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HHS Proposes Payment Model, Rules for Insurers Designed to Improve Affordability of Health Insurance in Exchanges

On November 30 the U.S. Department of Health and Human Services (HHS) proposed additional rules to govern several programs authorized under the Affordable Care Act (ACA) that are intended to ensure that health insurance sold in health insurance exchanges (exchanges) beginning in 2014 is affordable, including: risk adjustment, reinsurance, risk corridors, medical loss ratios, advance payment of premium tax credits, and cost sharing reductions. The proposed rules also impose user fees on insurers when HHS administers an exchange or risk adjustment in a state and clarifies key questions about health insurance sold to small employers.[1] The stakes in these programs are large. Under risk adjustment alone, HHS estimates $45 billion will be transferred among insurers by 2017.

The specific parameters HHS proposes in the draft payment notice will permit insurers to begin pricing products for sale in the new 2014 insurance marketplace, clarifying one of the significant remaining uncertainties about health reform.

The proposed rules will be published in a draft payment notice in the *Federal Register* on December 7, and HHS will consider comments received by January 7, 2012. The final payment notice for 2014 will be published in the *Federal Register* in early 2013. HHS intends to publish an annual payment notice, formally the "HHS Notice of Benefit and Payment Parameters," to revise the risk adjustment model, reinsurance parameters, insurer user fees, and other exchange-related issues.

Executive Summary

The ACA imposes a series of regulations, effective in 2014, on health insurance sold in the individual and small group markets. These requirements are designed to improve consumer access to affordable insurance, regardless of health status or pre-existing conditions. HHS proposed last month a collection of rules to implement these consumer protections. In light of what are, in most states, seismic changes to current insurer enrollment and pricing practices, the ACA also included a number of measures intended to preserve the stability of the market and to subsidize lower income enrollees in health plans. While HHS published final rules implementing these provisions in March 2012,[2] these additional rules provide further details and modify some earlier rules. The payment notice also announces key deadlines for insurers and states under these programs.

- **Risk adjustment**. The ACA requires each state to have a system to transfer payments from insurers that enroll healthier-than-average individuals to insurers that enroll sicker-than-average individuals. The draft payment notice announces details of how HHS will determine the relative health of each insurer's enrollees and will calculate the payments to be made between insurers. HHS announces that, although it will audit insurer reporting to ensure the transfers accurately reflect each enrollee's

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, http://www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf (Nov. 30, 2012).

[2] Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17220 (Mar. 23, 2012); Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310 (Mar. 27, 2012).

relative health status, it will wait at least two years before it adjusts risk adjustment transfers based on the results of data validation.

- **Reinsurance**. A temporary reinsurance program, funded by $10 billion in contributions in 2014 from all health insurers and group health plans, will protect individual market insurers from potentially high health claims from newly enrolled individuals in the early years of the exchanges. The ACA and the March 2012 rule indicated states would have considerable flexibility in designing reinsurance, but the draft payment notice considerably reduces variation among states. All reinsurance contributions will be collected by HHS and payments will be allocated to states based on need, not based on where contributions were collected. HHS proposes a national contribution rate for 2014 of $5.25 per member per month. HHS also clarifies which plans are not subject to making contributions and announces that reinsurance payments will cover 60% of an individual's annual claims between $60,000 and $250,000.

- **Advance Premium Tax Credits and Cost Sharing Reductions.** The proposed rule provides detailed guidance to exchanges and health plans on how to design and administer plans to deliver the subsidies provided by the ACA to low-income individuals in the form of advance premium tax credits and cost sharing reductions. The proposal specifies, for 2014, the amount of the reductions in out-of-pocket spending limits that will, together with reductions in deductibles and other cost sharing, ensure the affordability of exchange-offered heath plans.

- **SHOP exchanges**. The notice proposes amendments to the March 2012 regulations for Small Business Health Options Programs (SHOPs) and establishes distinct requirements for federal SHOPs. The proposal emphasizes employee choices in the federal SHOP, and proposes a method for calculating employer size to determine SHOP eligibility.

- **User fees**. Most states will have a federal or a state- partnership exchange in 2014. HHS announces that it intends to collect a user fee from insurers of 3.5% of premiums to cover the cost of operating a federal exchange. HHS does not explain whether or how this user fee will be allocated between the state and federal governments in a state-partnership exchange. The fee for risk adjustment will be less than $1 per member per year for plans subject to federally-administered risk adjustment. Administrative expenses for reinsurance are built into the reinsurance contribution rate.

