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CLIENT ALERT

Doing the Cha-Cha on Exchange Rules: CMS Moves Forward on Standardized Plan Offerings but Steps Back from Instituting Minimum Network Adequacy Standards

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March 2016

On March 8, 2016, the Centers for Medicare & Medicaid Services ("CMS") released a final rule titled "Patient Protection and Affordable Care Act; CMS Notice of Benefit and Payment Parameters for 2017" ("Final Rule")[1] setting policies and regulatory standards for health insurance exchanges ("Exchanges") and qualified health plan ("QHP") offerings for the 2017 plan year, which starts January 1, 2017.

CMS declined to finalize the more stringent network adequacy requirements that it previously suggested in its proposed rule, released on December 2, 2015 ("Proposed Rule"),[2] although the agency incorporated other new and revised standards for QHPs. Other CMS proposals from the Proposed Rule were also finalized, including revisions to (i) the grace period and other enrollment-related provisions; (ii) cost-sharing standards; (iii) medical loss ratio ("MLR") requirements; (iv) the rate review program; and (v) the risk adjustment, reinsurance, and risk corridors programs, including the announcement of a public meeting at CMS headquarters in Baltimore on March 31, 2016, on this subject.

This Client Alert discusses the more impactful policies that CMS announced through the Final Rule. Stakeholders should review the Final Rule in its entirety in order to fully assess its impact on their related offerings as they finalize their own QHP applications and/or bid and benefit submissions for Exchange plan year 2017, or work with their upstream QHP to finalize such submissions.

[1] 81 Fed. Reg. 12204 (March 8, 2016), *available at* https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf. CMS released a pre-publication version of this Final Rule on February 29, 2016.
[2] *See* "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017," 80 Fed. Reg. 75487 (Dec. 2, 2015).

The State-Based Exchange on the Federal Platform ("SBE-FP")

CMS is finalizing its proposal to establish the new Exchange model known as the "state-based Exchange on the federal platform" ("SBE-FP") in order to accommodate current states that are employing this approach and in anticipation of additional state transitions. SBE-FPs are state-based Exchanges that use the federal Exchange online platform to perform certain Exchange-related tasks, such as eligibility and enrollment functions, maintenance of IT infrastructure, and certain consumer call center and casework processes. Four states—Hawaii, Nevada, New Mexico, and Oregon—currently use this new model.

SBE-FPs remain responsible at the state level for plan management and consumer support functions. "Plan management" includes certifying QHPs and overseeing QHPs and issuers to ensure that QHP obligations in the following areas are no less strict in a SBE-FP than they are under a federally facilitated Exchange ("FFE"): available up-to-date, complete formulary; network adequacy; essential community providers; meaningful differences; maintenance of records; compliance reviews; and change of ownership.

A state decision to implement a SBE-FP would be carried out through the Exchange Blueprint approval process, with submission of a new or updated Exchange Blueprint at least three months before the annual open enrollment period. At the end of the Blueprint process, a state and the Department of Health and Human Services ("HHS") will enter into a federal platform agreement. CMS intends to release the template agreement and additional guidance on the Blueprint process later this year.

Market Standards for QHPs Offered Through a SBE-FP

With its introduction of the SBE-FP model, CMS is finalizing its proposal that QHPs offered under the model will be subject to the same eligibility and enrollment standards as those offered on the FFE. If an SBE-FP does not substantially enforce these standards, HHS reserves its ability to step in and do so. In response to commenter concerns about state customization abilities, CMS confirmed that the FFE standards would apply only to the SBE-FP market in which the state elects to participate (e.g., only the Small Business Health Options Program ("SHOP") or individual market, or both).

FFE and SBE-FP User Fee

Like states deferring entirely to an FFE, CMS will collect a user fee from issuers on the SBE-FP in order to cover the cost of the federal services provided. For 2017, fee rates will be 3.0 percent of the monthly premium charged by the issuer for each policy in the FFE. CMS has requested a waiver from the Office of Management and Budget for the SBE-FP model to reduce the user fee to 1.5 percent on a transitional basis. Although states may select from a menu of specific services under the SBE-FP model, CMS does not anticipate unbundling the user fee at this time.

Standardized Plan Options

In order to simplify the consumer plan selection process, CMS is finalizing the six standardized plan options set forth in the Proposed Rule that issuers may choose to offer in the individual market Exchanges for plan year 2017. CMS defines a "standardized option" as a QHP with a cost-sharing structure specified by CMS. Each standardized option consists of a fixed deductible, fixed annual limitation on cost sharing, and fixed copayment or coinsurance for a key set of essential health benefits ("EHBs") that comprise a large percentage of the total allowable costs for an average enrollee (i.e., the EHB assessed through the actuarial value calculator plus urgent care).

