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REFORM Update

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The Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (DHHS) recently proposed rules for the following health care reform requirements:

- Premium stabilization programs
  - Risk adjustment program
  - Reinsurance program
  - Risk corridor program
- Premium assistance and cost-sharing reductions under the Exchange
- User fees for federally-facilitated Exchanges
- Federally-facilitated Small Business Health Option Program (SHOP)
- Modifications to medical loss ratio requirements

CMS and DHHS have requested comments on these proposed regulations.

Premium Stabilization Programs

The individual insurance market will change dramatically in 2014. State-launched Exchanges will be a new marketplace for individual and small group health insurance coverage. If a state fails to establish an Exchange, the federal government will administer a state Exchange on its behalf. States can also administer the Exchange along with the federal government.

In 2014, the rating rules for the individual and small group markets will also change radically. Our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_55.pdf discusses these changes. The new rating rules, coupled with premium assistance for low- and moderate-income individuals, will create some uncertainty in the insurance market. Insurance carriers will have more individual members. At the same time, they will need to adjust the process they use to determine rates.

Programs to stabilize premiums will reduce the uncertainty and limit the risk for insurance carriers in 2014 and beyond.

Risk adjustment program

The risk adjustment program is a permanent program that increases payments to health insurers who cover people at higher-risk, such as the chronically ill. The program will also reduce the incentives for carriers to avoid covering higher-risk candidates. It will lower the possible impact of adverse selection in the individual and small group market.

This program will apply to individual and small group health plans in and outside the Exchanges. The program will transfer funds from lower-risk, non-grandfathered plans to higher-risk, non-grandfathered plans. The federal government will establish the program's administrative standards. For a federally-facilitated Exchange, DHHS will operate the risk adjustment program. A state-operated Exchange can defer administration to DHHS. A state that operates its own Exchange may establish a risk adjustment program. The state can use the method DHHS developed to manage the program or it may submit an alternative to DHHS for approval.

DHHS proposes to charge a per capita fee administration fee to insurance carriers that the risk adjustment program covers. The fee will cover administrative expenses in states where DHHS operates the program. DHHS anticipates that the fee will be no more than $1 per enrollee per year.

The general method used for this program will require a plan to determine an average risk score. The average risk score represents the plan's overall risk exposure. This score will be based on the relative average risk of a plan's enrollees. A payment transfer formula will calculate whether a plan receives a risk adjustment payment, or is assessed a risk adjustment charge. The rules also set forth the data collection process and the timing for data collections related to this program. A validation process will be adopted to make sure the data used to administer this program is correct.

The details for calculating the average risk score and the application of the payment transfer formula are complex. Employers do not need to understand the particulars. However, they do need to recognize that the risk adjustment program should help stabilize the premiums in the individual and small group market, beginning in 2014.

Reinsurance program

The transitional reinsurance program is a temporary program that will apply from 2014 through 2016. It will reduce the risk of insuring individuals by partially offsetting the expense of high-cost claimants. The reinsurance program covers only non-grandfathered, individual insurance plans. However, group health plans will be responsible for funding the program.

The program will pay individual health insurance carriers for eligible claims. DHHS will collect the reinsurance contributions from contributing entities. Contributing entities will include group health insurance carriers and third party administrators (TPAs) on behalf of self-insured group health plans. A self-insured, self-administered health plan would be required to contribute directly. The contribution will be a per capita, uniform contribution rate throughout the country.

The national contribution rate will be published in the annual HHS notice of benefit and payment parameters. Health care reform specifies that $10 billion will be funded in 2014, $6 billion in 2015 and $4 billion in 2016. The national contribution rate will be $5.25 per covered life per month, or $63 per covered life per year in 2014.

Contributions will be paid annually. Contributing entities will submit the average number of covered lives to DHHS by November 15 in 2014, 2015 and 2016. By December 15, DHHS will notify contributors of the amount that needs to be paid. Contributing entities will then have 30 days to pay.

Group health plans, specifically plans offering comprehensive health plan coverage, must contribute. If an individual is covered under both a group health plan and Medicare, the Medicare Secondary Payer rules will be used to assess whether the individual should be counted. If the group health plan is the primary payer for a member, then that member should be counted for contributions to the reinsurance

program. But if the group health plan is secondary to Medicare, then that member **should not be** counted for reinsurance contributions.

For plans offering a Health Reimbursement Arrangement (HRA) that coordinates with a comprehensive medical plan, the HRA is not required to pay reinsurance contributions. However, the underlying comprehensive medical plan will be subject to the reinsurance contributions.