The payment notice also clarifies some issues related to the HHS-administered temporary risk corridors program and changes the medical loss ratio rule to accommodate the risk adjustment, reinsurance, and risk corridors programs, collectively known as "premium stabilization" programs.

Key Provisions

Risk Adjustment

Because the ACA market reforms effective in 2014 will prevent insurers from excluding individuals based on their pre-existing conditions or setting rates based on health status, the ACA establishes a risk adjustment program to shift payments from plans with low-risk enrollees to plans with high-risk enrollees. The goal is to compensate plans for the relative health status of their enrollees, but not for factors that plans can continue to price into their premiums, including plan benefit design and administrative efficiency. HHS will administer risk adjustment in all states with federal or state-partnership exchanges. States with state-based exchanges can elect to run risk adjustment or have HHS administer the program. As a consequence, in 2014, HHS will run risk adjustment in most states. The draft payment notice announces the model HHS will use for calculating individual risk scores, which will be the basis for determining which plans should make payments and which plans should receive payments. HHS will use this model in all states where it administers risk adjustment.

Covered Plans. All non-grandfathered health insurance sold in the individual and small group markets is subject to risk adjustment. The draft payment notice provides further details about the scope of the program. Large group insurance, self-insured group plans, student health plans, and excepted benefits plans are

exempt. Catastrophic plans, other individual market plans, and small group market plans will each be risk adjusted amongst themselves, in separate pools. Because risk adjustment is tied to the 2014 market reforms and the reforms are effective only for plan years beginning on or after January 1, 2014, risk adjustment will also begin for plan years beginning on or after that date. For example, if a small group has a plan year that begins July 1, 2013, it will not be subject to risk adjustment until July 1, 2014.

Risk Adjustment Model. HHS announced in the payment notice that its model will calculate individual risk scores based on the age, gender, and certain diagnoses of each individual enrolled in a risk adjusted plan. HHS has experience risk adjusting payments for the Medicare Advantage (MA) program and it will use its existing Hierarchical Condition Category (HCC) classification system to determine what weight, if any, to give each diagnosis in determining each individual's overall risk score. Because only a fraction of individuals in risk adjusted plans will have diagnoses that HHS has determined are relevant in estimating risk, most individuals' risk scores will be determined entirely by age and gender. As expected, HHS's risk adjustment model is concurrent – it uses current-year diagnoses to generate individual risk scores for the current year. Tobacco use is not a factor in the risk adjustment model; insurers might not have complete data on the tobacco use of their enrollees and claims data will predict much of the health risk that tobacco use would cause. The model is also based only on medical claims, not prescription claims. HHS said it chose not to include prescription claims in its model to avoid creating incentives to modify discretionary prescribing. Calculations will be made differently for plans at different actuarial values, to reflect that the plan's share of costs varies depending on actuarial value. The model will also reflect that costs may be higher for individuals who receive cost sharing reductions under the ACA, which may induce higher usage. HHS generates R-squared statistics for its model, a measure of expected accuracy where 1.0 would represent perfectly predicting plan liability. The R-squared statistics vary by age group and plan actuarial value and range from 0.29 to 0.36, in line with other risk adjustment models.

Assessment of Risk Adjustment Payments and Charges. After calculating a risk score for each individual enrolled in a risk adjusted plan, HHS will calculate plan average actuarial risk and risk adjustment payments and charges. Although the rating rules limit insurers to including three covered children under age 21 in the premium, all individuals covered under a policy will be scored for risk adjustment. Payments and charges will be designed so that charges assessed against insurers in each state equal payments made to insurers, without the need for adjustments to equalize the transfers. HHS will send an invoice to plans by June 30 of the year following the benefit year reflecting their payments and charges.

Data Collection. HHS previously announced that when it runs risk adjustment, it will use a "distributed" data approach in which enrollee-specific data will remain on insurers' computer systems. HHS will have access to those systems to generate risk scores and transmit scores to HHS for calculation of payments and charges. The draft payment notice proposes requiring that insurers complete testing of data systems for risk adjustment, including testing of appropriate interaction with HHS systems, by October 2013. Individual enrollees will be identified throughout risk adjustment by a masked identification number generated by insurers, not by any personally identifiable information. Data must be made available to HHS by April 30 of the year following the benefit year so HHS can complete invoicing by June 30. This data will also be used for reinsurance claims.