The six plan options include a bronze plan, a standard silver plan, a gold plan, and three silver plan options at the 73 percent, 87 percent, and 94 percent actuarial levels that correlate to the three cost-sharing reduction plan levels ("silver plan variations"). The general features of the standardized options include:

- four drug formulary tiers (generic, preferred brand, non-preferred brand, and specialty drug tiers), with the option for issuers to offer additional lower-cost tiers, if desired;
- no more than one in-network provider tier;
- certain deductible-exempt services, such as primary care, specialist visits (at the silver and gold plan levels), and generic drugs;
- preference for copayments over coinsurance; and
- standard deductibles of $6,650 for the bronze plan; $3,500 for the standard silver plan; $1,250 for the gold plan; and a range of $250 to $3,000 for the silver plan variations.

An issuer may offer a standardized option at one or more levels of coverage, although, if it chooses to offer the standard silver plan, it also must offer the three associated silver plan variations. An issuer may offer more than one plan for each standardized option within a service area, subject to "meaningful difference standards" (discussed below). Issuers may continue to offer an unlimited number of non-standardized plans, with CMS stating that it will not limit the total number of QHPs that may be sold through an Exchange in a rating area or county, aside from any limitations under the meaningful difference standards and other applicable QHP certification requirements.

In the Final Rule, CMS revised and clarified a number of elements of the standardized plan options that were set forth in the Proposed Rule. For the bronze plan, CMS revised the coinsurance rates for the top three drug tiers and made a technical correction to the actuarial value calculation. The preferred brand drug tier now has a 35 percent coinsurance, the non-preferred brand drug tier now has a 40 percent coinsurance, and the specialty drug tier now has a 45 percent coinsurance (instead of a 50 percent

coinsurance for all three, as set forth in the Proposed Rule). For the standard silver plan, CMS increased the copayment for generic drugs to $15 (instead of $10) and revised the actuarial value calculation. Further, CMS clarified that copayment amounts listed for the drug tiers are for 30-day prescription fills at retail pharmacies, issuers (or their prescription benefit managers) may offer a lower cost-sharing rate for mail-order prescription fills, issuers may create a lower-cost tier for the generic drugs tier for standardized options but may not do so for the three higher drug tiers in the standardized options, and issuers may offer the standardized options as family plans by doubling the maximum annual limitation on cost sharing and doubling the deductible.

With respect to the display of standardized options on the Exchanges, CMS is conducting consumer testing to help evaluate ways to make it easier for consumers to find and identify standardized plans and to distinguish them from non-standardized plans. CMS is not varying the standardized options by state or by region. State-defined standardized plans that are different from CMS's standardized options will not be displayed in the same manner as the standardized options on the federal platform, even if the only differences are to comply with state laws. Similarly, CMS will not display standardized options designed by the Office of Personnel Management that are applicable only to multistate plan issuers in a differential manner. QHP issuers or web-brokers will not be required to adhere to differential display requirements of standardized options when using a non-Exchange website.

Meaningful Difference Standards

CMS is finalizing its proposal to modify the meaningful difference standards currently applicable to QHPs on the federal Exchanges. For instance, CMS is removing health savings account eligibility as an option for meeting the meaningful difference standard since this criterion overlaps with the cost-sharing criterion (i.e., a plan that meets the meaningful difference standard for health savings account eligibility also meets the standard under the cost-sharing criterion). In addition, CMS is removing the "self-only" (i.e., individual coverage) and "non-self-only" (i.e., enrollee group or family coverage) criteria from the meaningful difference standard because the allowance of dependents is the only difference between such plans, and these statuses alone are not indicative of meaningful differences among QHPs. CMS is maintaining the "child-only" and "non-child-only" statuses, as CMS expects that there would be meaningful differences between such plans.

Additional Required Benefits

Under Section 1311(d)(3)(B) of the Affordable Care Act, states may mandate that QHPs cover additional benefits over and above EHBs. Those benefit mandates enacted after December 31, 2011, that are not directly attributable to federal EHB compliance are not considered EHBs and states must defray enrollee costs associated with these additional benefits. CMS clarified that such additional benefits mandated on or before December 31, 2011, are considered EHBs. For benefits mandated after this date, while a state would not need to defray costs if the additional requirements apply only to non-QHP

markets, CMS cautions states that Title I standards must apply uniformly under Section 1252 of the Affordable Care Act.

