reflect the differences between the Medicare and the expected risk adjustment population; and
- Calculate risk scores with concurrent models (current year diagnoses predict current year costs).

Risk Adjustment Methodology: Payment Transfer Formula

The payment transfer formula HHS proposes to use:

- Transfers funds between plans with more healthy enrollees to less healthy enrollees within a risk pool, within a market, within a State.
- Results in “balanced” payment transfers within a market within a State; and
- Adjusts payment transfers for cost factors of plan metal level, geographic rating area, induced demand, and age rating, so that transfers reflect health risk and not other cost differences.

Payment transfers depend on both the plan average risk score and the plan’s cost factors relative to the market average of these factors.

Risk Adjustment Program: User Fees

- HHS proposes to charge a user fee on issuers participating in the HHS-operated risk adjustment program.
- The fee would be a per capita rate lower than $1 per enrollee per year. The fee does not cover Federal employee costs.
- Issuers would provide monthly enrollment estimates through the distributed data collection mechanism described later in this presentation.
- Fees would be collected simultaneously with payment and charge processing.

Risk Adjustment and Reinsurance Programs: Distributed Data Requirements

When HHS operates risk adjustment for a State, issuers will provide data on an issuer-owned and operated dedicated, secure data environment.

- Risk adjustment data will include enrollee-level plan enrollment data, and enrollee claims and encounter data that resulted in a payment to institutional and medical providers.
- HHS will not access or store sensitive enrollee information; issuers will be required to mask any sensitive data.
- HHS will test an issuer's data environment in 2013 (March through October).
- The risk adjustment data submission deadline is April 30th of the year following a benefit year; all risk adjustment data must be submitted by April 30th of the year following the benefit year in order to be recognized for payments and charges.

HHS would use the same data collection approach when it operates the reinsurance program for a State.

Risk Adjustment Program: Data Validation

When HHS operates risk adjustment, we propose a six-stage data validation process:

1. Sample Selection - HHS will provide issuers with an audit sample of approximately 300 enrollees/issuer.
2. Initial Audit – Issuers will contract with an auditor to complete an initial validation audit of these enrollees.
3. Second Audit - HHS will contract with an auditor to perform a second validation audit to ensure accuracy of the initial validation audit.
4. Error Rates - Findings will be used to estimate risk score error rates.
5. Appeals - Audit finding disputes may be resolved through appeal.
6. Adjustments - Payments and charges will be adjusted prospectively starting with benefit year 2016.

Transitional Reinsurance Program

Critical element in helping to ensure a stabilized individual market in the first years of Exchange operation

Section 1341 of the Affordable Care Act provides that:

- A transitional reinsurance program must be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016.
- All health insurance issuers and third party administrators on behalf of self-insured group health plans, must make contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market.

Transitional Reinsurance Program: Overview

- In order to heighten efficiency and reduce administrative burden, HHS would collect contributions from health insurance issuers and self-insured group health plans.
- To ensure fair and equitable distribution of funds, 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.

Transitional Reinsurance Program: Contributions

- The proposed 2014 national, uniform contribution rate is $5.25 per enrollee per month.
- We propose to collect contributions under the contribution rate from all contributing entities:
  - By November 15th, a contributing entity would submit its enrollment count based on one of the permitted counting methods.
    - These counting methods are based on those set forth in the proposed Patient-Centered Outcomes Research Trust Fund Rule.
- We propose to exclude certain coverage and plans 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.

Transitional Reinsurance Program: Payments

- We propose uniform payment parameters that would apply to all States:
  - $60,000 attachment point
  - $250,000 reinsurance cap
  - 80 percent coinsurance rate
- Payments under uniform payment parameters would be made using the total contributions pool collected under the national rate, and would be adjusted uniformly if payment requests exceed total contributions. This method will apply whether HHS or the State is operating the reinsurance program.
- Quarterly estimates of payments would be given to eligible plans to provide issuers with information necessary for rate-setting.
- Payments would be made annually.
  - By June 30th of the year following the applicable benefit year, issuers would be notified of the total reinsurance payments they will receive.

Transitional Reinsurance Program: State Supplemental Parameters

A State may modify the uniform reinsurance payment parameters if the State:

- Operates a reinsurance program; and
- Elects to collect additional contributions directly from health insurance issuers in the State (above that collected under the national contribution rate) or uses State funding sources for reinsurance payments.

