2015 INSURANCE MARKET STANDARDS AND REPORTING REQUIREMENTS

March 31, 2014—In a series of March releases, the Department of Health and Human Services (HHS) has begun building the framework under which regulators and insurers must operate in calendar year 2015. HHS hopes that the early release of information for 2015 requirements and standards will enable states, insurers, businesses, and consumer's time to prepare and properly respond to the changes in the coming year. Please note key 2014 dates emphasized in this material:

MAY 2014	JUNE 2014	NOV. 2014	DEC. 2014
Declaration Letter Submission Deadline 5/1/2014	**2015 Exchange Blueprint Approval Deadline** 6/15/2014.	**Annual Open Enrollment Period for 2015** Benefit Year Begins 11/15/14 through 2/15/2015.	**All Project Periods for Use of 1311 Funds in 2014** State-partnership and State-based Marketplaces End On 12/31/2014.

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HHS 2015 Health Policy Standards Fact Sheet

HHS released a fact sheet [http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-03-05-2.html] March 5 outlining the transitional policy options and the final rule for notice of benefits and payment parameters for 2015. This rule addresses issues affecting individuals' market premiums, temporary risk corridors, open enrollment period for 2015, state flexibility issues, out of pocket expenses, and, several issues specifically related to the Small Business Health Options Program (SHOP).

Bulletin on Extension of the Transition Policy

On Nov. 14, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a letter to the State Insurance Commissioners [http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.pdf] outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. The letter provided insurers the option, if permitted by their state, to renew their current policies for current enrollees without adopting all of the 2014 market rule changes. CMS also indicated that it would consider extending the transitional policy beyond 2014.

The March 2014 bulletin [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf] extends this transitional policy for two years, to policy years beginning on or before

Oct. 1, 2016. This gives consumers in the individual and small group markets the choice of staying in their plan or joining a new marketplace plan as the new system is fully implemented. Policies subject to the transitional relief are not considered to be out of compliance with the ACA provisions relating to single risk pool requirements. This policy also applies to large businesses that currently purchase insurance in the large group market but that, as of Jan. 1, 2016, will be redefined by the ACA as a small business purchasing insurance in the small group market.

State Option

At the option of the states, health insurance issuers that have issued or will issue a policy under the transitional policy anytime in 2014 may renew the policies any time through Oct. 1, 2016, and affected individuals and small businesses may choose to re-enroll in the coverage through Oct. 1, 2016. States that did not adopt the Nov. 14, 2013 transitional policy may choose to implement the transitional policy for any remaining portion of the 2014 policy year. Moreover, states can elect to extend the transitional policy for a shorter period than through Oct. 1, 2016, but may not extend it to policy years beginning after Oct. 1, 2016. States may choose to adopt both the Nov. 14, 2013 policy as well as extending it through Oct. 1, 2016, or adopt one but not the other, in the following manner:

- For both the individual and the small group markets;
- For the individual market only;
- For the small group market only; or
- A state may also choose to adopt the transitional relief policy only for the large business that currently purchase insurance in the large group market but that, for policy years beginning on or after Jan. 1, 206, will be redefined as small business purchasing insurance in the small group market.

Issuers offering renewals must provide notice to consumers informing them of their options and the new consumer protections that are available in other plans. Specifically, issuers must inform consumers about the protections their renewed plan will not include, and how they can learn about the new options and financial assistance available to them through the marketplaces. This policy applies to "early renewals" in states that permit it. The issuer notice forms to be used when: (1) a cancellation notice has already been sent and the issuer is providing an option to the policyholder to continue existing coverage; and (2) a cancellation notice has not yet been sent and the issuer is providing an option to the policyholder to continue the existing coverage, are included as attachments to the Bulletin.

Hardship Exemption

On Dec. 19, 2013, CMS issued guidance [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf] indicating that individuals whose policies are cancelled because the coverage is not compliant with the ACA qualify for a hardship exemption if they find other options to be more expensive and are able to purchase catastrophic coverage. The hardship exemption will continue to be available until Oct. 1, 2016, for those individuals whose non-compliant coverage is cancelled and who meet the requirements specified in the guidance.