At least two cases present special problems for collecting data necessary for risk adjustment (and reinsurance):

- For *newborns*, the infant's diagnoses and claims often appear in the mother's record. For risk adjustment purposes, infants and mothers need to be treated differently. HHS solicits comments on operational issues involved in separating claims for newborns and mothers .

- *Staff-model HMOs* and other plans that do not routinely generate service-specific claims will need to provide data on their diagnoses and costs using their internal cost accounting system or estimated market-specific costs, if the internal accounting system does not provide the necessary data.

Data Validation. HHS proposes requiring that insurers hire auditors to validate a sample of their risk adjustment data each year. HHS would conduct a second audit of a sub-sample of data examined by the

insurers' auditors. These audits would generate risk score error rates, which HHS will eventually use to correct risk adjustment transfers. These corrections will be made on a prospective basis. For example, audits completed based on the 2017 benefit year will generate error rates that could be used to adjust risk adjustment transfers based on data for the 2018 benefit year. Applying the error rates on a concurrent basis could undermine the stability that the risk adjustment system is designed to generate because error rates will not be finalized by the time insurers are invoiced for risk adjustment. However, at least until 2016, HHS says it does not intend to use error rates generated by data validation to correct risk adjustment transfers at all, because there is considerable uncertainty about what the magnitude and frequency of errors will be. It is unclear, in general, what remedies HHS has if insurers do not comply with the risk adjustment requirements, but for data validation HHS proposes that it may adjust risk adjustment transfers for insurers that refuse to participate in data validation. HHS intends to establish an administrative process for insurers to appeal error rates generated by the audits.

State Risk Adjustment Models. States running their own risk adjustment programs will also have to use the HHS model unless HHS approves an alternate state model. States seeking to use an alternate model for the 2014 benefit year must submit their proposed models to HHS by January 7, 2013. HHS explains the criteria it will use in determining whether a proposed state risk adjustment methodology is accurate and administratively feasible. Even if a state chooses to operate risk adjustment using the HHS model, it must still receive HHS approval of its risk adjustment program. Given the tight timeframe, HHS proposes a collaborative process for state risk adjustment programs for the 2014 benefit year, without requiring formal HHS approval. In order for a state to administer risk adjustment for the 2015 benefit year, it will need to receive HHS approval by March 1, 2014.

User fees. HHS intends to collect a user fee to fund some of its administrative expenses for risk adjustment. The fee will be assessed on a per capita basis on all insurers with covered plans participating in the federal program. HHS estimates administrative costs funded by risk adjustment user fees would be less than $20 million in 2014 and the per enrollee costs would be no more than $1 a year. User fees would be collected in June following the benefit year to align with invoicing of payments and charges.

Reinsurance

In the draft payment notice, HHS announces significant changes to the operation of the reinsurance program; while the ACA describes a program as principally a state initiative, the draft payment notice describes one that is fundamentally federal in character. For three years beginning in 2014, insurers that offer non-grandfathered individual market coverage will be eligible to receive reinsurance payments when individuals incur high medical costs. These reinsurance payments will be funded by all commercial insurers and group health plans offering major medical coverage, a total of $10 billion in 2014. In rules finalized earlier this year, HHS indicated that it would collect reinsurance contributions from self-insured group health plans and insurers, if states chose not to make collections from insurers; HHS would then distribute these contributions to states that chose to run their own reinsurance programs in proportion to overall reinsurance contributions in the state. HHS would set parameters for reinsurance payments, but states were free to modify them. HHS would run all aspects of reinsurance in states that chose not to establish a reinsurance entity.

Now, in order to reduce the administrative complexity of the program given its short duration, the draft payment notice proposes to considerably curtail state flexibility. The new rules reduce incentives for states to elect to operate their own reinsurance programs.

Reinsurance Contributions. HHS now intends to collect all reinsurance contributions from all insurers and group health plans in all states. The ACA and the existing rules say reinsurance contributions will be $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. In 2014, HHS will also collect $20.3 million for the administrative expenses of the program and $2 billion that the ACA requires to be contributed to the U.S. Treasury. Based on HHS's estimate of the number of individuals enrolled in plans required to make contributions, HHS plans to collect $5.25 per member per month. If that results in less than $12.02 billion, because there are fewer enrollees than estimated, HHS will proportionally reduce payments for reinsurance, the Treasury, and its own administrative expenses. If more than $12.02 billion is collected, the excess will fund

additional reinsurance payments. Any funds not used for reinsurance payments for the 2014 benefit year will be used for the 2015 benefit year. HHS will distribute those contributions to state reinsurance entities based on demand from insurers in those states for reinsurance payments, or will make payments to insurers directly in states where HHS administers reinsurance. Reinsurance distributions will not be tied to the states where contributions were collected. HHS solicits comment on whether it could, consistent with the ACA, defer collecting the $2 billion allocated for the Treasury until 2016.