States' supplemental payment parameters would not affect the amount of reinsurance payments made under the uniform payment parameters.

Temporary Risk Corridors Program: Overview

- Section 1342 of the Affordable Care Act directs HHS to establish a temporary risk corridors program during the years 2014 through 2016.
  - Applies to qualified health plans in the individual and small group markets
- Protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between HHS and issuers offering qualified health plans to help ensure stable health insurance premiums.
- Federal program under the statute (in contrast to risk adjustment and reinsurance, which States have the option to operate).

Temporary Risk Corridors Program: Overview (cont.)

- The temporary risk corridors program provides for the sharing between a QHP issuer and the Federal government of profits and losses resulting from inaccurate rate-setting during the early years of Exchanges.
  - Risk corridors compare a QHP's allowable costs (claims costs) with its target amount (premiums less allowable administrative (non-medical) costs).
- We propose to permit a QHP to include profits and taxes within its allowable administrative costs.
  - We propose to allow issuers to include a reasonable profit margin of 3% of premiums where appropriate.
  - Profits would be subject to the overall cap on allowable administrative costs of 20% of after tax premiums.
  - To align with MLR, taxes would not be subject to the overall cap on allowable administrative costs of 20% of after tax premiums.

Temporary Risk Corridors Program: Schedule

We propose a schedule for the temporary risk corridors program:

- June 30: the notification date to QHP issuers concerning reinsurance and risk adjustment payments and charges.
- July 31: the risk corridors reporting deadline – by this date, QHP issuers must submit required information to HHS.
  - We are also proposing to amend the MLR reporting deadline to be consistent.

Cost-Sharing Reductions (CSRs) and Advance Payments of the Premium Tax Credit (APTCs): Overview

- Beginning in 2014, individuals who enroll in qualified health plans (QHPs) through Exchanges may receive premium tax credits to make health insurance more affordable, and financial assistance to help reduce out-of-pocket costs (cover cost sharing) for health care services.
- This proposed Payment Notice supplements previous rulemaking on APTCs and CSRs.
  - The Health Insurance Premium Tax Credit Rule (77 Fed.Reg. 30,377 (May 23, 2012)) sets the standards for determining a taxpayer's eligibility for premium tax credits and for computing the premium tax credit.
  - The Exchange Establishment Rule (77 Fed.Reg. 18,310 (Mar. 27, 2012)) sets some basic standards for Exchanges and issuers related to the administration of APTCs and CSRs.

New Standards Related to Advance Payments of the Premium Tax Credit (APTCs)

- We propose that Exchanges make advance determinations of premium tax credit eligibility for individuals enrolling in coverage through the Exchange, and notify the QHP issuer of the enrollee's APTC amount.
  - The issuer would then reduce the premium charged to the individual by the amount of the APTC.
- We propose that issuers of QHPs and stand-alone dental plans submit information to the Exchange on the portion of the premium allocated to essential health benefits.
  - This information permits the calculation of APTCs.

New Standards Related to Cost-Sharing Reductions (CSRs)

The Affordable Care Act directs QHP issuers to:

- Reduce cost sharing for individuals with household incomes between 100% and 400% of the FPL, who are enrolled in a silver level QHP, through an individual market Exchange;
- Eliminate cost sharing for Indians with household incomes under 300% of FPL who are enrolled in a QHP through an individual market Exchange; and
- Eliminate cost sharing for Indians enrolled in a QHP through an individual market Exchange, regardless of income, when services are provided by the Indian Health Service or related providers.

New Standards Related to CSRs (cont.)

- We propose that QHP issuers develop variations of their QHPs.
  - Under these variations, a portion of the cost sharing would be paid by the Federal government, and the remainder would be paid by the enrollee.
- QHP issuers would be required to assign eligible enrollees to the appropriate plan variation based on an eligibility determination made by the Exchange.
- This approach would ensure that eligible enrollees receive the appropriate cost-sharing reductions at the point of service.

New Standards Related to CSRs (cont.)

We also propose standards related to the payment of cost-sharing reductions:

- QHP issuers would submit to the Exchange an estimate of the dollar value of the cost-sharing reductions they would provide.
  - HHS would review this data and provide advance payments to issuers to offset the cost of the reductions.
- QHP issuers would submit the actual value of the cost-sharing reductions after the close of the benefit year.
  - HHS would reconcile the advance payments with the actual cost-sharing reduction amounts.

