

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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2. Transitional Reinsurance Program
3. Temporary Risk Corridors Program
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6. Small Business Health Options Program (SHOP)
7. Medical Loss Ratio Program (MLR)

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 final HHS Notice of Benefit and Payment Parameters (Payment Notice) expands upon these standards and proposes parameters and additional details for these programs.
- The Payment Notice also establishes standards for the 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).
- We are publishing a separate IFC and NPRM simultaneously with the Payment Notice. The IFC contains additional provisions related to CSRs and risk corridors. The NPRM contains provisions related to the SHOP.

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 Payment Notice, we finalize:

- 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

- In the Payment Notice, we are finalizing as proposed 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 also finalize as proposed 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

In the Payment Notice, we are finalizing our proposal 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 will 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

In the Payment Notice, we are also finalizing the payment transfer formula HHS will use when operating risk adjustment. This formula:

- Transfers funds between plans with more healthy enrollees to plans with 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

- In the Payment Notice, we are finalizing our proposal to charge a user fee to issuers participating in the HHS-operated risk adjustment program.
- The fee is a per capita rate of \$0.96 per enrollee per year. The fee does not cover Federal employee costs.
- Issuers will provide monthly enrollment estimates through the distributed data collection mechanism described later in this presentation.
- Fees will be collected simultaneously with risk adjustment payment and charge processing.

Federally-Certified Risk Adjustment Methodology

- Massachusetts submitted to HHS an alternate risk adjustment methodology, which we have certified for use in Massachusetts.
- The Massachusetts risk adjustment methodology uses four concurrent models to predict plan liability.
 - The models are based on HCC grouping logic, but the number and makeup of individual HCCs differ from the HHS model.
- Massachusetts will use the HHS payment transfer formula with modifications to several cost factors.
- The data used to calibrate and operate the program are from the State's all payer claims database (APCD); calibration data were supplemented with MarketScan New England data.

Risk Adjustment and Reinsurance Programs: Distributed Data Requirements

In the Payment Notice, we are finalizing our proposal that issuers will provide data on an issuer-owned and operated dedicated, secure data server when HHS operates risk adjustment or reinsurance for a State.

- 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.
- Issuers will be notified by HHS when testing of an issuer's data environment will commence.
- All data to calculate risk adjustment payments and charges and reinsurance payments must be submitted by April 30th of the year following the applicable benefit year.

Risk Adjustment Program: Data Validation

In the Payment Notice, we proposed and are finalizing a six-stage data validation process when HHS operates risk adjustment:

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 data validation results from benefit year 2016.

We will consult with stakeholders as we provide further details regarding this data validation approach.

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 response to comments, we are finalizing in the Payment Notice our proposal to collect contributions from all health insurance issuers and self-insured group health plans. This collection strategy will heighten efficiency and reduce administrative burden in the reinsurance program.
- To ensure fair and equitable distribution of funds, we are also finalizing our proposal that reinsurance payments will be determined based on the total pool of all reinsurance contributions collected and total paid eligible claims nationally.
- Contributions will be collected once annually each benefit year beginning in late 2014.
- Reinsurance payments will be made once annually for each benefit year, based on a uniform coinsurance rate, attachment point, and reinsurance cap.

Transitional Reinsurance Program: Contributions

- In the Payment Notice, we finalize the 2014 national contribution rate at \$63.00 per enrollee per year.
- We will collect contributions under the national 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 Patient-Centered Outcomes Research Trust Fund Rule (77 FR 72721, December 6, 2012).
- We are finalizing, with slight modification, our proposal to exclude certain coverage and plans from making reinsurance contributions if they:
 - Are not considered “commercial books of business”;
 - Are not be “major medical products”; or
- We are also finalizing, with slight modification, our proposal to exclude a number of specific types of plans including HSAs, integrated HRAs, and expatriate coverage (as defined by the Secretary).

Transitional Reinsurance Program: Payments

- In the Payment Notice, we are finalizing as proposed uniform payment parameters that would apply to all States:
 - \$60,000 attachment point
 - \$250,000 reinsurance cap
 - 80 percent coinsurance rate
- Payments under the uniform payment parameters will be made using the reinsurance contributions collected under the national contribution rate, which will be adjusted uniformly if payment requests exceed total contributions collected. This method will apply whether HHS or the State operates the reinsurance program.
- Quarterly estimates of payments will be given to reinsurance-eligible plans to provide issuers with information necessary for rate-setting.
- Reinsurance payments will be made annually.
 - By June 30th of the year following the applicable benefit year, issuers will be notified of the total reinsurance payments they will receive.

Transitional Reinsurance Program: State Supplemental Parameters

In the Payment Notice, we are finalizing as proposed that a State may supplement the uniform reinsurance payment parameters if the State:

- Operates reinsurance; 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 supplemental reinsurance payments.

Separate and apart from the reinsurance program, a State may use State funds raised in any manner to create a separate reinsurance program.

