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Overview of the June 19, 2013 Proposed Rule on Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards

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Table of Contents

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Introduction

On June 19, 2013, the U.S. Department of Health and Human Services (HHS) issued a notice of proposed rulemaking (NPRM) on *Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards* (http://www.gpo.gov/fdsys/pkg/FR-2013-06-19/pdf/2013-14540.pdf). This document provides a high-level summary of these rules and highlights the items for comment. Comments are due to HHS no later than 5:00 p.m. on July 19, 2013.

Part 144: Requirements Related to Health Insurance Coverage

In this section, HHS proposes the following changes to definitions:

- Delete references to the definition of group health plans that do not reflect the Affordable Care Act (ACA) amendments to the definition of "small employer." New language would state that coverage offered to an association member other than in connection with a group health plan is considered individual health insurance coverage.
- Amend the definition of "policy year" to mean a calendar year for which health insurance coverage provides coverage for health benefits. This definition applies to non-grandfathered coverage in the individual market or in a market in which a state had merged the individual and small group markets.
- Amend the definitions of "small employer" and "large employer" to reflect the ACA language that defines large employers as having an average of at least 101 employees and small employers as having at least 1 but not more than 100 employees.

Items for Comment

HHS solicits comments on what interpretations of the statute, if any, are necessary to ensure smooth implementation across the Public Health Services Act, the Employee Retirement Income Security Act, and the Code, including comments to ensure that shared provisions are administered to have the same effect at all times, as required under the Health Insurance Portability and Accountability Act (HIPAA) §104 and HHS's memorandum of understanding.

Part 147: Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

Fair Health Insurance Premiums (§147.102)

HHS proposes to clarify the definition of rating area within the small group and individual markets. For the small group market, a rating area is determined using the principal business address of the group policyholder. For the individual market, a rating area is determined using the address of the primary policyholder, regardless of the location of other individuals covered under the plan or coverage. HHS notes that this proposed rule would be applied both inside and outside the Exchange. HHS also proposes a cross-reference that clarifies the connection between the premium rating and single risk pool requirements.

Items for Comment

HHS seeks comment on its revision to the definition of rating area within the small group and individual markets.

Guaranteed Availability and Renewability of Coverage (§§147.104, 147.106)

HHS proposes to clarify language to ensure that the guaranteed availability and renewability requirements apply to the individual, small group, and large group markets. HHS proposes amendments recognizing the distinction of the large and small group markets for purposes of the guaranteed availability and guaranteed renewability requirements. The clarification would ensure, for example, that a health insurance issuer must offer to a large employer all products that are approved for sale in the large group market but not those products approved for sale only in the small group market, and vice versa. HHS proposes similar amendments with regard to guaranteed renewability within the large and small group markets.

HHS proposes a clarification to state that, as of January 1, 2015, all non-grandfathered coverage must be offered on a calendar year basis. HHS notes that this will apply to coverage in the individual market or in a market where the state has merged the individual and small group markets. HHS notes that, for purposes of new enrollment effective on any date other than January 1, the first policy year following such enrollment may comprise a prorated policy year, ending on December 31.

Part 153: Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

In this section, HHS proposes accounting requirements and record retention standards. HHS notes that it intends to engage in further consultations with stakeholders and to propose additional standards related to the oversight of the premium stabilization programs in future

regulations and guidance. This includes standards that would govern data validation for risk adjustment when HHS operates a risk adjustment program on behalf of a state.

Items for Comment

HHS seeks comment on the proposed requirements and standards related to state-operated reinsurance and risk adjustment programs.

1. Subpart A – General Provisions

Definitions (§153.20)

HHS proposes to revise the definition of "contributing entity" to include a group health plan that is partially self-insured and partially insured, but only where the insured coverage does not constitute major medical coverage (whether or not the self-insured coverage is major medical coverage).

2. Subpart C – State Standards Related to the Reinsurance Program

Maintenance of Records (§153.240(c))

HHS proposes to revise existing language such that if a state establishes a reinsurance program, the state would be directed to maintain documents and records relating to the reinsurance program (whether paper electronic, or in other media) for each benefit year for at least 10 years. HHS would require states to ensure that their contractors, subcontractors, and agents similarly maintain and make relevant documents and records available upon request. HHS notes that a state may satisfy this standard through archiving and ensuring that they are accessible if needed for investigation, audit, or other review.

Items for Comment

HHS seeks comment on the proposed maintenance of records requirement for state-operated reinsurance programs.

General Oversight Requirements for State-Operated Reinsurance Program (§153.260)

HHS proposes that a state establishing its reinsurance program would be required to ensure that such reinsurance entity keep, for each benefit year, an accounting of the following: (1) all reinsurance funds received from HHS for reinsurance payments and for administrative expenses, (2) all claims for reinsurance payments received from issuers of reinsurance-eligible plans, (3) all reinsurance payments made to issuers of reinsurance-eligible plans, and (4) all administrative expenses incurred for the state's reinsurance program. HHS noted that such accounting must be kept in accordance with generally accepted accounting principles.

