

# 2015 NOTICE OF BENEFIT AND PAYMENT PARAMETERS FINAL RULE

## AUTHORS

Tammy Tomczyk, FSA, MAAA  
Kurt Giesa, FSA, MAAA  
Beth Fritchen, FSA, MAAA  
Ryan Mueller, FSA, MAAA

On March 11, 2014 HHS published its Final Notice of Benefit and Payment Parameters for 2015<sup>1</sup>. The notice contains rules and parameters that will apply to the individual and small group health insurance markets in 2015, and modifications to previously promulgated rules for calendar year 2014. This document represents a summary of our interpretation of the final notice and does not constitute, nor is it a substitute for, legal advice.

<sup>1</sup> Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule," March 11, 2014 <http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf>

# HEALTH INSURANCE MARKET REFORM REQUIREMENTS

## 1. Requirements Relating to Health Insurance Coverage

- Policy year is defined as the 12 month period designated in the policy documents for grandfathered individual coverage and student health insurance coverage (rather than calendar year)

## 2. Composite Rating/Premium

- The final rule clarifies that composite rating as has been historically applied is no longer allowed since it is prohibited by Section 2701 of the PHSA. However, “composite premiums” may be used whereby the composite premium is equal to the sum of the age rated premium for all covered employees and dependents of the group, divided by the number of members covered
- A composite premium structure may be used for small group plan years starting on or after January 1, 2015
  - The composite premiums calculated at the time of issue or renewal must be locked in for the entire plan year, regardless of changes in the group’s composition throughout the year
  - If offered to any small group, then required to be offered to all non-grandfathered policies sold **inside and outside** the SHOP, except in an FF-SHOP when employee choice is offered
- A uniform tiered composite premium structure will be allowed if it conforms to the following:
  - One composite premium is developed based on all adults age 21 and older (regardless of status as an employee, spouse or dependent child) and one composite premium is developed based on all individuals under age 21
  - Any load for tobacco status must be applied at the member level to the composite premium
    - Note: the tobacco load must be based on the applicable enrollee’s per-member premium, not the composite premium surcharge for all enrollees
  - Rates for a given family composition would be the sum of the applicable composite rates, taking into account no more than three covered children under age 21
  - States may require an alternate methodology if approved by HHS; alternates must assure that children are charged only child premiums
- Composite rating is **not** available for groups enrolled through the FF-SHOP when the employer offers employees the option of selecting among all plans available at a given metal level
- If an issuer elects to offer composite premium rating, the issuer cannot limit the offer of composite rating to only certain groups (e.g., groups of certain sizes)
- States can establish different tiered-composite premium standards with approval from HHS

## 3. Student Health Coverage

- Defined as individual coverage
- Not required to guarantee issue coverage to individuals who are not students or dependents of covered students
- Exempt from the requirement that non-grandfathered individual coverage be offered on a calendar year basis

# STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT

## 1. Risk Adjustment Provisions

- The 2015 risk adjustment user fee will be \$0.08 PMPM; this is unchanged from the 2014 risk adjustment user fee
- There is a slight update to the 2014 risk adjustment model
  - The regulation is explicit on the CSR adjustment for induced utilization of newly Medicaid-eligible beneficiaries enrolled in Silver plan variations in the individual market (i.e., Medicaid Alternative Plans). The adjustments will be the same as the Silver plan variation into which their Medicaid beneficiaries are enrolled
- While no specific proposals were outlined, CMS is considering changes to the risk transfer calculation in future years to better adjust for geographic cost variations and cites the following:
  - Some states have defined a large number of rating areas
  - Geographic cost factors for less populous regions may be based on a small number of plans, raising concern about the accuracy of the geographic cost factors and potential distortion of risk transfer payments that may result
  - No changes are being proposed for 2015, but CMS will be monitoring the 2014 risk adjustment data to determine if premium distortions are occurring as a result of the current geographic rating areas
- In determining whether a group is eligible to participate in the risk adjustment program, the counting of employees must take into consideration employees that are not full-time
  - For states that default risk adjustment activities to the Feds, if a state's counting definition does not take into consideration part-time employees, the counting methodology used by the SHOP will be used to determine whether a group is a "small group" for risk adjustment purposes. Otherwise, the state's counting method will apply
  - For states where the state's counting definition is used, there could be groups that meet the "small group" definition for participating in the Exchange, but do not meet the definition for participating in risk adjustment
- A more detailed outline of proposed risk adjustment data validation methodology is provided (mostly outlined previously in the summer of 2013 through "ACA HHS-Operated RADV Process White Paper")
  - Stage 1: Sample size
    - 2014 and 2015: 200 enrollees per issuer
    - 2016 and beyond: Formula-driven (White Paper)
    - A sample will be broken into 10 strata, driven by risk level, the presence of HCCs, and age group
      - An error rate approach will result in larger samples from "more risky" subsets of the population
      - Sampling assumptions for error rates and variances will be based on Medicare Advantage for the initial year. After the initial year, HHS will evaluate whether sufficient error rate and standard deviation data exists to calculate sample sizes
  - Stage 2: Initial Validation Audit (IVA)
    - The auditor must be reasonably capable of performing the initial validation audit and reasonably free of conflicts of interest
    - Issuers must notify HHS of the identity of the auditor and must attest to the absence of conflicts of interest
      - Auditor's qualifications and relationship to issuer will be reviewed/verified
    - Audit review must be performed by certified medical coders (AHIMA or AAPC)