HHS Notice of Benefit and Payment Parameters for 2015 Final Rule

HHS also released a final rule [https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-05052.pdfhttps://s3.amazonaws.com/public-inspection.federalregister.gov/2014-05052.pdf] describing the payment parameters applicable to the 2015 benefit period and standards relating to:

- Premium stabilization programs;
- The open enrollment period for 2015;
- The annual limitations on cost sharing;
- Consumer protections;

- Financial oversight; and the Small Business Health Options Program (SHOP);

Highlights of the Final Rule

CMS has published a fact sheet [https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-05052.pdf] summarizing the final rule.

Premium Stabilization Programs—HHS has previously outlined the major provisions and parameters related to the advance payments of premium tax credit, cost-sharing reductions, and premium stabilization programs. The premium stabilization programs are intended to promote price stability, especially in the early years of implementation of the new health law. This rule finalizes additional provisions related to the implementation of these programs, including certain oversight provisions for the premium stabilization programs, as well as key payment parameters for the 2015 benefit year. These programs—the risk adjustment, reinsurance, and risk corridors programs—are intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets.

The HHS Notice of Benefit and Payment Parameters for 2014 final rule finalized the risk adjustment methodology that HHS will use when it operates risk adjustment on behalf of a State. This final rule establishes updates to the risk adjustment methodology for 2014 to account for certain private market Medicaid expansion alternative plans. It also establishes the counting methods for determining small group size for participation in the risk adjustment and risk corridors programs.

Open Enrollment Period for 2015—CMS has finalized the annual open enrollment period for the 2015 benefit year which will begin Nov. 15, 2014 and extend through Feb. 15, 2015. These dates are especially important to States planning to operate an exchange after 2014 and are preparing to obtain approval from HHS of their operational readiness.

Approval of Exchange Blueprint—The rule provides more time for states to transition to a state-based marketplace after 2014 by moving the date on which a state must have an approved or conditionally approved Exchange Blueprint in place from June 15 of the previous plan year rather than Jan. 1 of the previous plan year.

Annual Limitations on Cost-sharing—The ACA sets limits on cost-sharing and requires that these limits be updated annually based on the percent increase in average premiums per person for health insurance coverage. For 2015, CMS updated these limits based on projections of average per enrollee employer sponsored insurance (ESI) health insurance premiums from the National Health Expenditure Accounts (NHEA). As a result, the annual maximum annual limitation on cost-sharing for 2015 for self-only coverage is $6,600 ($13,200 for a family), and a maximum annual limitation on deductibles for 2015 for plans in the small group market for self-only coverage of $2,050 ($4,100 for families) which are both lower than originally proposed.

The rule also prohibits cost-sharing for stand-alone dental plan covering the pediatric dental essential health benefit (EHB) in any marketplace to exceed $350 for one covered child and $700 for two or more covered children.

Quality Health Plan (QHP) Safety and Quality Standards—The final rule aligns QHP issuer standards with Medicare Hospital Conditions of Participation requirements for a quality assessment and performance improvement program and discharge planning for the first two years of operation. CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) which health-care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs.

Small Business Health Options Program (SHOP)—The final rule permits states to allow enrollment in a QHP through the SHOP by using the website of an agent or broker in those states that allow that activity under state law.

2015 Marketplace Blueprint Application

On March 7, CCIIO released its 2015 Marketplace Blueprint application http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1254283.html?DLPage=1&DLSort=1&DLSortDir=descending which any state seeking to operate a state-based marketplace, a state-based SHOP marketplace, or participate in a state partnership marketplace for plan year 2015 must complete to receive HHS approval for operation. The ACA requires HHS to approve or conditionally approve all plan year 2015 marketplace applications no later than June 15, 2013 for operation in 2015. States must first submit a declaration letter to CMS CCIIO by or before May 1, 2014. Please note that as yet CCIIO has not issued guidance for states wishing to transition state-based Exchanges to federally-facilitated exchanges. NCSL has submitted a request for CCIIO to issue that guidance as soon as possible. Instructions for completion of the declaration letter and the application template are available on the CCIIO web site [http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1254283.html?DLPage=1&DLSort=1&DLSortDir=descending].