- States will need to establish State authority to do this as the authority provided under section 1341 is not applicable.

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 from 2014 through 2016.
 - Applies to qualified health plans (QHPs) in the individual and small group markets
 - Is Federally administered
- Protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between HHS and QHP issuers to help stabilize health insurance premiums.

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).

Temporary Risk Corridors Program: Overview (cont.)

- A QHP may include profits and taxes and regulatory fees within its allowable administrative costs. In the Payment Notice, we are generally finalizing the provisions as proposed.
 - QHP issuers may include a profit margin of up to 3% of premiums where appropriate.
 - Profits will be subject to the overall cap on allowable administrative costs of 20% of after tax premiums.
 - To align with MLR, we are modifying our proposed provisions such that taxes and regulatory fees will not be subject to the overall cap on allowable administrative costs of 20% of after tax premiums.

Temporary Risk Corridors Program: Overview (cont.)

In the Payment Notice, we clarify that:

- For purposes of calculating risk corridors payments and charges, reinsurance contributions will be treated as a regulatory fee to calculate the risk corridors target amount, instead of as an adjustment to allowable costs.
- Issuers should not include risk corridors payments and charges when estimating taxes under the risk corridors formula.
- Non-profit entities may account for community benefit expenditures as taxes when calculating the target amount.

Temporary Risk Corridors Program: Schedule

In the Payment Notice, we are also finalizing the following provisions as proposed:

- 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.
- These deadlines are consistent with MLR reporting deadlines.

Federally-Facilitated Exchange & Federally-Facilitated SHOP User Fee

- In the Payment Notice, we are finalizing our proposal that issuers participating in an FFE or FF-SHOP must pay a monthly user fee to fund operations.
- For the 2014 benefit year, the monthly user fee rate equals 3.5 percent of the monthly premium charged by the issuer.
- An issuer must pool FFE and FF-SHOP user fee costs among all of its plans in a particular market.
- Does not affect the ability of a State to use grants to develop operational functions of a Partnership Exchange or to build interfaces with an FFE or FF-SHOP (consistent section 1311 of the Affordable Care Act).
- We will consult with stakeholders when determining the technical process to remit user fees.

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

- Beginning in 2014, individuals who enroll in 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 essential health benefits.
- The Payment Notice and IFC supplement 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)

- Exchanges will make advance determinations of eligibility for APTCs for individuals enrolling in coverage through the Exchange, and notify the QHP issuer of the enrollee's APTC amount.
 - In the Payment Notice, we are finalizing our proposed policy that the issuer will then reduce the premium charged to the individual by the amount of the APTC.
- We are finalizing in the Payment Notice, as proposed, that Exchanges must take into account past APTC payments during the benefit year when making an eligibility redetermination and recalculating APTC amounts in the middle of the benefit year.
- We are finalizing a slight modification to our proposal that issuers of QHPs and stand-alone dental plans will submit information to the Exchange on the portion of the premium allocated to essential health benefits.
 - This information will be used to calculate APTC amounts.
- We are finalizing a modification to our proposed approach to APTC allocation so that Exchanges have greater flexibility in allocating the APTC if one or more individuals in a tax household enroll in more than one policy through the Exchange.

Standards Related to Cost-Sharing Reductions (CSRs)

Sections 1402 and 1412 of the Affordable Care Act direct QHP issuers to:

- Reduce cost sharing for individuals with low and moderate household incomes, 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.

Standards Related to CSRs (cont.)

- 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.
- In the Payment Notice, we are finalizing the proposed policy that QHP issuers will 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 will be required to assign eligible enrollees to the appropriate plan variation based on an eligibility determination made by the Exchange.
- This approach ensures that eligible enrollees receive the appropriate cost-sharing reductions at the point of service.

New Standards Related to CSRs (cont.)

- In the Payment Notice, we are finalizing our proposal that QHP issuers submit to the Exchange an estimate of the dollar value of the CSR expected to be provided based on a standard methodology.
 - HHS will review this data and provide advance payments to issuers to offset the cost of the reductions.
- We are finalizing a modification of our proposal such that HHS may adjust the advance payments during the year if the QHP issuer provides information demonstrating that CSRs will significantly exceed the advance payment amounts.
- We are modifying our approach to CSR reconciliation. QHP issuers will submit the value of the CSRs after the close of the benefit year.
 - HHS will reconcile the advance payments with the actual cost-sharing reduction amounts.
 - In addition, the IFC establishes a simplified methodology for calculating the amounts of cost-sharing reductions provided.