- The issuer must provide the auditor with all relevant information applicable to the benefit period
- HHS will be providing further guidance regarding the validation process for enrollment and demographic data
- Medical records: “clinical documentation of hospital inpatient or outpatient treatment or professional medical treatment form which enrollee health status is documented and related to accepted risk adjustment services that occurred during a specified period of time”
- Additional guidance on the use of telehealth services is forthcoming
- A risk adjustment error occurs when a discrepancy changes an enrollee’s risk score; other discrepancies will not be considered risk adjustment errors
- A senior reviewer must confirm errors discovered in the risk adjustment process. For 2014 and 2015, a senior reviewer is defined as a medical coder having three years of experience. For 2016 and beyond, senior reviewers must have five years of medical coding experience
- Stage 3: Second Validation Audit (SVA)
  - A second validation auditor will be retained by HHS
  - The second validation auditor will adhere to the same standards as those applied to the initial validation auditor
  - A small subsample of enrollees from the IVA will be reviewed by second validation auditor
  - A sampling methodology that allows for pair-wise means testing to determine whether results from initial and second validation audit are statistically different (95% confidence interval) is proposed
  - If results are statistically different, a larger sample size from IVA will be used to conduct pair-wise means testing
- Stage 4: Error Estimation
  - If the results from the SVA are statistically different from the results of the IVA, the error rate from the SVA using a larger sample size will be used to adjust the average risk score for a given issuer
  - There would be a one-for-one replacement of enrollee risk scores for enrollees sampled from the SVA with a uniform adjustment for all other enrollees
  - Error estimations would be performed on a stratum-by-stratum level and weighted accordingly to obtain the adjusted overall risk score for an issuer. The adjusted risk score would be used to compute an adjustment factor, which would only be applied if the adjusted average risk score and the original average risk score are statistically different (using a 95% confidence interval)
- Appeals
  - Expected to begin in the spring of the year
  - The error rate will be applied to risk adjustment scores
- Payment Adjustments
  - Risk adjustment payment transfers will be based on adjusted plan average risk scores
  - Validation audits will be used to determine applicable the error adjustment for each issuer’s risk adjustment covered plans
  - Adjustments will be applied to the following year’s risk adjustment amount (e.g., adjustments for benefit year 2016 will take effect in 2018)
- Provisions are added to include oversight related to the risk adjustment process when HHS operates risk adjustment on behalf of a state
  - Issuers may be subject to civil money penalties if the issuer does not engage in the IVA within the prescribed timeframe or if the initial validation audit arrangement does not comply with the regulations
  - If an issuer does not complete an initial validation audit or does not comply with the IVA, a default risk adjustment charge will be applied

- The methodology for determining the charge will be forthcoming in future regulations
- Provisions related to data security, management and transmission will be addressed in future regulations
- Timeline of risk adjustment validation activities (for benefit year 2014 experience):
  - IVA – Begins in Summer 2015
  - SVA – Continues into 2016
  - Conclusion – Some point in 2016, to include HHS distributing findings to issuers, processing appeals, and final reporting of risk scores
  - For benefit year 2016, risk adjustment activities are expected to be finalized in the summer of 2018
- HHS Audits
  - HHS will only audit issuers in states where HHS is operating the risk adjustment program on behalf of the state
  - Further details regarding audits will be forthcoming in future regulations
  - If an audit results in the finding of a material weakness or deficiency, the issuer must submit a corrective action plan within 30 days of issuance of the final audit report, implement the corrective action plan, and provide HHS with written documentation of the corrective actions