Plans that **will not** be subject to the reinsurance contribution include:

- Coverage limited in scope, such as dread disease, critical illness, and so on.
- Coverage under an expatriate plan, a group plan that covers employees who perform substantially all work outside the United States.
- Any plans considered excepted benefits under PHS Section 2791(c), which generally means limited-scope benefits under a separate contract or requiring a separate election and separate contribution. Stand-alone dental and vision plans would be considered excepted benefits.
- Health Savings Accounts (HSAs), because they are not considered medical plans.
- Health Flexible Spending Accounts (FSAs), because coverage is not considered comprehensive due to the $2,500 statutory maximum.
- Employee Assistance Programs (EAPs), disease management programs and wellness programs, because these programs are not considered comprehensive coverage.
- Stop loss and indemnity reinsurance policies, because they do not constitute medical coverage.
- Tricare and any other governmental plans.
- Indian tribal coverage, because it is not considered commercial insurance coverage.

The $63 annual contribution will be required for each covered life. To minimize the administrative burden, DHHS will allow counting methods similar to the ones used for Comparative Effectiveness Research (CER) fees. Insurance carriers will determine the counting method for fully insured plans. Self-funded plans should select one of the following methods:

1. **Actual Count Method** – The TPA will add the number of covered lives on each day of the first nine months of the calendar year. The sum of covered lives would be divided by the total number of days in that nine-month period.
2. **Snapshot Factor Method** – The TPA will add the number of lives covered on any date during the same corresponding month in each quarter. The TPA will divide that total by the number of dates used. A plan can select more than one date during the quarter. If more than one date is used for one quarter, then the same number of dates must be used for the other quarters. The dates picked for counts must be in the same week for all three quarters counted. For example, if February 3 is used as a count day, then the second month of the second and third quarters must also be used. In this example, those months would be May and August. The rules also require the dates to fall in the same week, so the other two count dates must be during the first week of May and August. For reinsurance purposes, the first three quarters of the year are used. Employers can count actual covered lives on those dates. However, the snapshot factor method also allows a conversion for calculating

covered lives. Any single coverage elections are counted as one. The number of family elections, however, would be multiplied by 2.35 to estimate covered members.

3. **Form 5500 Method** – The TPA may use data from the Form 5500 for the last applicable plan year. If a plan offers only single coverage, then the TPA would add the total participants covered on the first and last days of the plan year and divide by two. If the plan also covers family members, the TPA would add the total participants covered on the first and last day of the plan year to determine covered lives.

The TPA pays the reinsurance fee. It is not clear whether the employer or the TPA will choose the counting method for a self-funded plan.

In some cases, employers offer employees a choice of several plan options. Employers offering some self-funded options and other fully insured options will need to use the actual count or snapshot method. This restriction is included because the carrier will pay the reinsurance fee for the insured members. The actual count and snapshot methods will count only the members covered under the self-funded plans.

Employers may also use different vendors to deliver benefits under a self-funded medical plan. For example, they may use Blue Cross Blue Shield to administer medical benefits, and Medco for pharmacy benefits. In this situation, the multiple vendors will be treated as a single self-funded plan for reinsurance fee purposes.

Distributions from the reinsurance program will be made annually for qualified claims covered under individual non-grandfathered plans. Since the distributions mitigate costs associated with unpredictable risk from rating rule changes and the new premium subsidies, the program will only be available for individual policy years beginning on or after January 1, 2014.

The reinsurance program will be based on the calendar-year. This will ensure adequate collection of the contributions to preserve fairness in making reinsurance payments. It will also align with the medical loss ratio requirements and the risk corridor program described in the next section.

The reinsurance program will work in the same way as reinsurance (stop loss) works for employer plans. Once member claims exceed the attachment point, a percentage of the claims will be reimbursed until the reinsurance cap is met. The attachment point, coinsurance rate and reinsurance cap are called the payment parameters. They will be changed each year. The 2014 national payment parameters are as follows:

Attachment Point	$60,000
Coinsurance Rate	80%
Reinsurance Cap	$250,000

If the DHHS determines that the total request for reinsurance payments will exceed contributions collected, then reinsurance payments will be adjusted by a uniform, pro rata adjustment rate. If the contributions exceed payments, the excess funds will be used for the next year's reinsurance payments.