Exceptions Process for Non-Formulary Drugs

CMS is finalizing its proposal to revise EHB prescription drug requirements. CMS requires plans to provide an exceptions process to enable enrollees to request coverage of non-formulary, but clinically appropriate, drugs. However, some states have coverage appeals laws or regulations that are more stringent than, or are in conflict with, the regulatory exceptions process. Through the Final Rule, CMS amends the regulations to provide that an issuer, which complies with its state coverage appeals laws or regulations, is considered to comply with the requirement to offer an exceptions process if its state coverage appeals laws or regulations (i) are more stringent than, or in conflict with, the exceptions process requirements and (ii) provide a process for enrollees to request and access non-formulary drugs. Under this process, plans also must provide for standard internal review, external review, and expedited review processes separate and apart from the existing coverage appeals processes. Excepted drugs assessed under this alternate process are treated as EHBs and must count toward annual cost sharing and a plan's actuarial value.

Network Adequacy

In the Final Rule, CMS backed away from its proposal to specify new minimum quantitative network adequacy metrics in the FFE market. Current network adequacy rules employ a broad standard requiring simply that "a network [be] sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[3] Instead of adopting the more stringent proposed standards, CMS provides that it will defer to states and their potential adoption of the standards included in the National Association of Insurance Commissioners' ("NAIC's") Health Benefit Plan Network Access and Adequacy Model Act ("NAIC Network Adequacy Model Act").[4] Noting that the NAIC Network Adequacy Model Act highlights quantitative standards, including minimum numbers of providers as well as limits on travel and wait times, CMS announced its expectation that states will actively implement these provisions and that the agency would be monitoring states' progress in this area.

CMS announced its intention to revisit the network adequacy proposals announced in the Proposed Rule. Meanwhile, CMS will continue to apply its current approach to network adequacy review, which expects networks to ensure reasonable access. CMS further stated that it is taking steps to implement consumer network adequacy ratings for future open enrollment periods that would advise consumers of the breadth of a

[3] 45 C.F.R. 156.230(a)(2).
[4] The NAIC Network Adequacy Model Act is available at http:// www.naic.org/store/free/MDL-74.pdf.

plan's network. Additional details on these ratings are contained in the 2017 Letter to Issuers.[5]

Although it declined to adopt quantitative network adequacy standards, CMS is finalizing several specific network adequacy requirements. Issuers in the FFE must provide enrollees with 30 days' notice of termination before their providers' contracts are terminated and must ensure continuity of care where enrollees are under active treatment by a terminated provider. CMS is also finalizing several proposals to curb surprise billing, as discussed below.

Third-Party Payment of QHP Premiums

Regulations at 45 C.F.R. 156.1250 state that an issuer offering individual market QHPs, including stand-alone dental plans ("SADPs"), must accept premium and cost-sharing payments from third-party entities on behalf of plan enrollees; such third-party entities include the Ryan White HIV/AIDS program, Indian tribes, and state and federal government programs. CMS is finalizing its proposal to clarify that the reference to "state and federal government programs" in the Final Rule includes programs of the political subdivisions of the state, namely counties and municipalities, which are referred to as "local governments." Further, if a federal, state, or local government is authorized to administer its premium and cost-sharing assistance through grantees or sub-grantees, the payments may not be rejected on the grounds that they came from the grantee or sub-grantee and not directly from the government program.

CMS is also clarifying that while issuers offering individual market QHPs, including SADPs, generally do not collect cost-sharing payments, their downstream entities, or agents of the issuer, are required to accept third-party cost-sharing payments made by the entities listed at Section 156.1250 on behalf of QHP enrollees if the downstream entities or agents routinely accept cost-sharing payments from enrollees. An agent of the QHP issuer with a mail-order pharmacy, including a prescription benefit manager with a mail-order pharmacy, must accept the third-party cost-sharing payments directly from the entities listed at Section 156.1250.

CMS is considering whether to expand the list of entities from which issuers are required to accept payment under Section 156.1250 to include not-for-profit charitable organizations, subject to certain guardrails intended to minimize risk pool impacts, such as limiting assistance to individuals not eligible for other minimum essential coverage and requiring assistance until the end of the calendar year. CMS will address this in future rulemaking.

[5] Center for Consumer Information and Insurance Oversight and Centers for Medicare & Medicaid Services, 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf.

Patient Safety Standards

For plan years beginning on or after January 1, 2017, a QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital uses a "patient safety evaluation system," as defined in 42 C.F.R. 3.20. Further, the QHP issuer must ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement, in order to improve care coordination and health care quality for each patient. Documentation to demonstrate compliance with the discharge planning requirement (for example, the hospital's CMS Certification Numbers, or "CCN") would be submitted to an Exchange, upon request by the Exchange.

CMS has established reasonable exceptions to the QHP issuer's patient safety requirements. Specifically, for plan years beginning on or after January 1, 2017, QHP issuers must verify that their applicable contracted hospitals with greater than 50 beds (that are not working with a patient safety organization ("PSO")) implement an evidence-based initiative that improves health care quality through the collection, management, and analysis of patient safety events and reduces all-cause preventable harm, prevents hospital readmission, and improves care coordination.