Federally-Facilitated Exchange (FFE) User Fee

- In order to fund the operation of the Federally-facilitated Exchange, issuers participating in an FFE would be required to pay a monthly user fee to support the operation of the FFE.
- For the 2014 benefit year, we propose a monthly user fee rate equal to 3.5 percent of the monthly premium charged by the issuer.
- We seek to align this rate with rates charged by State-based Exchanges, and may adjust this rate to conform with State-based Exchange rates in the final Payment Notice.
- This policy does not affect the ability of a State to use grants described in section 1311 of the Affordable Care Act to develop functions that a State elects to operate under a Partnership Exchange, and to support State activities to build interfaces with a Federally-facilitated Exchange.

Federally Facilitated Small Business Health Options Program (FF-SHOP): Proposed Provisions

- Employer choice of plans to offer employees in an FF-SHOP
  - Employer selects a coverage level, employee has choice of any QHP within the level (as set forth under the law).
  - Comment sought on an option that allows employer to offer QHPs at next higher level if made available by issuer.
  - Comment sought on transitional policy allowing or directing an employer to select a single QHP for all employees.
- Methods for employer contribution in the FF-SHOP
  - Proposed rules sets forth a single method for the initial years of FF-SHOP:
    - Contribution is a set percentage of a reference plan premium.
    - If proposed market rules for small group are adopted, these premiums will vary by age.
    - Employer can choose to use a calculated composite premium so all employees pay the same amount for reference plan coverage.

Federally-facilitated Small Business Health Options Program (FF-SHOP): Proposed Provisions (cont.)

- Proposed Exchange QHP certification

  An FFE may only certify a QHP:

  - If the QHP issuer also offers silver and gold QHPs in FF-SHOP;
  - If the QHP issuer does not participate in the State's small group market, but another issuer in the issuer group offers silver and gold QHPs in FF-SHOP; or
  - If neither the QHP issuer nor any issuer in the issuer group participates in the State's small group market.

  Thus, no issuer would be required to begin offering small group market plans.

- Broker compensation in the FFE and FF-SHOP
  - QHP certification standard would be met if issuer pays the same broker compensation for similar plans inside and outside the Exchange.

Federally-facilitated Small Business Health Options Program (FF-SHOP): Proposed Provisions (cont.)

- Proposed minimum participation rate in an FF-SHOP:
  - Is subject to sections 2702 and 2703 of the Public Health Service Act, as implemented in HHS regulations.
  - Would be set at 70%, excluding employees covered by another group or governmental plan.
  - Could be adjusted to match State law or customary practice.
- Proposed definitions related to employees and employer size:
  - Are consistent with Affordable Care Act definitions, full-time employee defined generally as 30 or more hours per week.
  - Adopt full-time equivalent method of determining employer size for SHOP
  - FF-SHOP would use these definitions in its operations.
  - Until 2016, States and employers in States with State-based SHOPs may use State methods to determine full-time status and employer size.

Medical Loss Ratio Program (MLR): Overview

MLR Program Overview

- The medical loss ratio (MLR) program requires health insurance issuers to pay rebates to enrollees when their MLRs fall below certain thresholds (generally, 80% in the individual and small group markets and 85% in the large group market).

Medical Loss Ratio Program (MLR): Proposed Provisions

Proposed MLR provisions in the draft Payment Notice would:

- Account for the reinsurance, risk adjustment, and risk corridors programs in MLR and rebate calculations;
- Extend MLR reporting deadline from June 1 to July 31, and rebate disbursement deadline from Aug. 1 to Sept. 30, to accommodate the premium stabilization programs for 2014 and later reporting years; and
- Allow Federal income tax exempt not-for-profit issuers to deduct both community benefit expenditures (up to a certain cap) and State premium taxes from premium in calculating MLR and rebates to ensure a level playing for issuers within each State.

Next Steps

- Proposed Payment Notice can be found at: https://www.federalregister.gov/public-inspection (November 30, 2012)
- We welcome comments on the proposals in this notice.
  - Comments are due on December 31, 2012.
  - Submit through regulations.gov.
- We intend to work closely with issuers and States throughout the implementation of these programs.
- Questions?