Contributing Entities. The draft payment notice clarifies existing rules about entities required to make reinsurance contributions: group health plans and commercial insurance that offer major medical coverage. Thus, Medicare Part C or D, Medicaid managed care, state Children's Health Insurance Plans, Basic Health Plans, and state and federal high-risk pool coverage would not be required to make reinsurance contributions because they are not commercial insurance, nor is health coverage provided to members of American Indian tribes because of their tribal membership. Coverage provided to employees of federal, state, local, or tribal governments would generally be required to make reinsurance payments. The major exception is military coverage provided to active and retired military personnel and their dependents through TRICARE and the Veterans Health Administration. Also excluded from making contributions are health reimbursement arrangements integrated with a group health plan, health savings accounts, health flexible spending arrangements, stop-loss and indemnity reinsurance policies, and excepted benefit policies. Policies excluded from making contributions are also ineligible for receiving reinsurance payments.

Calculation of Contributions. Because contributions will be calculated on a per-enrollee basis, HHS is requiring insurers and employers required to make contributions to notify HHS of the number of their enrollees by November 15 in 2014, 2015, and 2016. HHS announces several options contributing entities can use to count enrollees:

1. Counting the number of enrollees enrolled on each day of the first nine months of the year and dividing by the number of days;
2. Calculating an average based on counts of the number of enrollees on a day (or several days) in each of the first three quarters, provided that the dates chosen in the second and third quarters must be in the corresponding week as the date chosen in the first quarter (for example, January 1, April 1, and July 1);
3. For insurers, counting the number of policies offered in a quarter and multiplying by the average number of enrollees per policy as determined by its most recent state insurance filing; or,
4. For self-insured plans, the average number of enrollees as reported to the U.S. Department of Labor.

The proposal contains rules designed to prevent a single enrollee covered under multiple plans offered by the same employer from being counted twice. HHS will notify each contributing entity of its amount due by December 15 or by 15 days after submission of its enrollee count, whichever is later. Contributions will be due within 30 days of invoicing.

Payment Parameters. HHS is designing the temporary reinsurance program so that insurers in the individual market have sufficient assurance that they will not be saddled with unusually high claims (and therefore moderate premiums), while also ensuring that insurers still have some liability for high claims and therefore have an incentive to manage health costs. The payment notice proposes, for 2014, a reinsurance attachment point of $60,000, a coinsurance rate of 80%, and a reinsurance cap of $250,000. This means that when an insurer in the individual market has a non-grandfathered enrollee who has incurred more than $60,000 in claims in a year, the insurer will be eligible for reinsurance payments covering 80% of the enrollee's costs in excess of $60,000, until the enrollee has incurred $250,000 in costs in a year. Existing commercial reinsurance coverage typically has an attachment point around $250,000, HHS says. While the March 2012 rules permit states running their own reinsurance programs to alter these parameters, the draft payment notice limits state flexibility by permitting states to alter the reinsurance parameters only in ways that would increase reinsurance payments. Those increased payments must be made from additional state collections from in-state insurers, not self-insured group health plans. Insurers must submit reinsurance claims by April 30 of the year following the benefit year and HHS or the state will notify insurers of their reinsurance payments by June 30. Only plans subject to the 2014 market reforms are eligible to receive reinsurance payments. Thus, grandfathered plans

and excepted benefits plans are excluded, but student health plans are eligible.

State Administration of Reinsurance. States that run their own reinsurance program in 2014 and choose to alter the reinsurance parameters must publish a state payment notice in 2013 announcing the state's payment parameters, within 30 days after the publication of the final 2014 HHS payment notice. The deadline was originally March 1, 2013, but given the delay in publication of the HHS payment notice, that deadline may be unrealistic. HHS says the deadline will be March 1 in subsequent years. The state payment notice must also include any state modifications to insurer data requirements for reinsurance payments, reinsurance contribution rates, or risk adjustment methodology and data validation. The state payment notice must also indicate if the state would like to use more than one reinsurance entity to make reinsurance payments. If a state elects to administer reinsurance payments, HHS will transfer half the administrative fee it collects to that state, in proportion to reinsurance payments requested in that state under the national payment parameters. HHS says it intends to promulgate additional guidance and rules on apportioning administrative fees to states, but says that such fees may only be used for the reasonable cost of administering the reinsurance program and may not be used for excessive executive compensation, promotional giveaways, staff retreats, or lobbying.