CMS clarified that the evidence-based initiatives described in this reasonable exception provision are not intended to address all aspects of all-cause preventable harm, hospital readmission, care coordination, and health care quality in one single initiative. CMS does not intend to provide an exhaustive list of initiatives to allow for flexibility and innovation for future advances in patient safety.

Plan Certification and Best Interest Standards

CMS clarified that QHPs meeting minimum certification standards may still be denied certification if they are not in the "interest of the qualified individuals and qualified employers." CMS intends to take a measured approach in denying certification in this manner. Denials would mostly result from material noncompliance with certification requirements, financial insolvency, and data errors in applications and submissions. CMS assured concerned commenters that it intends to certify the vast majority of plans meeting certification standards.

Small Business Health Options Program

CMS is finalizing its proposal that federally facilitated Small Business Health Options Program ("FF-SHOPS") will offer "vertical choice" in plan years beginning on or after January 1, 2017. This will permit employers to offer a choice of plans at all available coverage levels from a single issuer. States utilizing the federal platform for SHOP may recommend against the vertical choice offering in that state with written justification to CMS in advance of the annual QHP certification deadline. States operating a SHOP will not be obligated to offer vertical choice.

CMS modified premium payment policies in the SHOP. CMS also finalized the following requirements: (i) SHOP issuers must continue group coverage outside the SHOP where an employer terminates SHOP enrollment, (ii) SHOP employers must provide employees with an open enrollment period of at least one week, and (iii) employees must receive 90 days' notice before dependents age off of plans.

Premium Adjustment Percentage, Cost-Sharing Reductions

As required under the Affordable Care Act, CMS finalized the premium adjustment percentage and cost-sharing limitations for 2017. Maximum cost-sharing amounts for 2017 will be set at $7,150 for self-only coverage and $14,300 for other than self-only coverage. A typical silver level self-only PPO plan would feature a $2,175 deductible and 20 percent in-network coinsurance rate. A similar HMO plan would feature a slightly higher deductible and additional cost sharing for certain services outside the deductible and coinsurance.

Rate Review

CMS is finalizing its proposal about adjustments to standards for rate increases subject to review in order to cover a rate increase for a single risk pool if the average increase for all enrollees weighted by premium volume for any plan within the product meets or exceeds the applicable rate increase threshold.

The agency was concerned that currently, an increase in the plan-adjusted index rate would not reflect changes to adjustment factors for rating areas, age, or tobacco use, leading to some members receiving a larger rate increase.

CMS is finalizing its proposal to collect and publicize a Unified Rate Review Template from all issuers offering single risk pool coverage in the individual and small-group market, regardless of whether there is a proposed rate increase, decrease, or unchanged rates, as well as rates for new plans. CMS cites authority for expanding this requirement beyond proposed premium increases to Section 1003 of the Affordable Care Act requiring the Secretary of HHS to monitor premium increases and ensure "that consumers get value for their dollars."

Rating Areas

CMS declined to require more uniformity in the size of state-established rating areas or to establish a minimum size for rating areas. In the Proposed Rule, CMS had noted wide variation in the size of rating areas among the various states, a circumstance that CMS believed could lead to pockets of smaller rating areas with higher-risk groups.

Annual Eligibility Redetermination

CMS previously established a renewal and reenrollment hierarchy to minimize potential enrollment disruptions. To further minimize potential disruptions of enrollee eligibility for

cost-sharing reductions, CMS finalized the creation of a new reenrollment hierarchy for all enrollees in a silver-level QHP that is no longer available for reenrollment. Through the Proposed Rule, CMS sought comment on whether the hierarchy, together with rules related to guaranteed renewability, should permit a QHP enrollee to be automatically reenrolled into a plan not available through an Exchange, and under what circumstances such a reenrollment should occur.

CMS was sympathetic to commenters who believed that enrollees should return to the FFEs to actively reenroll in the coverage that best fits their needs. However, CMS recognized that automatic reenrollment hierarchies must exist to help those who do not take advantage of the opportunity to actively choose coverage. Therefore, while acknowledging that reenrollment between products can result in disruption to provider networks, benefits, and continuity of care, CMS believed it was important to maintain enrollees' access to cost-sharing reductions in silver plans, which might be vital to their ability to pay for coverage or care. CMS finalized this provision largely as proposed.