Although reinsurance payments will be annual, DHHS will provide eligible plans with quarterly estimates of the expected payments. This will allow insurance carriers to rely on these projections for rate development. Health insurance carriers will be required to submit any data needed for reinsurance claims by April 30th of the following year. For 2014, all claim data for reinsurance claims must be

submitted to DHHS by April 30, 2015. DHHS must notify health carriers of the total amount of reinsurance payments that will be made by the program no later than June 30th of the following year. For 2014, DHHS needs to notify carriers by June 30, 2015.

The federal government will establish annual parameters for the reinsurance program. States can implement an additional reinsurance program to supplement the federal plan. However, the state must fund any modification to the federal benefits. The parameters of any state modifications must be published annually by March 1 of the calendar year prior to the applicable benefit year.

The new regulations recognize that the March 1 deadline might be difficult for the 2014 benefit year. Thus, for 2014 only, states can publish their notice by March 1, 2013 or by the 30th day following the publication of the final HHS notice of benefit and payment parameters, whichever is later. States can opt to collect any additional contributions needed for the state program modifications. If the state chooses not to collect the additional contributions, then DHHS will collect them. The guidance requires states to use these additional funds for reinsurance payments or administrative expenses.

State can modify the national parameters in the following ways:

1. Decreasing the national attachment point
2. Increasing the national reinsurance cap
3. Increasing the national coinsurance rate

States cannot make modifications that would reduce reinsurance payments. State modifications to the national program will wrap the benefits provided under the national plan.

It is anticipated that reinsurance payments in 2014 will decrease premiums between 10 to 15 percent in the individual market. These projected decreases are in comparison to the projected premiums without the reinsurance program.

Risk corridor programs

The risk corridor program is also a temporary program. This federally administered program protects against uncertainty for rate setting in the new individual market. The program limits individual insurance carrier losses and gains. It will apply to qualified health plans offered in the Exchange.

The new regulations explain how the targeted amount will be calculated. The risk corridor ratio is the ratio of allowable costs to the targeted amount. The targeted amount is defined as premiums earned, minus allowable administrative costs. The risk corridor ratio will indicate whether an insurance carrier must pay or receive funds from the risk corridor program.

DHHS **will pay** qualified health plan insurance carriers through this program, in any of the following circumstances:

- The plan's allowable costs for any benefit year are more than 103 percent, but not more than 108 percent, of the targeted amount. DHHS will reimburse 50 percent of the allowable cost in excess of 103 percent of the targeted amount.
- The plan's allowable costs for any benefit year are more than 108 percent of the targeted amount. In this case, DHHS will reimburse an amount equal to the sum of 2.5 percent of the

targeted amount, plus 80 percent of the allowable cost over 108 percent of the targeted amount.

Qualified health plan insurance carriers **will be required to pay** DHHS in the following circumstances:

- The plan's allowable costs for any benefit year are less than 97 percent, but not less than 92 percent, of the targeted amount. The insurance carrier will be required to remit 50 percent of the difference between 97 percent of the targeted amount and the allowable cost.
- The plan's allowable costs for any benefit year are less than 92 percent of the targeted amount. The insurance carrier will be required to remit an amount equal to the sum of 2.5 percent of the targeted amount, plus 80 percent of the difference between 92 percent of the targeted amount and the allowable cost.

The risk corridor program will have no impact on employer-sponsored health plans.

Premium Assistance and Cost-Sharing Reductions Under the Exchange

These proposed rules also include standards for advance payments of the premium tax credits and cost-sharing reductions. Eligible individuals earning between 100 and 400 percent of the Federal Poverty Limit (FPL) may be able to receive premium tax credits. Cost-sharing reductions are available to eligible individuals who make between 100 and 250 percent of the FPL. Cost-sharing reductions allow low-income individuals to have a higher level of benefits than the benchmark plan, a 70 percent value.

The Exchange will determine eligibility for tax credits in advance. Using information available at the time of enrollment, the Exchange decides:

1. Whether the person meets the income and other requirements to qualify for advance premium tax credits.
2. The amount of the premium tax credit for which the person is eligible.

Cost-sharing reductions decrease out-of-pocket costs for qualifying individuals when they need health services. The federal government will provide advance projected payments to insurance carriers to offset the increased benefits provided for the cost-sharing reductions.

The new regulations discuss special rules for family policies. The rules explain cost-sharing reductions for people who are in different tax households but covered by the same qualifying health plan (QHP). The plan variation that applies here is the one for which all members of the family are eligible. For example, A and B are a parent and child that live together but are separate households for tax purposes. A and B purchase a silver plan for family coverage in the Exchange. Individually, A's household income is 245 percent of the FPL and qualifies for a 73 percent value plan. B's household income is 180 percent of the FPL and qualifies for an 87 percent value plan. If they purchase a family policy, they will be collectively eligible for a 73 percent value plan. Nothing stops them from purchasing two single policies if that would be to their advantage.