Risk Corridors

The ACA establishes a temporary risk corridors program intended to stabilize the profits of insurers offering qualified health plans (QHPs) in exchanges during the first three years of exchange operation. Under risk corridors, when QHP insurer profits exceed a certain margin, the insurer will be required to pay a percentage of those profits to HHS. When losses on the QHP exceed a specified amount, HHS will make payments to the insurer. In the payment notice, HHS proposes to revise its calculation of these corridors so that profits are defined as the greater of 3 percent of premiums or the actual premiums earned by the insurer less administrative costs and costs of coverage. While the changes to the risk corridors formula are broadly consistent with the ACA, they will make the corridors calculation more favorable to insurers. HHS notes the revision will also align risk corridors calculations with those under the medical loss ratio rules. Insurers would be required to submit to HHS information necessary to calculate the corridors by July 31 of the year following the benefit year and payments would be due within 30 days of HHS invoicing insurers.

Medical Loss Ratio

The ACA requires that the formula used for calculating the medical loss ratio (MLR) be changed as of 2014 to account for risk adjustment, reinsurance, and risk corridor payments or receipts as a reduction of or addition to premium revenue. HHS guidance to date on MLR has been silent as to how issuers are to account for premium stabilization programs in MLR reporting, accounting, and calculating rebates due (if any), since these programs do not take effect until 2014. The proposed rule would modify the MLR definitions, for MLR reporting years beginning in 2014, to include premium stabilization amounts as part of the total premium revenue reported to HHS. However, these amounts would be: (1) removed from the adjusted earned premium, so they would not have any impact on the amounts used in calculating the MLR denominator and rebates, and (2) included as an adjustment to incurred claims included in calculating the MLR numerator. While the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare and Medicaid Services (CMS) believes that this approach preserves consistency between the MLR and risk corridor and related calculations by treating them as adjustments to cost, not revenue, it asks for comments on this proposal.

The rule would also delay by two months the MLR reporting and rebate deadlines, beginning with the 2014 reporting year, to coordinate them with the reporting cycles of risk adjustment, reinsurance, and risk corridors. Specifically, MLR reporting would be due on July 31, instead of June 1, and the due date for rebates would change to September 30 from August 1.

Finally, the MLR proposed rules would address the issue of how to treat the deduction by tax-exempt non-profit insurers of community benefit expenditures. Specifically, it would allow such insurers to deduct both state premium taxes and community benefit expenditures from earned premium in the MLR calculation. Both the National Association of Insurance Commissioners (NAIC) Model Act and the current HHS MLR rules limit the

deduction from premium for community benefit expenditures to a reasonable amount (although with different formulas). Based on these approaches and the 2011 MLR data it has seen to date, HHS proposes to limit the deduction from premiums for tax-exempt, non-profit insurers to the higher of either three percent of premiums or the highest premium tax rate charged in a state. HHS specifically asks for comments on allowing non-profits to deduct both premium taxes and community benefit expenditures as well as its proposed community benefit expenditures deduction limit.

Advance Premium Tax Credits and Cost Sharing Reductions

The draft payment notice proposes a number of changes to previously issued rules and announces HHS proposals administering 2014 payments to QHPs for the portion of an eligible enrollee's premiums paid through refundable advance premium tax credits (APTCs) and for required cost sharing reductions (CSRs). In addition, the proposal provides parameters for designing cost sharing variations in plans for eligible enrollees for 2014.

Exchange Administration of APTCs and CSRs. The proposal would make several technical amendments to sections of the March 2012 rule to clarify how HHS will make advance payments to QHPs in situations in which different family members may qualify for different subsidies because, for example, they are in different taxpaying households. In such cases, HHS proposes that, where the family members choose coverage under one family policy, they would only be eligible for the subsidized family policy of the highest income person in the family.

The proposal would also clarify the consequences when an individual's eligibility for subsidies changes during a year in which some advanced payments for the premium credit have already been credited to the individual or, conversely, where he or she was previously ineligible and now becomes eligible.

HHS proposes a methodology for exchanges to allocate APTC payments in cases where more than one individual in a family is eligible for a tax subsidy and the individuals collectively enroll in more than one QHP policy, QHP, or dental plan. HHS also clarifies the obligation of state-based exchanges that elect to facilitate premium collection and payment to QHPs, an option provided under the ACA, to reduce premiums collected from QHP enrollees by the amount of their APTC, and to display the APTC on enrollees' billing statements.

