CMS's Final Exchange and Insurance Market Standards Impact Qualified Health Plan Filings for 2015 and Beyond

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On May 16, 2014, the Centers for Medicare & Medicaid Services ("CMS") released a final rule titled "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond" ("Final Rule") addressing requirements for health insurance issuers, Insurance Exchanges ("Exchanges"), Navigators, and others operating under the Affordable Care Act ("ACA"). Issuers, in particular, should become familiar with the requirements of the Final Rule in a timely fashion. Applications to become certified as a 2015 qualified health plan ("QHP") in a federally facilitated exchange ("FFE") are due to the Center for Consumer Information & Insurance Oversight ("CCIIO") by June 27, 2014. Issuers risk losing enrollees if their plan filings submitted to CCIIO fail to comply with the limitations on design changes under the guaranteed renewability requirements, and risk enforcement actions from failing to comply with other aspects of the Final Rule.

The Final Rule, which was published in the May 27, 2014, issue of the *Federal Register* (79 FR 30240), describes the types of design changes that insurers can make in their products under federal guaranteed renewal requirements, allows states to further delay offering employee choice in their Small Business Health Options Program ("SHOP") under certain conditions, and identifies the conditions under which fixed indemnity plans will be exempt from certain ACA requirements. Additionally, the Final Rule provides details on quality reporting requirements; strengthens CMS's enforcement authority regarding quality and casework requirements; requires plans to provide an expedited process to determine whether they must cover non-formulary drugs; adjusts the methodologies for the risk corridor, reinsurance programs and medical loss ratio ("MLR"); foreshadows a more active CMS role in marketing oversight; and provides insight into CMS's perspective on enrollee inducements in the Exchanges.

This Client Alert highlights only a few of the key provisions included in the Final Rule. If you would like to discuss how these and other provisions of the Final Rule may impact your organization in 2014, 2015, or beyond, please contact the authors of this Client Alert or the Epstein Becker Green attorney who regularly handles your legal matters.

Renewal Standards Limit Scope of Plan Changes for 2015

Guaranteed renewability provisions require health insurance issuers offering health insurance coverage in the large, small, or individual group markets to renew or continue in force the coverage at the option of the plan sponsor or individual subscriber. However, an exception allows issuers to modify a plan or an individual product if the modification is made uniformly across all of the plans or products within the market. In the Final Rule, CMS specifies that modifications made uniformly across product offerings solely based on federal or state requirements will satisfy this exception. In addition, other modifications will meet this exception if the revised product is:

- from the same issuer;
- of the same product type (HMO, PPO, etc.);
- covers a majority of the same counties in the service area;
- changes cost sharing based on changes in cost and utilization or to maintain the same level of coverage as a bronze, silver, gold, platinum, or catastrophic plan; and
- offers the same covered benefits, except for changes with a small (no more than 2 percent) impact on rates.

These provisions also apply to product and plan changes for issuers seeking to renew QHP offerings. A product or plan offering that changes beyond the scope of a uniform modification may be considered a new offering. The issuer would then be required to notify current plan sponsors or individual enrollees regarding plan termination and provide information on the availability of other options.

Potential Further Delays in Employee Choice Option in SHOP

The Final Rule makes several changes in rules governing SHOP exchanges for 2015, including rules relating to employer and employee election periods in the SHOP. Perhaps most significantly, the Final Rule allows another year delay in the “employee choice” option for SHOP coverage, subject to certain conditions.

Specifically, the ACA requires that SHOPs allow employers to give employees and dependents the option to choose from among all QHPs (or all stand-alone dental plans) at a given actuarial level (e.g., bronze or silver). CMS previously delayed this SHOP “employee choice” option to January 1, 2015, for the federally facilitated SHOP (FF-SHOP), and allowed state SHOP exchanges the option to delay it until 2015. The delay

has meant that, in most states, employers selecting SHOP coverage in 2014 have had fewer coverage options to make available to employees and dependents.[1]

The Final Rule allows a SHOP to again delay the employee choice option to 2016, but only if a state insurance commissioner submits a written recommendation explaining that delay is in the best interests of small employers, employees, and dependents, given the likelihood that employee choice would lead to higher prices because of insurer beliefs about adverse selection. Further, in the FF-SHOP, the recommendation must be submitted to the U. S. Department of Health and Human Services ("HHS") by June 2, 2014. As of June 3, at least 11 states have asked CMS for permission to not implement the employee choice model in 2015: Alabama, Alaska, Arizona, Kansas, Louisiana, Maine, New Hampshire, North Carolina, Oklahoma, Pennsylvania, and South Carolina.

The preamble to the Final Rule states that HHS anticipates issuing a decision by June 10, 2014, so that issuers can decide whether to participate in the SHOP for a given state. Finally, it is emphasized in the preamble that HHS will not further delay the choice option beyond 2015.