## 2. Parameters for the Transitional Reinsurance Program

- Major medical coverage for the purposes for the reinsurance contributions will be defined as coverage for a broad range of services and treatments and providing minimum value in accordance with Sec. 156.145, or subject to AV requirements under Sec. 156.140
- Self-insured group health plans that do not use a third party administrator (TPA) in connection with claims processing/adjudication or plan enrollment will be exempted from the reinsurance contribution for 2015 and 2016 benefit years. Not using a TPA is defined as the group retaining responsibility for claims payment/adjudication and enrollment, but leasing a network would be allowed as would outsourcing of pharmacy and excepted benefits, and a *de minimus* (<5%) amount of core services
- Uniform reinsurance contribution rate for the 2015 benefit year
  - The annual per capita contribution rate for 2015 will be \$44 (\$3.67 per month). This is equal to the \$6 BN for the reinsurance payment pool, plus the \$2 BN that goes to the Treasury plus \$25.4 MM for administering the program, divided by the number of enrollees in plans required to make the contribution
  - Reinsurance contributions will be made in two installments to HHS – one at the beginning of the calendar year following the benefit year, and one at the end
    - Both will be based on the annual enrollment count that plans must provide by November 15 of the applicable benefit year
    - The payment made at the end of the year following the benefit year will be to fund the Treasury's portion of the payment (e.g., the \$2 BN in 2015)
    - The full amount of the payment would be reported for the applicable benefit year for the purposes of the MLR and risk corridor calculations
  - If less than the full \$12.02 BN needed to fund the program is collected, collections will be allocated 74.8% to reinsurance payments, 24.9% to payments to the Treasury, and 0.3% to administrative expenses
  - If more than the full \$12.03 BN is collected, 100% of the excess will go to reinsurance payments
  - HHS plans to pay out all reinsurance funds collected for a benefit year by adjusting the coinsurance rate up or down from the 80%, but to no more than 100% and then rolling the balance, if any, over to the next year
  - The Administration is estimating \$0.14 PMPM for expenses associated with administering the Transitional Reinsurance Program

- For 2015, the attachment point will be \$70,000, with a reinsurance cap of \$250,000, and coinsurance of 50%
- The attachment point for 2014 will be reduced from \$60,000 to \$45,000 to recognize lower than expected premiums for reinsurance-eligible plans and “recent policy changes”
- Student health plans are not eligible for payments under the Transitional Reinsurance Program, but will, absent another exception, be required to make the contribution
- For individuals eligible for cost sharing subsidies with single coverage, HHS will subtract from the paid claims amount the difference between the annual limit on cost sharing for the standard plan and the annual limit for the plan variation
  - This will avoid double-counting the payments for cost sharing reduction (CSR) subsidies
  - For policies with multiple members, the difference between the annual limit on the standard plan and the limit for the plan variation will be allocated to members based on paid amounts
- Audits of Reinsurance Programs
  - HHS may conduct financial and programmatic audits of state-run reinsurance programs
  - HHS may audit contributing entities to see that appropriate data were submitted and that the appropriate amounts were paid
  - HHS may audit issuers of reinsurance-eligible plans, focusing on claims records validating the requests for reinsurance payments
- The intent is that the reinsurance contribution be made only once for a covered life
  - Generally, the idea is that the contribution would not be required for plans that are “supplemental” to another plan
  - If it is not clear which plan is supplemental, the plan that offers the greater portion of inpatient hospital benefits would be considered primary
- Because no territory established a Transitional Reinsurance Program, the individuals in the territories will not be eligible to receive reinsurance payments, and therefore contributions will not be required on behalf of enrollees residing in the territories
- Form 5500 counting would be allowed even if the plan year were not a calendar year. Form 5500 counting allows the reporting entity to report the average of the enrollment at the beginning and end of the plan years