Plan Design to Achieve Required CSRs. The proposed rule would require exchanges to certify that all QHP insurers provide plan variations required to obtain the income-based subsidies of the ACA. In turn, the exchanges would have to provide to HHS information on the actuarial value (AV) of all QHPs and variations. QHP participation in the exchange would depend on their compliance in meeting the requirements to provide CSRs.

The proposal defines three types of required variations to QHPs to meet the CSR requirements: a silver plan variation to provide CSRs to enrollees with incomes below 400 percent of the federal poverty level (FPL) and two variations designed to satisfy ACA provisions that provide additional CSRs to American Indians.

The proposal clarifies that these variations to so-called "standard" plans are not actually different plans. They are simply variations created for the sole purpose of delivering CSRs. The variations are required to cover the same benefits, utilize the same providers, and require the same out-of-pocket spending for benefits other than EHBs.

Therefore, for each QHP at all metal levels, the proposal would require insurers to provide two variations for eligible Indians: one for the Zero Cost Sharing Variation and one for the Limited Cost Sharing Variation.

Silver Level Variations. For each silver QHP, the proposal would require the insurer to submit to the exchange, in addition to the standard plan (and the variations required for Indians), three variations: first, one for those with incomes between 100 and 150 percent of FPL (at 94 percent AV); second, one for those between 150 and 200 percent of FPL (87 percent AV); and third, one for those between 200 and 250 percent of FPL (73 percent AV).

Consistent with the proposals HHS made in its February 2012 bulletin on AV and CSRs, in order to prepare each variation, the proposal would require the insurer to first reduce the maximum annual limitation on cost sharing (also known as out-of-pocket limits), as specified in the proposal.

The ACA pegs the required maximum annual limitation on cost sharing for all QHPs to the same level as the dollar limits on cost sharing for high deductible health plans. These numbers are calculated annually by the Internal Revenue Service (IRS). Because the IRS will not publish the 2014 limits until spring, HHS has prepared its own estimate of what those limits will be and proposes to apply its estimates for the purposes of calculating the required maximum annual limitation on cost sharing for Silver Plan variations for 2014.[3]

Based on its estimates of these limits ($6,400 for self only coverage and $12,800 for other than self), HHS has determined that if applied to the silver plan variation for those between 250 and 400 percent of FPL in 2014, the plan variations would exceed the AV targets required by the ACA without any other CSRs to deductibles, copays and coinsurance. In addition, HHS believes that there is sufficient uncertainty in its estimates of the impact of the IRS-based limits that it must modify the other silver plan variations to ensure that insurers can design silver plan variations that have both annual maximum limitations on cost sharing and other CSRs.

Therefore, HHS is proposing the following schedule of reduced maximum annual cost sharing for 2014:

Income	**Self-only Coverage**	**Other than Self-only Coverage**
100-150 percent of FPL	$2,250	$4,500
150-200 percent of FPL	$2,250	$4,500
200-250 percent of FPL	$5,200	$10,400
250-400 percent of FPL	No reduction in annual limitation	No reduction in annual limitation

As HHS does not expect its analysis to change with the release of the actual IRS limits, it is proposing that insurers may rely on the maximum annual limitations on cost sharing that HHS will publish in the final regulation to develop their silver plan variations for the 2014 benefit year. It will publish limits for 2015 in its next annual notice of benefit and payment parameters.

Following the application of these maximum annual limitations on cost sharing, each QHP issuer will modify its other cost sharing to achieve the required AV level for each of the three variations. In doing this, the proposal specifies that the cost sharing for any particular benefit in a variation with a higher AV may not exceed the cost sharing for that benefit in a variation with a lower AV. Thus, for example, cost sharing for a hospital visit in a 94 percent AV variation must be lower than for such a visit in an 87 percent AV variation. HHS is also proposing the same rule for deductibles (e.g., a 94 percent AV variation must have a lower deductible than an 87 percent AV variation).

The proposal also clarifies that enrollees are not eligible for any CSRs until they meet the deductible in their QHP variation. Thus, the CSRs that might otherwise apply to copays and coinsurance do not apply during the deductible period. The QHP is responsible, according to the proposal, for ensuring that enrollees eligible for CSRs receive them and pay no more than required. Plans would not be able to require enrollees to pay higher cost sharing up-front and seek reimbursement for their CSRs.