The regulations also clarify how changes in a tax filer's situation during the year affect eligibility for premium assistance tax credits and cost-sharing reductions. A change may be self-reported by a tax-filer or be the result of periodic data matching. Once a change in the tax filer's situation is identified, the Exchange must re-determine the eligibility for premium credits or cost-sharing reductions.

When the Exchange recalculates premium credits, it must account for any advance premium credits already paid on behalf of the tax filer. The recalculated premium credits should result in a total annual premium credit that corresponds to the projected premium tax credits for the year. Remember, the IRS will audit paid premium credits against allowed premium credits based on year-end income. Any overpayment of the premium credits will require a repayment up to certain limits. Underpaid premium credits will result in additional tax credits to the tax filer. To limit audit activity, the Exchange must estimate premium credits as closely as possible to tax credit eligibility.

Here is an example. Tax filer A is eligible to enroll for a QHP. Because his expected 2014 household income is $33,150, equal to 300 percent of the FPL, he is eligible for advance tax credits. He enrolls in the second-lowest-cost silver plan for his area, which has a gross monthly premium of $300. His premium is capped at $265 per month (9.5 percent of his household income converted to a monthly amount). He receives a $35 subsidy. In June, A reports a decrease in his annual household income. The projected 2014 income is now $27,925, which is 250 percent of the FPL. His premium is subsequently capped at $187 a month. His new subsidy is now $113 a month based on his expected annual income. However, to determine premium credits, he must take into account what he has already paid. With his lower 2014 income, A is eligible for a $1,356 tax credit ($113 x 12). That annual amount, however, must be reduced by $210 (6 months of the $35 subsidy). Therefore, he is eligible for $1,146 in premium tax credits for the remaining months of the year. This equates to a $191 monthly subsidy for that time. His premium for the silver plan for the rest of the year will actually be $109 a month.

The cost-sharing reductions work a bit differently. Remember, cost-sharing credits are delivered through adjusted plan designs in the Exchange. With a mid-year change in income, an individual will simply be moved to the plan design adjusted for the new expected income.

The regulations clarified how the Exchange should handle advance premium tax credits. One of the Exchange's responsibilities will be to collect premium payments. For enrollees eligible for premium tax credits, the Exchange reduces the premium by the credits for which the individual qualifies. The Exchange must bill for the total premium and adjust for eligible premium tax credits. Enrollees need to know the total premium cost and the premium tax credit amount in order to correct inaccurate advance payments.

The Exchange regulations also discuss QHP certification related to premium tax credits and cost-sharing reductions. The rules primarily concern operating in the Exchange and modifying plan designs to allow cost-sharing reductions. Health insurance carriers should first modify the maximum out-of-pocket costs in order to meet the required actuarial value. For these proposed regulations, DHHS estimates the annual maximum limit on cost-sharing for 2014 will be $6,400 for single coverage and $12,800 for family coverage. The IRS will release the actual amounts later in 2013.

The regulations include a table of the maximum annual limitations on 2014 cost-sharing when individuals are eligible for cost-sharing reductions:

Eligibility Based on Household Income Related to the FPL	Self-Only Coverage	Family Coverage
100% - 150% of FPL (94% plan)	$2,250	$4,500
150% - 200% of FPL (87% plan)	$2,250	$4,500
200% - 250% of FPL (73% plan)	$5,200	$10,400

Plan designs may need changes in order to meet the actuarial values. A variation of +/-1 percent is permitted for the cost-sharing reduction's actuarial value. However, for the 73 percent plan variation, there are additional rules. The standard silver plan in the Exchange has an actuarial value of 70 percent, with a 2 percent variance allowed. For the modified plan for cost-sharing reductions, the 1 percent variance is permitted, but that plan must have at least a 2 percent difference compared with the carrier's standard silver plan. If the standard silver plan a carrier offers is a 72 percent plan, then the modified plan must have a 74 percent value.

Premium tax credits are not available to individuals enrolled in a catastrophic plan. In addition, different cost-sharing reductions and enrollment rules apply to Native Americans. Cost-sharing reductions do not apply to stand-alone dental plans, even if the plan offers pediatric dental benefits as part of Essential Health Benefits (EHBs). However, if a QHP provides pediatric dental benefits as part of the EHBs, then cost-sharing reductions would be available as part of the more generous plan offering.