### 3. Provisions for the Temporary Risk Corridors

- In the future, HHS may consider multi-state plans QHPs for the purposes of the risk corridor program, provided differences from an issuers’ QHPs are due to OPM rules related to multi-state plans. To date, no such rules have been promulgated by OPM
- For 2014, risk corridor data will be collected using the same form used to collect MLR data, and at the same time (July 31 of the year following)
  - HHS will have post-payment audit authority of QHP issuers, and these audits will be tied to the MLR audits
  - QHP issuers that do not comply with risk corridor provisions may be subject to civil money penalties. Non-compliance with risk corridors data submission requirements may be subject to enforcement actions under the False Claims Act
- A QHP must be subject to the market reform rules and premium rating rules to be considered for the risk corridor program (e.g., exclude stand-alone dental)
  - Eligibility for participation in the risk corridor program will be based on the state and not the Federal definition of small group (The state definition may exclude part-time employees, and so could include some large groups under the Federal definition. Note that this is different from the treatment used in the MLR and risk-adjustment rules)

- For 2014 only, HHS will increase the profit margin floor to offset the effects of the transitional policy allowing carriers to renew non-ACA-compliant policies in 2014
  - HHS believes the effect on the market will vary with the percentage of enrollment in transitional plans, and so will develop an adjustment reflecting this percentage referred to as the “adjustment percentage” on a state-by-state basis
    - The adjustment percentage will only apply to plans with allowable costs greater than 80% of premiums
    - Profits will set be equal to the greater of (1) three percent and the adjustment percentage of after-tax premiums earned, and (2) premiums earned less allowable costs and administrative costs
    - MLR calculations will be done as if the adjustment percentage were zero
    - HHS will collect enrollment data used to set the adjustment percentage at the beginning of 2015.
  - HHS believes allowable costs, including claims, for enrollees in transitional plans would be 80 percent of the allowable costs that would have resulted from the broad risk pool. HHS considers this 80% a “reasonable reflection of the effects of underwriting on the transitional plans” HHS plans to use this assumption in determining the adjustment percentage
  - HHS will require all plans in a state to report the number of small group and non-group enrollees in both transitional and non-transitional plans and it will use that information to establish state-specific adjustments that issuers would use in the risk corridor program; this information will be collected at the beginning of 2015
  - HHS acknowledges that this relief will only flow to QHPs, though the effect of the transitional plans will be felt market-wide
  - HHS projects that the changes made to the program will be budget neutral in 2014 and may make future adjustments to the program, either upward or down, to achieve this goal

#### 4. Distributed Data Collection

- HHS Dedicated Distributed Data Environment Reports
  - HHS plans to send interim reports to plans including preliminary risk scores and reports showing aggregated total claims eligible for reinsurance payments
  - Plans will be required to confirm that the reports accurately reflect the data in its distributed data environment, or it must describe any discrepancies
  - Issuers will be required to update the eligibility and claims files quarterly, but may adjust the files up until April 30 following the benefit year
  - HHS will issue a final report after the April 30 data submission deadline. Issuers would have 15 days to confirm the report is accurate or to notify HHS of discrepancies
  - By June 30 of the year following the benefit year, HHS will provide a final risk adjustment, reinsurance payments, and cost sharing reconciliation report to issuers
- Reporting of Payments and Charges Under Reconsideration
  - Reporting for the purposes of MLR and risk corridor payments will be based on the June 30 reports, even if discrepancies remain
  - Amounts related to discrepancies that are paid or recovered after the June 30 reports are issued would be reported in the following benefit year
- Default Risk Adjustment Charge
  - If an issuer fails to provide sufficient information to allow HHS to calculate a risk adjustment charge, HHS will assess a default risk adjustment charge equal to the number of covered members in a plan multiplied by a default risk adjustment PMPM

- The default risk adjustment PMPM will be equal to the seventy-fifth percentile of the absolute value of the statewide risk transfer payment amounts PMPM for the risk pools and the market
- HHS will monitor the default risk charge methodology and may adjust the percentile in the future
- Good Faith Safe Harbor
  - Civil money penalties (CMPs) will not be applied in 2014 if plans fail to adhere to certain provisions of dedicated distributed data environment provided plans were making a good faith effort in 2014
  - However, CMPs may be applied in 2015, even if the non-compliance in 2015 relates to the 2014 plan year, e.g., the requirement to have final data for 2014 loaded by April 30, 2015