HHS proposes to allow QHP issuers' silver plan variations to differ from the required AV values by just one percent (e.g., a 94 percent AV plan may be between 93 and 95 percent). However, HHS proposes that the silver plan variation requiring a 73 percent AV must differ by at least two percent from the standard, 70 percent

[3] The actual IRS established limits will apply to those who do not qualify for CSRs.

AV silver plan.

Payments to QHPs for CSRs. The proposal specifies how HHS will make payments to QHPs for the CSRs. HHS proposes that, prior to the benefit year, issuers would have to provide the exchange with estimates of the total value of the expected CSRs for the silver plan variations and the variations for Indians at all metal levels.

QHP issuers may, as provided for in the ACA, seek advance payment from HHS for CSR payments it will make. HHS is proposing a simple methodology for estimating these payments for 2014 because of the lack of experience on which to base them. Advance payments would be the subject of a reconciliation process modeled on Medicare Part D, based on the submission to HHS of actual data on CSRs.

Small Business Health Options Program (SHOP) Exchange

Small businesses will be able to purchase health insurance for their employees in SHOP exchanges beginning with the 2014 plan year. HHS published final rules for the administration of SHOPs in the March 2012 exchange rules and proposes additional rules in the draft payment notice. The new rules emphasize employee choice of plans via the federal SHOP exchange and clarify how employees will be counted for employer eligibility in the SHOP, as well as how agents and brokers can participate in SHOPs.

Employee Choices in the Federal SHOP. The ACA and the existing exchange rule requires all SHOPs to offer a particular innovative purchasing model, in which an employer selects at least one metal level and employees are permitted to enroll in any QHP offered by any insurer in that metal level on the SHOP. The rule also permits SHOPs to offer employers other options. For example, a SHOP could permit an employer to select only a single QHP in which to enroll all its employees. In the draft payment notice, HHS proposes to limit the federal SHOP to the first innovative model. HHS seeks comment on whether employers should be allowed or directed to select a single QHP for all employees (the most common method today in the small group market) during a transitional phase. HHS also is considering and seeking comments on a "buy-up" model that would allow employees to purchase certain plans at the next highest metal level, recognizing that this would increase choice but also the danger of adverse selection.

Employer Premium Contribution. The proposed rules describe the employer contribution methods that will be offered by the federal SHOP, which HHS notes comport with existing federal law. In federal SHOPs, employer contributions will be based on the premium of a "reference plan." Each employer: (a) will select a QHP within the coverage level it has designated for its employees that will serve as the reference plan on which premium contributions will be based; (b) will define a percentage contribution towards premiums for employees, and, as applicable, dependent coverage, under the reference plan; (c) may choose to establish different percentages for different employee categories, to the extent legally permissible under law; and, (d) will have the opportunity to select either a composite premium or one where employee contributions vary with age, except in states that prohibit age rating or require composite billing. The resulting contribution amount will then be applied to each employee's premium regardless of the QHP selected. HHS notes that while this is not the only allowable employer contribution mechanism, it is the only one that will initially be available through the federal SHOPs. HHS also notes that the IRS plans to issue additional guidance for plan years 2014 and beyond concerning the methods of employer contribution that qualify for favorable tax treatment.

Employer Size Calculation. When HHS released the exchange rules in March 2012, it deferred to future rulemaking the question of how to calculate employer size for purposes of determining whether an employer is a small or large employer. Only small employers may purchase insurance through SHOP exchanges before 2017. Most states, in line with federal law before the ACA, define the small group market as serving employers with 50 or fewer employees. The ACA alters the federal definition to include employers with 100 or fewer employees. The ACA permits states to preserve the old definition for the purpose of their SHOP exchanges until 2016, at which point the proposed rules would have states count all full-time employees, plus part-time employees as fractions of an employee, relative to hours worked. The rule defines full-time employees as those who work an average of at least 30 hours per week.

For federal SHOPs, the federal definition of full-time employee will apply immediately. HHS also recognizes

that use of inconsistent definitions by federal SHOPs and state insurance regulators through 2016 could lead to situations where an employer is determined to be a large employer, and thus ineligible for coverage in a federal SHOP, while at the same time meeting the state law definition of small employer and thus eligible to purchase small group coverage outside the federal SHOP.