CMS is finalizing its proposal that would provide for auto-reenrollment through the Exchange, as opposed to permitting auto-reenrollment outside the Exchange. Whenever feasible, the Exchange will, and the FFE will attempt to, reenroll enrollees in silver metal-level QHPs no longer available through the Exchange into the silver metal-level QHP offered by another QHP through the Exchanges of the same product network type with the lowest premium. If the QHPs that have become unavailable are in metal levels other than silver, then, whenever feasible, the Exchange should, and the FFE will seek to, reenroll the affected enrollees in the QHP available on the Exchange from the same metal level of the same product network type with the lowest premium.

Nonpayment of Premiums

CMS identified the need for additional flexibility for issuers to establish reasonable policies regarding premium collection that would permit issuers to collect a minimal amount of premium less than that which is owed without necessarily triggering the consequences for nonpayment of premiums. CMS proposed to provide flexibility to allow issuers the option to adopt a premium payment threshold policy to avoid situations in which an enrollee who owes only a de minimis amount of premium has his or her enrollment terminated for nonpayment of premiums.

Accordingly, CMS is finalizing these policies to give additional issuer flexibility to determine when amounts collected would be considered to satisfy the obligation to pay amounts due, so long as issuers implement such a policy uniformly and without regard to health status, and the premium payment threshold adopted is reasonable. This change will allow issuers flexibility to (i) effectuate an enrollment, (ii) not place an enrollee in a grace period for failure to pay 100 percent of the amount due, and (iii) not terminate enrollments after exhaustion of the applicable grace period for enrollees.

The Final Rule also gives issuers flexibility to set binder payment deadlines within a set of parameters that CMS believes balances concerns about consumer protection and

issuers' desire to have flexibility regarding business decisions. CMS also notes that the Final Rule allows issuers to set the binder payment deadline on the coverage effective date but not on a date earlier than the coverage effective date.

Any amount that is unpaid but within the tolerance of a reasonable premium payment threshold established by an issuer remains an amount owed by the enrollee and cannot be forgiven by the issuer. This remains true whether the premium payment threshold is utilized for any of the following payments: binder payments, regularly billed payments, or amounts owed by an enrollee while in a grace period.

Also, CMS does not wish to make the premium payment threshold a mandatory policy or to set a mandatory threshold at a fixed percentage, as specific facts may justify a higher or lower one. As the premium payment threshold policy is implemented at the option of each issuer, CMS does not believe there is a reason to delay implementation of this section of the Final Rule due to operational complexity.

Annual Open Enrollment Period

CMS finalized the dates for the open enrollment period for coverage year 2017 as November 1, 2016, through January 31, 2017, as well as the coverage effective dates for the benefit year beginning January 1, 2017. The agency proposed this time period and these coverage effective dates to remain consistent with the 2016 open enrollment period. This timeframe will continue to partially overlap with the annual open enrollment period for Medicare and most employer offerings, which will benefit consumers by facilitating smooth transitions between coverage and creating process efficiencies for issuers handling enrollments and reenrollments during the same period.

CMS is similarly defining the open enrollment period for coverage year 2018 to be November 1, 2017, through January 31, 2018. However, CMS plans to shift to an earlier open enrollment end date for the 2019 open enrollment period and all future open enrollment periods. Starting with the 2019 coverage year and beyond, CMS is setting an open enrollment period that runs through December 15. This change achieves CMS's goals of shifting to an earlier open enrollment so that all consumers who enroll during this time will receive a full year of coverage and reducing selection risk for issuers. CMS believes that shifting the open enrollment period end date to December 15 for the 2019 coverage year provides sufficient time for all entities involved in the annual open enrollment period process to make the necessary adjustments to meet this earlier deadline. CMS also believes that, as the Exchanges grow and mature, a month-and-a-half open enrollment period provides sufficient time for consumers to enroll in or change QHPs for the upcoming coverage year.

Special Enrollment Periods

CMS is not finalizing new qualifying events, eliminating current qualifying events, or changing the scope of current qualifying events for special enrollment periods at this time, but it is continuing to study these issues. CMS intends to conduct an assessment

of QHP enrollments that have been made through special enrollment periods in the FFE to ensure that consumers properly accessed coverage. The agency will require documentation for select special enrollment periods going forward.

Three-Month Grace Period

CMS is finalizing its amendment to regulations about termination of coverage or enrollment for enrollees who receive advance payments of the premium tax credit ("APTC") but fail to timely pay premiums. The amendment eliminates language limiting the three-month grace period for enrollees who are receiving APTC to only those enrollees who made a payment during the benefit year. Finally, CMS is finalizing that a QHP issuer may not terminate enrollment for nonpayment of premium of an enrollee receiving APTC if the enrollee satisfies the requirement to pay all outstanding premiums or, if applicable, an issuer's premium payment threshold.