## EXCHANGE ESTABLISHMENT STANDARDS

### 1. Establishment of an Exchange After 2014

- HHS has decreased the time a state must have in effect an approved or conditionally approved Exchange Blueprint and readiness assessment from 12 months to 6.5 months prior to the Exchange's first effective date of coverage
- The deadline for approval of the Exchange Blueprint is June 15th of the previous plan year
- The deadline for States to submit Exchange Blueprint has been moved from November 15th to June 1st

### 2. Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Employers and Employees Enrolling in QHPs

- SHOPs, in States that allow this activity under State law, may permit enrollment in a SHOP QHP through an Internet Website of an agent or broker under the standards outlined in §155.220(c)(3) if a State SHOP or the FFE-SHOP has the technical capability

### 3. Privacy and Security of Personally Identifiable Information

- Section 155.260(a)(1) provides the criteria under which an Exchange may use or disclose Personally Identifiable Information (PII) the Exchange creates or collects
  - HHS has determined that the criteria under this section unduly limits the ability of an Exchange to ensure its efficient operations
  - An Exchange will be permitted to use or disclose eligibility and enrollment PII to ensure the efficient operation of an Exchange that may not be directly connected to the Exchange minimum functions
- The Secretary may approve other uses and disclosures of eligibility and enrollment PII, provided that HHS determines that
  - The information will be used only for the purpose of and to the extent necessary in ensuring the efficient operation of the Exchange consistent with the Affordable Care Act
  - The use and disclosure is appropriate and permissible under relevant law and policy
- Prior to using or disclosing PII, the Exchange would need to obtain consent from the individual
- In certain situations Exchanges are permitted to share PII with "non-Exchange entities"
  - The definition of "non-Exchange entities" is any individual or entity that gains access to PII submitted to an Exchange or collects, uses or discloses PII gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions agreed to with the Exchange
  - Three additional binding privacy and security criteria apply for "non-Exchange entities"
    - Privacy and security standards must be as protective as those standards for the Exchange
    - Privacy and security standards must comply with workforce compliance, written policies and procedures, compliance with the IRS code and consequences of improper use and disclosure



- Privacy and security standards must take into account the operational and technical environment of the non-Exchange entity
- Non-Exchange entities are required to bind any downstream entities to the same privacy and security standards and obligations that the non-Exchange entity has agreed to in its contract or agreement with the Exchange

#### 4. Annual Open Enrollment Period for 2015

- The open enrollment period for 2015 would begin on November 15, 2014 and end on February 15, 2015
  - This would give issuers two additional months before accepting new enrollment and stagger the open enrollment period from the Medicare Advantage plan
- Exchanges would be expected to delay their QHP certifications by one month
- Enrollment must be made by December 15, 2014 for coverage effective January 1, 2015
- Enrollment between December 16, 2014 and January 15, 2015 would have an effective date of February 1, 2015
- Enrollment between January 16, 2015 and February 15, 2015 would have an effective date of March 1, 2015

#### 5. Functions of a SHOP

- For plan years beginning in 2015, FF-SHOPs must provide employers the option of selecting a level of coverage and making all plans within that metal level available to qualified employees
- FF-SHOPs will begin performing premium aggregation services on January 1, 2015 correlating to the employee choice provisions
  - Employers must follow premium payment timelines and processes established by HHS
    - A single standard process will be used for premium calculation, payment, and collection after the SHOP makes the premium aggregation available
    - HHS anticipates premium payments at least 2 days prior to the effectuation date of coverage
    - An FF-SHOP issuer is required to effectuate coverage unless they receive cancellation notice from the FF-SHOP
  - A standard methodology must be used for pro-rating premium in FF-SHOPs for months with partial coverage
    - For coverage less than a full month, the premium must be pro-rated by multiplying the premium times the ratio of the number of days of coverage in the partial month to the number of days in the month
  - Composite rating in FF-SHOPs is prohibited for employers that select the employee choice option
- Small group rates can have mid-year rate changes no more frequently than quarterly; this is a market-wide requirement
  - Issuers must submit rates to HHS 60 days in advance of the effective date
  - Issuers will be able to submit updated quarterly rates for the FF-SHOPs on April 8, 2014 for third quarter 2014
- Employers must be given the flexibility to offer different contribution rates for full-time and non-full-time employees
  - An employer may to define up to four different contributions levels
  - Contributions can vary by the following four categories: full-time employee only, full-time employee dependent, non-full-time employee only and non-full-time employee dependent
  - An employer would not be allowed to require premium contributions in an FF-SHOP be based on a calculated composite premium if the employer elects to offer its employees all QHPs within the employer's selected metal level of coverage