Requirements for Individual Fixed Indemnity Plans to Be Considered "Excepted Benefits"

Certain types of "excepted benefits" are exempt from a variety of federal requirements, including many of the ACA's market reforms. One type of excepted benefit is for hospital indemnity or other fixed indemnity insurance. The Final Rule modifies prior CMS criteria for individual fixed indemnity plans to be considered excepted benefits. Specifically, fixed indemnity plans may be considered excepted benefits if covered under a separate contract or policy of insurance and (1) the benefits are provided only to those with other health coverage considered minimum essential coverage, (2) there is no coordination between the provision of benefits under the indemnity plan and any benefit exclusion under any other health coverage, and (3) the indemnity plan pays benefits at a fixed dollar amount per period of hospitalization or illness and/or per service. Thus, for example, the policy could pay $100/day, $50/visit, $5,000/a particular injury, or $10,000/procedure. Prior CMS guidance required that the plan pay on a per-period basis only.

Details on Quality Reporting and Strengthened Enforcement Authority for Noncompliance with Operational Standards

The Final Rule provides more detailed standards for issuers offering QHPs in both state-based exchanges ("SBEs") and FFEs to collect and report data to support CMS's calculation of ratings for the Quality Rating System ("QRS") and to contract with an HHS-approved vendor to administer the Enrollee Satisfaction Survey to its enrollees. The data collected under each of these processes must be validated prior to submission. The quality ratings and satisfaction survey results must be displayed by both SBEs and FFEs starting in 2016, with 2015 serving as a period of testing for

[1] In the FF-SHOP, employers can offer only a single plan.

issuers and exchanges with respect to reporting and display of ratings. The Final Rule clarifies CMS's enforcement authority over quality compliance by requiring issuers to attest to compliance with these and other operational standards as a condition of certification, emphasizing that CMS will be assessing operational noncompliance as a possible basis for decertification. These standards include operational requirements for handling casework.

Expedited Prescription Drug Exceptions Process Required

All non-grandfathered individual and small group market plans are now required to include an expedited exceptions process as part of their provision of prescription drug benefits under the essential health benefits. Under this process, where an exceptions request is based on "exigent circumstances," an issuer must respond to an expedited exception request no more than 24 hours after receipt. Such circumstances exist where an enrollee is suffering from a health condition that could have significant consequences for the enrollee's life, health, or ability to regain maximum function or when the enrollee is under a course of treatment with a non-formulary drug. A drug approved through this process must continue to be covered throughout the related exigency. What remains unanswered by the Final Rule is how issuers should treat cost-sharing for drugs approved through the exceptions process for purposes of cost-sharing limits. CMS indicates that they will consider such questions for future rulemaking.

Changes to the Reinsurance and Risk Corridor Programs

The Final Rule provides that, in the event of a shortfall in collections for the reinsurance program, CMS will allocate the reinsurance contributions first to the reinsurance payment pool and then to administrative expenses and the Department of the Treasury. The Final Rule also increases the ceiling on allowable administrative costs and the floor on profits by 2 percent in the risk corridors formula to help address unexpected administrative costs and pricing uncertainties.

Changes to the Medical Loss Ratio Requirements

The Final Rule makes several revisions in MLR requirements. Due to the delay of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems ("ICD-10") (implementation to at least October 2015), the Final Rule extends the timeframe for which issuers can include ICD–10 conversion costs in their MLR calculation. The Final Rule also clarifies how issuers would calculate MLRs and rebates in those states that have merged their individual and small group markets. These two MLR revisions also apply to the risk corridors program. The Final Rule also provides for MLR adjustments for issuers providing coverage under the extended transition policy allowing issuers to offer ACA-non-compliant products, or for those that participated in SBEs or FFEs. CMS implemented such adjustments in recognition of the additional and unanticipated expenses that issuers may have incurred in communicating with enrollees, developing and filing new rate filings, and addressing technical issues occurring during the initial months of the Exchange programs.

CMS Review of QHP Issuer Marketing and Perspective on Inducements—Indications of Things to Come?

The preamble discussion foreshadows a possible move toward more active CMS oversight and review of QHP marketing materials, even though CMS has stated that oversight of QHP marketing will generally be left to the states, and provides insight into the agency's perspective on inducements. Current regulations and guidance include CMS recommendations as to content and format regarding accessibility and readability of marketing materials as well as nondiscrimination in marketing generally. The Final Rule governs QHP use of quality ratings information for marketing purposes and suggests, in response to comments, that CMS itself may review marketing materials "as QHP issuer monitoring and oversight activities evolve in future years."

CMS's new standards for Navigators and other marketplace assisters provide further insight into the agency's general view on inducements. The new standards prohibit assister entities from providing gifts, unless they are of nominal value, or providing items that promote third parties as an inducement for enrollment. A gift of nominal value is stated to be worth $15 or less. The key phrase here is "as an inducement for enrollment." The preamble states that assister entities may give nominal gifts, and may give third-party promotional items of unlimited value, to potential enrollees, as long as these items are not used to induce enrollment. QHP issuers may want to consider this language when establishing policies and procedures for their own operations.

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