Minimum Participation Rate. The existing SHOP rules permit both state and federal SHOPs to establish minimum participation rates, meaning that an employer may only purchase QHPs for its employees if a certain percentage of them enroll in coverage through the SHOP. Minimum participation rules are common in the small group market today to ensure employers do not exploit guaranteed issue requirements to enroll only a handful of older or sicker workers. The SHOP minimum participation rule is unique in that participation is tested by participation in any plan in the SHOP, not enrollment in a particular plan or with a particular insurer.

The proposed rule establishes a minimum participation rate of 70 percent for federal SHOPs. The rate is calculated by dividing the number of qualified employees accepting coverage in the SHOP by the number of qualified employees offered coverage (excluding employees not otherwise covered by another employer group plan or public program). Recognizing the degree of variation across state laws, regulations and market practices, the proposed rule provides for federal SHOPs to apply a different minimum participation rate in states where a state law sets the rate, or there is evidence that a higher or lower rate is used by the majority of QHP insurers in the small group market outside the SHOP. HHS notes that the application of any minimum participation rate requirement is subject to finalization of a recently proposed HHS rule that creates such an exception to the guaranteed issue requirement for small group insurers.

Agents and Brokers. Under the Exchange Rules, an exchange may include information on licensed agents and brokers on its website. The proposed rule adds a new provision permitting exchanges to provide information only on brokers or agents who have completed required exchange registration and/or training. It also further clarifies that federal exchanges will present information on their websites only regarding registered and/or trained agents and brokers.

Finally, the rule would also add a provision requiring insurers participating in federal exchanges and SHOPs to pay similar commissions inside and outside the exchange for similar health plans.

Insurer Participation in Federal SHOPs. The proposed rule requires insurers applying to participate in a federal exchange in the individual market to also participate in the SHOP, except where neither the insurer nor any other insurer in the same "issuer group" is participating in the small group market in that state. For the purpose of this provision alone, HHS defines an "issuer group" as insurers linked by common ownership or by a common nationally licensed service mark. Participation is defined as offering at least silver and gold level QHPs. The participation requirement can be met by another issuer in the same issuer group.

Federally Facilitated Exchange User Fees

The payment notice proposes a "user fee" for participating issuers offering QHPs through federal exchanges operating in states that do not establish state-based exchanges. The user fee would support federal exchange operating costs, including QHP certification, eligibility and enrollment, and consumer assistance and outreach.

The proposal would require issuers to remit a user fee to HHS each month based on a percentage of premium paid for members enrolled in the issuer's QHP on the federal exchange. The 2014 user fee rate would be 3.5% of premium, a rate targeted to align with user fees charged in state-based exchanges. HHS indicates that this rate may be adjusted in the final to take into account user fees charged in state-based exchanges.

HHS will provide further guidance on the process for collecting user fees, but proposes that such fees will be deducted from "Exchange-related program payments" (which likely refer to APTC and CSR payments to issuers for enrolled members eligible to receive such payments); the proposed rule indicates that if an

issuer does not receive any exchange-related program payments, the issuer would be invoiced for the user fee on a monthly basis. HHS seeks comment on its proposed methods for collecting user fees.

The proposal notes that the federal exchange user fee policy does not affect the ability of states relying on the federal exchange to apply for and use exchange establishment funding to develop state-partnership exchange functions and support work necessary to interface with the federal exchange. However, it is silent with respect to how user fees will be applied in state-partnership exchanges, in which states are operating exchange functions including plan management, consumer assistance and navigator programs. Additional federal guidance is required to determine how this will work and whether a portion of federal exchange user fees will be allocated to states to support these activities.

Finally, HHS seeks comment on its proposal to pool exchange user fees (or potentially all administrative costs) across a particular market or product. While user fees would be collected only from issuers participating in the federal exchange, HHS appears to be considering a requirement that issuers spread user fee costs evenly to all of their plans both inside and outside of the exchange. HHS suggests that such pooling may provide further protection against adverse selection and ensure that the costs of exchange user fees are spread evenly so as not to create pricing differences for products inside and outside of exchanges.

Conclusion

The draft payment notice answers some key questions with respect to health insurance pricing in 2014 that should facilitate the development of QHP products and rates for both state-based and federal exchanges in the coming months. Given the limited time remaining before exchange open enrollment in October 2013, HHS will need to act quickly if it makes any changes to these rules in response to comments. The limited flexibility these rules propose to give states with respect to reinsurance and risk adjustment and HHS's relatively low administrative expenses may encourage states to defer to HHS administration of these complicated programs, even in states that are electing to operate their own exchanges. The final rule and additional guidance are expected to further clarify federal exchange user fees, including administration of fees in state-partnership exchanges.

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