Surprise Bills

Many commenters supported CMS's proposal to address surprise out-of-pocket costs for consumers. However, several commenters asked that states be given the time and discretion to implement network adequacy standards. Others requested that CMS adopt NAIC Network Adequacy Model Act provisions. Concerns were raised that the proposal could have unintended consequences, such as disincentivizing providers from contracting with issuers in order to be able to balance billing charges, or incentivizing consumers and out-of-network providers to elect to perform procedures at an in-network facility.

CMS is finalizing, for 2018 and later benefit years, an amendment to its regulations to count services provided by out-of-network ancillary providers at in-network facilities towards the annual limitation on cost sharing if the issuer does not provide timely written notice to its enrollee. CMS's intent in delaying the effective date of this policy until the 2018 benefit year is to permit the agency to monitor ongoing efforts by issuers and providers to address the issue of surprise out-of-network cost sharing at in-network facilities across all CMS programs in a holistic manner. Also, CMS will amend its policy in the future to accommodate progress on this issue, if warranted. CMS's proposal is not intended to, and does not, preempt any state laws on this topic.

CMS stated that notice would be considered timely if provided by the longer of the issuer's prior authorization timeline (that is, when the issuer would typically respond to an enrollee's prior authorization request) or 48 hours. A form notice may be used and must inform the enrollee, in relevant circumstances, that additional costs may be incurred for an EHB provided by an out-of-network ancillary provider who is working in an in-network setting, including balance billing charges, unless such costs are prohibited under state law, and that any additional charges may not count toward the in-network annual limitation on patient cost sharing.

While CMS is not requiring that customized information be provided to the enrollee in such circumstances, including information on available network providers, costs, and how a consumer could appeal a determination, the agency strongly encourages QHP issuers to provide that type of information.

CMS clarified that the surprise bill protections apply to QHPs both on and off Exchanges, including those QHPs with tiered networks, but they do not apply to QHPs that do not cover out-of-network services. Such protections also do not apply to emergency services, which are governed by other federal regulations. It is worth noting, however, that SADPs must comply with these requirements, as they are required to meet all QHP certification standards, although CMS stated that instances in which surprise bill protections would apply for these types of plans would be rare.

Impact of Sequestration

Both the transitional reinsurance program and the permanent risk adjustment program are subject to the fiscal year ("FY") 2016 sequestration (beginning on October 1, 2015). The reinsurance program will be sequestered at a rate of 6.8 percent for payments made from FY 2016 resources (i.e., funds collected during FY 2016). CMS will sequester risk adjustment payments made using FY 2016 resources in all states in which CMS operates risk adjustment at a rate of 7.0 percent. If Congress does not enact deficit-reduction provisions that replace sequestration, these programs will be sequestered in future FYs, and any sequestered funding will become available in the FY following that in which it was sequestered (e.g., funds that are sequestered in FY 2016 from the reinsurance and risk adjustment programs will become available for payment to issuers in FY 2017 without further Congressional action).

The Three Rs: Risk Adjustment, Reinsurance, and Risk Corridors

Risk Adjustment. The CMS risk adjustment models predict annualized plan liability expenditures using age and sex categories and hierarchical condition categories ("HCCs"). For the 2017 benefit year, CMS is updating the risk factors in the risk adjustment model using the Truven Health Analytics 2012, 2013, and 2014 MarketScan® Commercial Claims and Encounters database. CMS also is finalizing more accurate model coefficients for the risk adjustment methodology, including:

- the incorporation of preventive services into the simulation of plan liability in the recalibration of the risk adjustment models for 2017, using procedure and diagnosis codes, prescription drug therapeutic classes, and enrollee age and sex; and

- the incorporation of more granular trend rates into the risk adjustment methodology for (i) medical and surgical expenditures, (ii) traditional prescription drug expenditures, and (iii) specialty prescription drug expenditures.

If a state is not approved to operate, or chooses to forgo operating, its own risk adjustment program, CMS will operate the risk adjustment program on the state's

behalf. CMS's operation of the risk adjustment program on behalf of states is funded through a risk adjustment user fee. For 2017, CMS has calculated the risk adjustment user fee to be $1.56 per enrollee per year (down from $1.75 in 2016), or $0.13 per member per month. CMS had originally estimated a higher risk adjustment user fee for 2017 but reduced the user fee to reflect lower contract costs and more accurate enrollment projections for the 2017 benefit year.

CMS has announced that it will hold a public conference to discuss potential improvements to the risk adjustment methodology for the 2018 benefit year and beyond. The conference will take place on March 31, 2016, at CMS headquarters in Baltimore, Maryland. The conference will focus on what CMS has learned from the 2014 benefit year about the risk adjustment program and specific areas of potential refinements to the risk adjustment methodology, including prescription drug model exploration, accounting for partial year enrollment, future recalibrations using risk adjustment data, and a discussion of the risk adjustment transfer formula. Prior to the conference, CMS intends to issue a white paper that will be open for public comment. Additional information and registration is available at https://www.regtap.info/.