- State-based SHOPS may set their own policy
- Dental stand-alone coverage may be offered using two different approaches
  - The employer could offer a single stand-alone dental plan
  - The employer could offer the choice of all stand-alone dental plans at a given AV dental level
  - Stand-alone dental plans are not permitted to charge different premium rates based on whether the dental plan is the only one offered or whether it is offered alongside many other stand-alone dental plans
  - HHS will not apply minimum participation rules for stand-alone dental plans

#### 6. Eligibility Determination Process for the SHOP

- The SHOP is prohibited from performing any individual market eligibility verifications or determinations including eligibility determinations for advance premium tax credit subsidies and CSR subsidies
- SHOP eligibility adjustment periods for both employers and employees would be limited to cases where there is an inconsistency between the information provided by an applicant and information collected through optional verification methods

#### 7. Application Standards for the SHOP

- The SHOP is prohibited from collecting any information other than what is required to make SHOP eligibility determinations or effectuate enrollment through the SHOP
- The SHOP is explicitly prohibited from performing any individual market eligibility determinations or verifications

## HEALTH INSURANCE ISSUER STANDARDS

### 1. Cost Sharing Provisions

- Provisions must be adjusted annually by the percentage by which average per capita premium for health insurance for the prior year exceeds the average per capita premium for health insurance for 2013. Due to uncertainty in premium growth as a result of influence from changes in benefit design and market composition, the 2015 percentage was calculated to be 4.2%, based on the projected increase of 2014 premium over 2013 premium by the National Health Expenditure Accounts (NHEA) for employer-sponsored coverage
  - Results are rounded to the next lowest multiple of \$50; family provisions are twice the single levels
  - Methodology will be revisited for accuracy as more information becomes available on premium rates
- Maximum out-of-pocket (MOOP) limits for 2015 are \$6,600 for self-only and \$13,200 for other than self-only coverage
  - MOOP limits for CSR plans for self-only coverage are as follows (limits for other than self-only are twice the self-only amounts shown):

FPL	AV	% REDUCTION IN MOOP	2015 MOOP SELF-ONLY	2015 MOOP OTHER THAN SELF-ONLY
100—150%	0.94	2/3	\$2,250	\$4,500
150—200%	0.87	2/3	\$2,250	\$4,500
200—250%	0.73	1/5	\$5,200	\$10,400

- Maximum deductibles for the small group market for 2015 are \$2,050 for self-only and \$4,100 for other than self-only coverage

- These deductible limits may be exceeded where the plan may not reasonably reach the AV of a given level of coverage without exceeding the annual deductible limit
- Cost sharing and MOOPs for non-EHB benefits (including benefits provided out-of-network) in CSR plans may not exceed cost sharing and MOOPs for non-EHB benefits in the standard Silver plan
- If only one zero cost sharing plan variation is submitted, the OOP spending required for each non-EHB benefit must be less than or equal to the lowest OOP spending required for the same benefit among all Silver plan variations
- Issuers may offer CSR plans with reduced cost sharing for non-EHB benefits in order to simplify benefit designs; however, such reductions would not be reimbursed by the Federal government
- Carriers are not required to submit an estimate to HHS for advance CSR payments. Instead, the Exchange will calculate and submit to HHS advance CSR payments for each policy as:

$$\text{Monthly CSR Premium} \times 0.80 \times \frac{1}{\text{Std Plan AV}} \times \text{Induced Demand} \times (\text{CSR AV} - \text{Std Plan AV})$$

- Std Plan AV does not account for any *de minimis* variation (e.g., uses 0.6, 0.7, 0.8, 0.9)
- The CSR AV provided in regulation and does not account for any *de minimis* variation
- Monthly premium in the formula above would include any tobacco loads and other rating factors applied for the individual
- Issuers would no longer need to submit an allocation of expected allowed claims between EHB and non-EHB portions since this will not be used in the calculation