HHS also proposes that a state that establishes the reinsurance program would be directed to submit to HHS and make public a summary report on its reinsurance program operations for each benefit year, in the manner and timeframe specified by HHS. HHS further proposes that a state that establishes its reinsurance program must engage an independent qualified auditing entity to perform a financial and programmatic audit of the program. A state must ensure that the auditing process addresses the prohibition concerning the improper use of reinsurance funds for administrative expenses. An audit must be conducted for each benefit year in accordance with generally accepted auditing standards, and the qualified auditing entity may be a government entity. HHS intends to provide more information on auditing standards in future guidance. HHS proposes that the state submit the results of the independent external audit for each benefit year and make public a summary of the results of the audit.

Items for Comment

HHS seeks comment on these proposed oversight requirements for state-operated reinsurance programs.

Restrictions on Use of Reinsurance Funds for Administrative Expenses (§153.265)

HHS proposes that a state operating reinsurance would be required to keep accurate account of reinsurance funds received from HHS for administrative expenses. If a state incurs fewer expenses in operating reinsurance for a benefit year than are allocated to it under the national reinsurance contribution rate, then the state would be required to carry over those funds for operating reinsurance in subsequent years. The standards for Exchanges that prohibit improper use of funds allocated toward administrative and operational expenses must be applied to state-operated reinsurance programs. The Exchange-related prohibitions that would be applied include staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

Items for Comment

HHS seeks comment on the prohibitions for state-operated reinsurance programs that are identified as an improper use of funds allocated toward administrative and operational expenses.

3. Subpart D – State Standards Related to the Risk Adjustment Program

Maintenance of Records (§153.310(c)(4))

HHS proposes that a state-operated risk adjustment program would be required to maintain documents and records relating to the risk adjustment program (whether paper, electronic, or in other media) for each benefit year for at least ten years. HHS notes that a state may satisfy this standard through archiving and ensuring that they are accessible if needed for investigation, audit, or other review.

Items for Comment

HHS seeks comment on the proposed maintenance of records requirement for state-operated risk adjustment programs.

Interim Report and State Summary Report (§153.310(d))

HHS proposes that a state provide interim and summary reports in order to obtain recertification from HHS to operate risk adjustment for a third benefit year.

- An interim report must include a detailed summary of the risk adjustment activities in the first ten months of the benefit year. This report would be due no later than December 31 of the first benefit year in which the state operated risk adjustment. Because the process of certification begins more than a year before the applicable benefit year, the first year for which an interim report based on the year's operations could be used for certification purposes is the third benefit year. HHS intends to provide more information on the risk adjustment interim report in future guidance.
- A detailed summary report of risk adjustment program operations for the most recent benefit year for which risk adjustment operations were completed will also be due to HHS. HHS proposes that the detailed summary include the results of a programmatic and financial audit, any material weaknesses or significant deficiencies identified in such audit, and how the state intends to take corrective action. The timeframe and manner of the detailed summary would be specified by HHS.

Items for Comment

HHS seeks comment on the content, format, and other requirements for a state-operated risk adjustment program to conduct an interim and detailed summary report.

General Oversight Requirements for State-Operated Risk Adjustment Programs (§153.365)

HHS proposes that a state operating risk adjustment must keep an account of all receipts and expenditures related to risk adjustment payments and charges and the administration of risk-adjustment-related functions and activities for each benefit year.

Risk Adjustment Methodology

HHS proposes two changes to the risk adjustment payment transfer formula that it will use when operating risk adjustment on a state's behalf. The two changes are: (1) in the case of family tiering states, billable members would be based on the number of children that implicitly count towards the premium under a state's family rating factors, and (2) a modification to the allowable rating factor formula that would be used for family tiering states.HHS notes that, aside from these proposed changes, payment transfers in family tiering states will be calculated using the

formulas provided in the Payment Notice: 78 FR at 1543-34. HHS also notes that the proposed changes would not apply to community rated states that do not implement family tiering rating factors.

4. Subpart E – Health Insurance Issuer and Group Health Plan Standards Related to the Reinsurance Program

Reinsurance Contribution Funds (§153.400)

HHS proposes that a health insurance issuer providing coverage under a group health plan would be required to make reinsurance contributions for lives under its health insurance coverage—even when such coverage does not constitute major medical coverage—if:

- The group health plan provides health insurance coverage for the same covered lives through more than one insurance policy that in combination constitute major medical coverage but individually do not.
- The lives are not covered by self-insured coverage of the group health plan (except for self-insured coverage limited to excepted benefits).
- The health insurance coverage under the policy offered by the health insurance issuer represents a percentage of the total health insurance coverage under the policy offered in combination by the group health plan that is greater than the percentage offered under any of the other policies.