2015 Letter to Issuers in the Federally-facilitated Marketplaces

On March 14, the Centers for Consumer Information and Insurance Oversight (CCIIO) released their final 2015 Letter to Issuers in the Federally-facilitated Marketplaces (FFM) [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf]providing guidance to issuers who wish to offer Qualified Health Plans (QHPs) in an FFM in 2015. The letter offers operational and technical guidance concerning the application and certification process, plan design, performance and oversight, and other operational details which require issuer compliance in order to qualify for certification. Specifically, these guidance documents propose or advance policies to:

- Standardize consumer notices when health insurers decide to discontinue or renew coverage;
- Initiate quality reporting and enrollee satisfaction surveys;
- Implement new Small Business Health Options Program (SHOP) functions;
- Strengthen standards for navigators and other consumer assisters;
- Improve premium stabilization policies for 2015; and
- Provide operational guidance and promote access to care in qualified health plans in the FFM.

Fact Sheet: Exchange and Insurance Market Standards for 2015 and Beyond and Final 2015 Letter to Issuers in the Federally-facilitated Marketplace [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/marketstandards-3-14-2014.html]

Frequently Asked Questions (FAQs) on the Use of 1311 Funds and No Cost Extensions

A newly released FAQ [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/no-cost-extension-faqs-3-14-14.pdf] provides clarification about grant funding under the ACA Section 1311(a) available to states in which the federal government will operate a Federally-facilitated Marketplace (FFM), including State Consumer Partnership Marketplaces (SPMs). All project periods for 2014 SPMs and SBMs end on December 31, 2014.

IRS Guidance Regarding the Eligibility for Premium Tax Credit for Victims of Domestic Abuse

The Internal Revenue Service (IRS) issued guidance [http://www.irs.gov/pub/irs-drop/n-14-23.pdf]explaining how a victim of domestic abuse could claim premium tax credits under the tax code. Notice 2014-23, released March 26, modifies a requirement that married taxpayers must file joint returns to qualify for premium tax credits under the Affordable Care Act (ACA). Current law describes individuals eligible for the tax credits as those who are married and

filing jointly, aren't claimed as someone else's dependent, and have income for the taxable year that falls within 100 percent and 400 percent of the federal poverty for the taxpayer's family size, the notice said. This March 26 notice states that a married taxpayer will satisfy the joint filing requirement when filing a 2014 tax return using the married-filing-separately status, provided that the taxpayer isn't living with their spouse when filing the tax return. This process will also allow the individual to be eligible for premium tax credits as long as they indicate the domestic abuse situation on their return.

Reporting of Minimum Essential Coverage

The Internal Revenue Service (IRS) released final rules [https://www.federalregister.gov/articles/2014/03/10/2014-05051/information-reporting-of-minimum-essential-coverage] providing guidance to providers of minimum essential health coverage who must report coverage to the IRS. Health insurance issuers, certain employers, and others that provide minimum essential coverage to individuals must report to the IRS information about the type and period of coverage and furnish the information in statements to covered individuals. **These final regulations affect** insurance issuers and carriers, employers, governments, and other persons that provide minimum essential coverage to individuals.

Unless otherwise provided by statute or regulation, a government employer that maintains a self-insured group health plan or arrangement may enter into a written agreement with another governmental unit, or agency to file the returns and to furnish the statements required by this section for some or all of the individuals receiving minimum essential coverage under that plan or arrangement. Governmental units or agencies must be part of or related to the same governmental unit as the government employer and agree to the designation. The rule establishes special rules for certain government-sponsored programs including:

1. **Medicaid and Children's Health Insurance Program (CHIP) coverage—**the state agency that administers the Medicaid or the CHIP program must file the returns and furnish the statement required by this section for those programs.
2. **Government-sponsored coverage provided through health insurance issuers—**an executive department or agency of a government unit that provides coverage under a government-sponsored program through a health insurance issuer (such as Medicaid, CHIP, or Medicare, including Medicare Advantage) must file all returns and statements required by the rule.

Reporting entities must file returns and transmittals on or before Feb. 28 (March 31 if filed electronically) of the year following the calendar year in which it provided minimum essential coverage to an individual.