## 2. FFE User Fees

- The rate for 2015 is 3.5% of premium, unchanged from the 2014 fee
- Issuers offering contraceptive coverage to beneficiaries in eligible religious self-insured groups at no cost are eligible for a user fee offset equal to the cost of the contraceptives, plus 15% for administrative costs and margin (increased from 10% in 2014)

## 3. AV Calculation for Coverage Level Determination

- The draft 2015 AV Calculator was not finalized; instead an amended version of the 2014 AV Calculator, in which the only significant change is that the maximum annual limit for MOOP expenses has been increased to \$6,850, is being finalized as the 2015 AV Calculator
- The maximum annual limit for MOOP expenses included in the final 2015 AV Calculator is \$6,850
- Future revisions for additional benefit designs will be made only if the changes in methodology are actuarially sound and have a minimal impact on the AV calculations performed by the existing AV Calculator
- Data underlying the continuance tables will be updated periodically
  - Continuance tables underlying the AV Calculator will not be updated for 2015, but will be reviewed for modification annually starting in 2016
  - Continuance tables will be updated to reflect more current enrollment data when HHS has determined that the enrolled population has changed materially, defined as more than 5 percent different
  - Baseline data underlying the calculator will be updated no more than every three and no less than every five years
  - In years when the underlying data is not updated the current data will be trended if the cumulative trend from the prior data update is more than 5%
  - In years when the underlying claims are not being updated, trend will be based on premium rate data or standard population data, using sources from both the individual and the small group markets to develop a single trend factor; In years when the underlying claims are updated, trend will be based on the updated claims data

- Carriers are allowed to use an alternative AV Calculation method under 156.135(b) for plans where they feel that developing an AV based solely on the cost sharing parameters applicable to an individual does not yield an appropriate AV for a specific family plan

#### 4. Cost Sharing Limits on Stand-alone Dental

- For 2015, stand-alone dental plans may not have annual cost sharing limits greater than \$350 for one covered child and \$700 for two or more covered children
  - This requirement is being imposed on all exchanges. Two state exchanges with current annual limits on cost sharing of \$1,000 for one covered child and \$2,000 for two or more covered children will be impacted
  - Actuarial value requirements of 70 percent or 85 percent will still be required to be met

#### 5. Additional Standards Specific to SHOP

- A small employer in the SHOP that ceases to be a small employer due to an increase in the number of employees may continue to be treated as a small employer or purchase a guaranteed issue policy in the large group market
- Composite premiums are not allowed in the FF-SHOP when the employer chooses a level of coverage and makes all QHPs within that level available to its employees; this includes stand-alone dental plans in the FF-SHOP
- All Exchanges will be allowed to establish standard methods for premium payment and aggregation in the SHOP
- Once premium aggregation becomes available in the FF-SHOP, carriers are required to effectuate coverage unless the FF-SHOP has not received initial premium payment in accordance with the payment timeline and sends a cancellation notice to the issuer. If payment is not received prior to the deadline established for the FF-SHOP, CMS will issue a cancellation notice or, in the case of payments subsequent to the initial premium payment, a termination notice to issuers for non-payment of premium

#### 6. Meaningful Difference in the FFE

- No limit will be set on the number of plans a QHP issuer may offer
- Meaningful difference standards will not apply to stand-alone dental plans
- Two plans within a service area and metal tier are considered meaningfully different if material differences can be identified between one or more of the following characteristics by a reasonable consumer (a difference threshold for the cost sharing metric is not indicated but may be included in the annual issuer letter as it was for 2014 plans)
  - Cost sharing
  - Provider network
  - Covered benefits (including prescription drugs)
  - Plan type (e.g., HMO, PPO)
  - Health savings account eligibility
  - Coverage tier
- Meaningful difference requirements may be waived if the number of plan offerings across all carriers at a given metal level within a county are limited
- A two-year phase in period will be applied for meaningful difference tests among plans of two issuers that merge, allowing them time to restructure their benefit plan designs

#### 7. Quality Standards

- Standards apply to all Exchanges, including state-based Exchanges

- The ACA requires that starting January 1, 2015 a QHP may contract with a hospital with 50 or more beds only if the hospital meets certain patient safety standards
- HHS feels implementing all requirements of this section could result in a shortage of qualified hospitals and providers for contracting with QHPs in 2015 and propose that for a phase-in period equal to the first two years (or until further guidance is issued, if longer):
  - Patient safety standards only apply to Medicare-certified and Medicaid-only hospitals issued a Medicaid-only CMS certification with 50 or more beds
  - QHP issuers may only contract with hospitals that have more than 50 beds if they are Medicare-certified or have been issued a Medicaid-only CCN
    - Must have ongoing quality assessment and performance improvement programs
    - Must have a discharge planning process applicable to all patients
- After the phase-in period, QHP issuers must ensure their contracted hospitals have agreements with PSOs, discharge programs in place, and their providers implement health care quality activities