User Fees for Federally-Facilitated Exchanges

The federal government provided funds to states to help establish Exchanges. Funds will also be granted to assist with operating costs in 2014. Beginning in 2015, the entity running the Exchange, whether it is the state or the federal government, will be responsible for the operational expenses. Health care reform allows an Exchange to fund operational expenses by charging user fees to participating insurers. The proposed regulations establish a user fee for the federally-facilitated Exchange.

The operational expenses include funds for:

- Providing consumer assistance tools
- Consumer outreach and education
- Managing the Navigator program
- Regulating agents and brokers
- Determining eligibility
- Administering advance premium tax credits and cost-sharing reductions
- Enrollment process
- Certifying QHPs
- Administering the Small Business Health Option Program (SHOP)

For 2014, the federal government proposes a user fee equal to 3.5 percent of the monthly premium the insurer charges for a plan in the Exchange. The government prefers the federal user fee to align with the rates state-based Exchanges charge. They may adjust this rate in the future to account for differences with the state-based user fees.

The federal government anticipates collecting the fee by deducting it from any Exchange-related payments to insurance carriers in the Exchange. Insurance carriers that do not receive any Exchange-related payments will be invoiced monthly.

Federally-Facilitated Small Business Health Option Program (SHOP)

The SHOP provides health insurance options for small businesses. It will operate differently from the individual Exchange. Employers will select both the metal tier of coverage they want to offer and the contributions they will make toward the coverage. Employees can select any plan offered in that metal tier in the SHOP. The Exchange will determine the employee contribution after subtracting the employer subsidy. The government is seeking comments on whether employees should be permitted to "buy-up" to the next higher metal tier.

The regulations provide safe harbor contribution methods for employers within the SHOP:

- Reference plan with a composite premium that is the same for each member. The employer can define the contribution as a percentage of the reference plan.
- Reference plan with a premium that depends on age. The employer can still define the contribution as a percentage of the reference plan.

Group insurance carriers often require minimum participation rates before offering coverage. A federally-facilitated SHOP will set a minimum participation rate of 70 percent, based on the number of eligible employees that elect coverage through the SHOP. It is not based on one specific carrier achieving a 70 percent participation rate. An individual with certain alternative coverage will be completely excluded from the 70 percent participation determination. Excludible alternative coverage includes the following:

- Group coverage through another employer
- Coverage through a governmental program such as Medicare, Medicaid or Tricare

The federally-facilitated SHOP may use a different minimum participation rate if the state sets a different rate, or if the majority of insurers in the state set a different participation requirement.

The SHOP will initially be available to small employers only. States can define the cut-off for a small group as fewer than 50 employees. However, states can change this number to fewer than 100 employees. To determine whether an employer meets the definition of a small employer, states must use full-time equivalents in the calculation for federally-facilitated SHOPs. Thirty hours a week is considered full-time. For example, assume ABC Company has 40 full-time employees and 40 part-time employees working 15 hours a week. If the state's cut-off is 50 full time employees, then ABC would not be eligible to purchase coverage through the SHOP. This is because ABC actually has the equivalent of 60 full time employees (40 full-time employees, plus 40 part-time employees viewed as 20 full-time equivalents, based on hours worked).

States have some discretion in defining the small group market in 2014 and 2015. All states will be required to define small group as below 100 lives in 2016.

Modifications to Medical Loss Ratio requirements

The Medical Loss Ratio (MLR) requires insurance carriers to meet specific benchmarks for the portion of premiums allotted to claims and to administrative expenses. More details on the MLR requirements can be found at http://www.mcgrawwentworth.com/Reform_Update/2012/Reform_Update_36.pdf.

These proposed rules amend the MLR regulations on how insurers should account for payments made from the premium stabilization programs. In addition, the timing of certain reporting requirements under the MLR rules is amended to accommodate the new premium stabilization program deadlines.

The reporting deadlines are pushed back to allow insurers to account for the benefits from the premium stabilization programs. As a result, the timing for rebates is also amended. Rebates that are provided as a premium credit must be applied to the first premium due on or after September 30 following the MLR reporting year.

Concluding Thoughts

These latest regulations from CMS and DHHS cover many issues on how the Exchanges will operate. The premium stabilization programs minimize the impact of the dramatic individual and small group market changes in 2014. These programs will help insurance carriers manage the uncertainty of premium setting in a changing market. Employers will need to include funds for the reinsurance program in their 2014 budgets.

More details were provided on how the Exchanges will manage premium assistance and cost-sharing reductions. Again, these details do not directly impact employers. However, employers who choose to discontinue health coverage need to understand the complex Exchange market.