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

- In the Payment Notice, we finalize our proposal to offer employer choice of plans to offer employees in an FF-SHOP.
 - Employer selects a metal level of QHPs, employee has choice of any QHP within the level (as set forth under the law).
 - In the FF-SHOP, an employer will be able to select a single QHP for all employees.
- We also finalize a method for employer contribution in the FF-SHOP.
 - Contribution is a set percentage of a reference plan premium.
 - These premiums (and the contributions) will vary based on each enrollee's 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)

- In the Payment Notice, we are finalizing a modified QHP certification standard in the FFE.
 - An FFE may only certify a QHP in the individual market Exchange:
 - 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 has a market share of the State's small group market greater than 20%, as determined by HHS based on the most recent MLR reports available at the time the QHP application is filed.
 - Thus, no issuer would be required to begin offering small group market plans.
- We also finalize as proposed provisions related to 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)

- In the Payment Notice, we finalize as 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.
- We also finalize as proposed definitions of full-time employee, small employer, and large employer:
 - Full-time employee defined generally as 30 or more hours per week.
 - Small employer and large employer definitions adopt full-time equivalent method of determining employer size for SHOP.
 - FF-SHOP would use these definitions in its operations beginning in 2013.
 - As a transitional measure, States and employers in States with State-based SHOPS may use State methods to determine full-time status and employer size until 2016.

Medical Loss Ratio Program (MLR): Overview

MLR Program Overview

The medical loss ratio (MLR) program requires health insurance issuers to pay rebates 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)

In the Payment Notice we finalize, with minor modification, MLR provisions that:

- 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 account for 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 promote a level playing field for issuers within each State.

NPRM -- Federally-Facilitated Small Business Health Options Program (FF-SHOP)

- In the NPRM, we propose provisions related to employer choice of plans to offer employees in an FF-SHOP.
 - The statute gives employers the option of selecting a coverage level and providing employees the choice of any QHP within that level (employee choice model).
 - We are proposing as a transitional policy that SHOPS would have to offer this option only in plan years beginning in 2015. Specifically:
 - A State-based SHOP could implement the employee choice model, but could also delay implementation of the employee choice model until 2015.
 - The FF-SHOP would not implement the employee choice model until 2015, and in 2014 would provide employers only with the option of selecting a single QHP for all employees.
- We also propose to make the length of special enrollment periods in the SHOP consistent with HIPAA.
 - If an eligible employee or eligible employee's dependent loses coverage under Medicaid or CHIP, or becomes eligible for State premium assistance under a Medicaid or CHIP program, the special enrollment period would last 60 days from the triggering event.
 - All other special enrollment periods would last 30 days from the triggering event.

IFC—Amendments to the HHS Notice of Benefit and Payment Parameters for 2014

- In response to public comments, we are also releasing an interim final rule with comment (IFC) simultaneously with the Payment Notice that builds on requirements in the final Payment Notice by proposing:
 - Adjustments to the risk corridors calculation that will align the calculation with the single risk pool requirement.
 - An alternate simplified methodology for calculating the amounts of cost-sharing reductions provided for reconciliation purposes.
- We believe it is important to establish and finalize rules on these provisions quickly because the adjustments to the cost-sharing reduction program and the risk corridors program is important for issuers to understand in order to set rates for submission and approval for the 2014 benefit year.
- We anticipate consulting with stakeholders as we implement these provisions.

IFC– Risk Corridors

- As established in the Premium Stabilization Rule, risk corridors is calculated by comparing a QHP's allowable costs (adjusted claims) to its target amount (adjusted premiums).
- This may result in an incongruity with the single risk pool requirement, which directs an issuer to set its premiums based on the pooled claims costs for all of its non-grandfathered health plans in a market within a State.
- We are proposing a modification to the definition of “allowable costs” for the risk corridors calculation, so that it is calculated based on the pooled claims of all of an issuer’s non-grandfathered health plans in a market.
- Allowable costs would be allocated to and among an issuer’s QHPs in proportion to the amount of the QHPs’ premiums.

IFC—Cost-Sharing Reductions

- In the IFC, we propose that issuers may choose one of two methodologies for determining the amount of CSRs provided for reconciliation purposes.
- Standard Methodology: Issuers will submit to HHS information on the actual value of CSRs provided – this methodology was finalized in the Payment Notice.
- Simplified Methodology: Issuers will calculate the value of the CSRs provided using a formula based on certain summary cost-sharing parameters of the standard plan, applied to the total allowed costs for each policy – this methodology is proposed in the IFC.
- This will allow QHP issuers to choose the methodology that best aligns with their operational practices, which should reduce the administrative burden on issuers in the initial years of the Exchanges.

Next Steps

- The final Payment Notice can be found at:
http://ofr.gov/OFRUpload/OFRData/2013-04902_P1.pdf.
- The IFC can be found at: http://ofr.gov/OFRUpload/OFRData/2013-04904_P1.pdf
- The IFC comment period closes April 30, 2013.
- The NPRM can be found at: http://ofr.gov/OFRUpload/OFRData/2013-04952_P1.pdf
- The NPRM comment period closes March 31, 2013.
- We intend to work closely with issuers and States throughout the implementation of these programs.
- Questions?