## 8. Financial Programs

- Payments for various programs will occur on a monthly basis and will include retroactive adjustments for prior months
- Payments and/or charges for the following items will be netted against each other starting in 2015:
  - Advance premium tax credits (APTCs)
  - Advance CSR payments
  - FFE user fees
  - Risk adjustment payments/charges
  - Transitional reinsurance payments/charges
  - Risk corridor payments/charges
  - CSR reconciliation amounts
- Amounts owed to or by multiple QHP issuers under the same tax identification number will be netted
- Issuers must notify HHS within 15 calendar days of any discrepancies in payments
  - Any adjustments will be made in subsequent payments; previous months' payment reports will not be adjusted
  - The full amount of any invoice must be paid each month, even if a discrepancy resolution is pending; if not paid, these amounts could begin to accrue interest or penalties in subsequent months
- Guidance on the timing of reinsurance, risk adjustment, and CSR reconciliation will be issued in the future
- Appeals related to reconsideration of final reconciliation payments must be filed within 60 calendar days after receiving a final reconciliation notification
  - A minimum threshold for material errors to request reconsideration is set at the lesser of 1% of total payments/charges, or \$10,000
  - A request for reconsideration may be submitted only if it specifies the findings/issues/errors and, to the extent it could have been previously identified to CMS, it was so identified and remains unresolved
  - Reconsideration decisions for APTCs, advance CSR payments, and FFE user fees are binding; an informal hearing option before a CMS hearing officer is available for all other reconsideration decisions if a request is made within 30 days of receiving notice of the reconsideration decision
  - If the CMS hearing officer upholds the reconsideration decision, the issuer has 15 calendar days from the date of the CMS hearing officer decision to request a review by the Administrator of CMS
- For MLR and Risk Corridor purposes, the amount of risk adjustment and Transitional Reinsurance payments/charges included in the June 30th report must be used, regardless of whether the amount in dispute.

Oliver Wyman is a global leader in management consulting that combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation.

For more information about the Actuarial Practice of Oliver Wyman, please contact us at [actuaries@oliverwyman.com](mailto:actuaries@oliverwyman.com).

To discuss this summary please contact:

TAMMY TOMCZYK

(414) 223 7988

[tammy.tomczyk@oliverwyman.com](mailto:tammy.tomczyk@oliverwyman.com)

BETH FRITCHEN

(312) 345 3378

[beth.fritchen@oliverwyman.com](mailto:beth.fritchen@oliverwyman.com)

KURT GIESA

(414) 223 2280

[kurt.giesa@oliverwyman.com](mailto:kurt.giesa@oliverwyman.com)

RYAN MUELLER

(414) 277 4680

[ryan.mueller@oliverwyman.com](mailto:ryan.mueller@oliverwyman.com)

[www.oliverwyman.com/actuaries](http://www.oliverwyman.com/actuaries)

Copyright © 2014 Oliver Wyman

All rights reserved. This report may not be reproduced or redistributed, in whole or in part, without the written permission of Oliver Wyman and Oliver Wyman accepts no liability whatsoever for the actions of third parties in this respect.

The information and opinions in this report were prepared by Oliver Wyman. This report is not investment advice and should not be relied on for such advice or as a substitute for consultation with professional accountants, tax, legal or financial advisors. Oliver Wyman has made every effort to use reliable, up-to-date and comprehensive information and analysis, but all information is provided without warranty of any kind, express or implied. Oliver Wyman disclaims any responsibility to update the information or conclusions in this report. Oliver Wyman accepts no liability for any loss arising from any action taken or refrained from as a result of information contained in this report or any reports or sources of information referred to herein, or for any consequential, special or similar damages even if advised of the possibility of such damages. The report is not an offer to buy or sell securities or a solicitation of an offer to buy or sell securities. This report may not be sold without the written consent of Oliver Wyman.