CMS has identified a number of topic areas that will be discussed in more detail in the white paper and at the upcoming public conference, including:

- potential future improvements to the risk adjustment methodology to ensure fair rating practices across risk pools (i.e., to account for the experiences of new, small, and fast-growing plans);

- better methods of accurately compensating for new treatments for high-cost conditions and modeling the severity of these conditions for high-cost enrollees, including ways to incorporate enrollee-level data for future recalibrations;

- effective methods for incorporating prescription drug data in future recalibrations of the federally certified risk adjustment methodology (i.e., to supplement diagnostic data by using the prescription drug data as a severity indicator, or as a proxy for diagnoses in cases where diagnostic data are likely to be incomplete, without creating incentives to modify discretionary prescribing to artificially increase the severity of diagnoses); and

- ways to make the risk adjustment methodology more predictive for partial-year enrollees, in a manner that accounts for higher-than-expected claims costs for partial-year enrollees, concerns that the methodology does not capture enrollees with chronic conditions who may not have accumulated diagnoses in their partial year enrollment, and the fact that partial-year enrollees are less likely to have spending that exceeds the deductible or annual limitation on cost sharing as compared to full-year enrollees of the same relative risk.

Other areas noted for future consideration included whether use of the geographic cost factor ("GCF") in the payment transfer formula reflects prevailing utilization and expenditure patterns in the geographic location of the plan's enrollees, and whether

accounting for socioeconomic status is feasible in the risk adjustment model in the future. CMS also stated that it will consider ways to enhance the risk adjustment data validation ("RADV") audits in operationally feasible ways without infringing on states' primary regulatory and oversight authority over health insurance issuers.

Reinsurance. Reinsurance payments are made to issuers of reinsurance-eligible plans for a portion of an enrollee's claims costs paid by the issuer (the coinsurance rate) that exceeds an attachment point (when reinsurance would begin), subject to a reinsurance cap (when the reinsurance program stops paying claims for a high-cost individual). The coinsurance rate, attachment point, and reinsurance cap together constitute the uniform reinsurance payment parameters.

CMS is finalizing its proposal that, if any reinsurance contribution amounts remain after calculating reinsurance payments for the 2016 benefit year (including after CMS increases the coinsurance rate from 50 to 100 percent for the 2016 benefit year), then CMS would lower the 2016 attachment point of $90,000 to pay out any remaining contribution amounts for the 2016 benefit year in an equitable manner. The final attachment point and coinsurance rate for the 2016 benefit year will be calculated based on total available reinsurance collections and accepted reinsurance payment requests.

Further, CMS has the authority to audit a contributing entity to assess compliance with the reinsurance program requirements. CMS is finalizing a requirement that a contributing entity that chooses to use a third party to assist with its obligations under the reinsurance program must ensure that such third party cooperates with any audits of the contributing entity's compliance under the reinsurance program. CMS also had proposed to extend the audit authority to such third parties directly but did not finalize that requirement.

Risk Corridors. CMS is finalizing the requirement that, for 2015 risk corridors and MLR reporting, if an issuer reported a certified estimate of 2014 cost-sharing reductions on its 2014 MLR and Risk Corridors Annual Reporting Form that is lower than the actual cost-sharing reductions provided for the 2014 benefit year, then CMS will make an adjustment to the issuer's 2015 risk corridors payment or charge amount in order to address the impact of the inaccurate reporting on the risk corridors and MLR calculations for the 2014 benefit year. CMS is also requiring the issuer to adjust the cost-sharing reduction amounts that it reports for the 2015 MLR and risk corridors reporting cycle by any difference between 2014 reported and actual cost-sharing reduction amounts.

For 2015 and later benefit years, CMS is finalizing the requirement that the issuer must true up claims liabilities and reserves used to determine the allowable costs reported for the risk corridors program for the preceding benefit year to reflect the actual claims payments made through June 30 of the year following the benefit year. CMS sought comments on the most appropriate way to true up estimates of unpaid claims for 2016 (e.g., by providing for a 2017 payment or charge calculated with the 2018 MLR, providing for a simplified true-up process, requiring that the 2016 estimate be based on

actual 2014 and 2015 amounts, or providing for no true-up at all in the final year); however, CMS did not address the true-up of 2016 experience in the Final Rule.