Final Regulations Implementing Information Reporting for Employers and Insurers under the ACA

The U.S. Department of the Treasury and the IRS also released final rules [https://www.federalregister.gov/articles/2014/03/10/2014-05050/information-reporting-by-applicable-large-employers-on-health-insurance-coverage-offered-under] to implement the information reporting provisions for insurers and certain employers which take effect in 2015. The rules offer employers that "self insure" a streamlined way to report under both the employer and insurer reporting provisions by providing a single consolidated form that employers will use to report to the IRS and employees. For employers that provide minimum value coverage to their full time employees, the final rules provide a simplified alternative to reporting monthly, employee-specific information on those employees. The fact sheet also provides and simple explanation of the information that must be reported.

U.S. Department of the Treasury Fact Sheet, http://www.treasury.gov/press-center/press-releases/Pages/jl2310.aspx

CCIIO also published a proposed rule March 21 updating operating policy based on their experience with the initial open enrollment. Updates may include clarifying federally-managed services available for states in the second year of operations, expanding the use of data for efficient operations of the exchange instead of minimum exchange functions, developing privacy standards in the exchange for the Federally-facilitated Exchanges (FFE) and non-exchange entities, implementing penalties related to false, fraudulent, or improper use of information, clarifying eligibility and appeals coordination responsibilities with state Medicaid agencies, and addressing treatment of retroactive eligibility from an appeal. This proposed rule would also establish requirements for Exchanges and QHPs to implement specific quality-related provisions of the ACA.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards

The proposed rule would amend existing rules pertaining to Navigators, Non-Navigator Assistance Personnel, and Certified Application Counselors in an FFE, or state partnership exchange. The proposed amendments would be directed at non-federal requirements that conflict with federal statutory or regulatory standards and prevent the performance of their required duties. Among several requests for comments, the rule asks for comments as to whether the Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselors provisions should also be applicable to state exchanges. The proposed language would put into regulatory text their position that Navigators must not be required to become an agent or a broker, or to carry errors and omissions coverage.

The proposed rule outlines additional new standards for Navigator conduct including prohibitions on:

- Charging consumers for Navigator services,
- Soliciting enrollees for their non- Navigator activities,
- Compensating Navigator organization employees based on the number of successful applications or enrollments completed,
- Providing gifts or promotional items to applicants,
- Going door-to-door or using other unsolicited means of direct contact to help consumers fill out applications or enroll (this does not include door-to-door activities for educational purposes), and
- Robocalls, or calls made using an automatic dialing system.

These new standards would also apply to Non-Navigator assistance personnel in FFEs, State Partnership Exchanges, and in State Exchanges if funded with an Exchange Establishment grant.

Amends existing rules to permit Exchanges would be given the authority to set their own recertification standards for Certified Application Counselors. The rules also propose amendments to permit Exchanges to certify individuals as application counselors including agents and brokers, as long as they comply with the specified standards of conduct.

Collection of Civil and Monetary Penalties (CMP) for the Provision of False or Fraudulent Information to an Exchange

The ACA's provisions creating procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and the individual responsibility exemptions also specified that civil and monetary penalties would be imposed in the event that an individual provided false or fraudulent information. HHS intends to work with states to oversee, monitor, and enforce compliance to ensure consistent enforcement practices. The rule establishes standards for notices of intent to issue a CMP which require that a written notice go out to the individual in writing, which would be either hand delivered or sent by certified mail, return receipt requested, or by overnight delivery service with signature required upon delivery.

Seven elements must be included in the notice including: (1) a description of the findings of fact; (2) the basis and reasons why the findings of fact subject the person to a penalty; (3) circumstance considered in determining the amount

of the penalty; (4) the amount of the proposed penalty; (5) the individuals' right to an administrative hearing; (6) the fact that a failure to request a hearing within 60 calendar days of notice would permit the assessment of the penalty to move forward, and; (7) information on how to file a request for a hearing. The Office of the Inspector General (OIG) would have the responsibility of imposing penalties. HHS is proposing a six year statute of limitations within which HHS may impose a penalty.

Miscellaneous Proposals

The proposed rule also addresses other issues related to eligibility, enrollment and termination of coverage, employer appeals process, Small Business Health Options Program (SHOP), and quality reporting.

Comment Period

Comments on the proposed rule must be received before 5 p.m. April 21, 2014 for consideration.