Good Faith Safe Harbor

CMS is permitted to impose civil money penalties ("CMPs") upon issuers of risk adjustment-covered plans and reinsurance-eligible plans for failure to adhere to certain standards relating to their dedicated distributed data environments. CMS previously applied a "good faith" test to an issuer's efforts to comply with these standards when determining whether to impose CMPs for noncompliance in 2014 and 2015. Starting in 2016 and beyond, CMPs may be imposed if an issuer of a risk adjustment-covered plan or reinsurance-eligible plan fails to (i) establish a dedicated distributed data environment in a timeframe and manner specified by CMS; (ii) provide CMS with access to the required data in such environment; (iii) adhere to the reinsurance data submission requirements; or (iv) adhere to the risk adjustment data submission and data storage requirements, even if the issuer has made good faith efforts to comply with these requirements.

The agency is not extending the "good faith" safe harbor to cover conduct throughout 2016 or in later years (including with respect to activities that occur in 2016 or later relating to data from earlier benefit years), but the agency did clarify that CMPs will not be imposed in 2016 or later based on activities that occurred in 2014 or 2015 if the issuer acted in good faith at that time.

Administrative Appeals and Enforcement Remedies

CMS has established an administrative appeals process for issuers, including a request for reconsideration, a request for an informal hearing before a CMS hearing officer, and a request for review by the Administrator of CMS. The administrative appeals process may be used to address issues related to the risk adjustment, reinsurance, and risk corridors programs, as well as issues related to the premium tax credit and cost-sharing reduction portions of the advance payments, or FFE user fee charges. CMS has determined that the administrative appeals process also will apply to user fee payments that CMS collects from SBE-FP QHP issuers that offer plans on an SBE-FP.

An issuer may file a request for reconsideration related to risk adjustment or reinsurance based only on the following: a processing error by CMS, CMS's incorrect application of the relevant methodology, or CMS's mathematical error. An issuer may not file a request for reconsideration related to errors made by the issuer (e.g., issues arising from the issuer's failure to load complete and accurate data to its dedicated distributed data environment within the data submission window).
A request for reconsideration must be filed in accordance with the following timeframes:

- for the premium tax credit and cost-sharing reduction portions of the advance payments, or FFE user fee charges, within 60 calendar days after the date of the

final reconsideration notification specifying the aggregate amount of such advance payments or user fees for the applicable benefit year;

- for a risk adjustment payment or charge, including an assessment of risk adjustment user fees, within 30 calendar days of the date of the notification;
- for a reinsurance payment, within 30 calendar days of the date of the notification;
- for a default risk adjustment charge, within 30 calendar days of the date of the notification of such charge;
- for reconciliation of the cost-sharing reduction portion of the advance payments, within 60 calendar days of the date of the notification of such payment or charge; and
- for a risk corridors payment or charge, within 30 calendar days of the date of the notification of such payment or charge.

Additionally, an issuer must pay the full amount owed to CMS as set forth in the applicable notification, even if the issuer files a request for reconsideration. Failure to pay an amount owed will result in interest accruing after the applicable payment deadline.

CMS also finalized proposed changes to FFE enforcement rules. Plan appeals of CMPs will now automatically suspend the assessment of CMPs until a final administrative decision is made. CMS clarified the effect of appeals on effective dates of a plan's decertification, and it will exempt plans from sanctions if they have made good faith effort to comply with requirements in 2014 and 2015. However, CMS declined commenter requests to continue the good faith compliance policy into 2016 and stated its intent to use a "progressive compliance model" going forward. Finally, CMS added new bases for decertification, including impeding displaying plans properly to consumers and a pending state enforcement action.

Medical Loss Ratio

CMS did not finalize its proposal to amend the reporting requirements for incurred claims for the MLR calculation. Currently, insurers must meet specified targets for the amount of premiums spent on medical claims and activities related to quality of care relative to administrative expenses. Part of the medical claims calculation includes the amount of estimated unpaid claim reserves. CMS had proposed to amend the definition of "medical loss ratio" to provide that unpaid claim reserves be reported at a six-month (as opposed to the current three-month) run-out period. CMS agreed with public comments suggesting that it may be more beneficial for all stakeholders if the agency does not modify the run-out period at this time but rather explores ways to restore the earlier MLR deadlines after two of the three premium stabilization programs expire.

The agency also sought comments on whether to modify the treatment of an insurer's investments in fraud prevention activities for purposes of MLR calculations. CMS decided not to adopt any changes to the treatment of fraud prevention activities for MLR purposes, based on consideration of the public comments suggesting that fraud prevention is principally a cost-containment activity (which generally is not permitted in the MLR calculation), that the NAIC has not changed its views regarding inclusion of fraud prevention as an adjustment to incurred claims, and that the treatment of fraud prevention may be addressed during the NAIC's review of quality improvement activities that is currently under way.

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This Client Alert was authored by **Helaine I. Fingold, Lesley R. Yeung, Jackie Selby, Basil H. Kim, Philo D. Hall,** *and* **Richard H. Hughes IV.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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