HHS proposes that the percentage of coverage offered under various policies would be determined based on the average premium per covered life for those policies. When the percentage of coverage for two or more insurance policies is equal, the policy issuer that provides the greatest portion of in-network hospitalization benefits will be responsible for reinsurance contributions. HHS acknowledges that an issuer of group health insurance coverage that does not, by itself, constitute major medical coverage may not be aware of the existence of, or premium for, other health insurance coverage obtained by a plan sponsor covering the same lives under a group health plan. HHS is therefore considering requiring such issuer to seek a representation from the plan sponsor regarding the relative percentage of coverage offered by the issuer.

Where a group health plan under which some benefit options for employees are insured by the issuer, and some offer benefits without the involvement of an issuer–because the group health plan or some non-issuer entity assumes the risk for that coverage option–HHS proposed that if a coverage option is insured by an issuer, the issuer would be responsible for the reinsurance contribution associated with that coverage option. Additionally, if an employee coverage option under such group health plan is not insured –because the group health plan or some non-issuer entity assumes the risk for that coverage option–the group health plan would be responsible for the reinsurance contribution associated with that coverage option.

Items for Comment

HHS seeks comment on:

- Whether and in what circumstances an issuer should be entitled to rely upon such representations and what other means HHS should consider ensuring that the relevant issuer is aware of its obligation to make reinsurance contributions. This includes any role that the employer should have in ensuring that issuers have necessary information to determine which issuer is responsible for reinsurance contributions.
- The methodology to determine which group health insurance issuer would be required to make reinsurance contributions, as well as alternative approaches that should be considered for determining responsibility for reinsurance contributions in such circumstances.
- The proposed approach to determine reinsurance contribution obligations where (1) a group health plan under which some benefit options are insured by an issuer and (2) some options offer benefits without the involvement of an issuer in insuring the benefits.

In considering a proposed definition for "major medical coverage" that would provide clarity around the responsibility to make reinsurance contributions, HHS seeks comment on what further clarification is needed and what the definition should be.

Maintenance of Records (§153.405(h) and §153.410(c))

HHS proposes that a contributing entity would be required to maintain documents and records (whether paper, electronic, or in other media) sufficient to substantiate the enrollment count submitted pursuant to that section for at least 10 years. HHS also proposes that an issuer of a reinsurance-eligible plan in a state where HHS operates reinsurance would be required to maintain documents and records (whether paper, electronic, or in other media) sufficient to substantiate the requests for reinsurance payments made pursuant to that section for at least 10 years.

Items for Comment

HHS seeks comment on the maintenance of records requirement for a contributing entity and an issuer of a reinsurance-eligible plan in a state where HHS operates the reinsurance program.

5. Subpart F – Health Insurance Issuer Standards Related to the Risk Corridors Program

In this section, HHS notes that certain requirements for qualified health plans (QHPs) do not apply to stand-alone dental plans. HHS believes that it would not be appropriate to subject stand-alone dental plans to the risk corridors program because such plans are excepted benefits and not

subject to the federal prohibition on underwriting premiums or the requirement to base pricing using the single risk pool. States have the option to prohibit underwriting for excepted benefit plans. HHS notes that stand-alone dental plans are also excepted from the reinsurance and risk adjustment programs, and stand-alone dental claims would not be pooled with an issuer's other claims for purposes of determining "allowable costs" in the risk corridors calculations.

Items for Comment

HHS seeks comment on this proposed approach for stand-alone dental plans.

6. Subpart G–Health Insurance Issuer Standards Related to the Risk Adjustment Program

HHS proposes to require an issuer that offers risk adjustment-covered plans to maintain documents and records (whether paper, electronic, or in other media) sufficient to enable the evaluation of the issuer's compliance with applicable risk adjustment standards. This standard would require an issuer of a risk adjustment-covered plan to retain additional records—not only those pertaining to data validation—to substantiate its compliance with risk adjustment standards, regardless of whether risk adjustment is operated by HHS or the state. HHS anticipates that the bulk of the record maintenance obligations will relate to data validation.

Items for Comment

HHS seeks comment on the proposed maintenance of records requirement for issuers offering risk adjustment-covered plans.

7. Subpart H–Distributed Data Collection for HHS-Operated Programs

Failure to Comply with HHS-Operated Risk Adjustment and Reinsurance Data Requirements (§153.740)

HHS proposes that it may pursue an enforcement action for civil money penalties against an issuer in a state where HHS operates reinsurance or risk adjustment. HHS notes that it will pursue enforcement if an issuer fails to: (1) establish a secure, dedicated distributed data environment; (2) provide HHS with access to enrollee-level plan enrollment information, enrollee claims data, or enrollee encounter data through its dedicated distributed data environment; (3) otherwise comply with the requirements related to a secure, dedicated distributed data environment; (4) adhere to the reinsurance data submission requirements; or (5) adhere to the risk adjustment data submission and data storage requirements.

Risk Adjustment

HHS proposes to apply the standards in connection with the imposition of civil monetary penalties to risk adjustment-covered plans. HHS notes that it intends to work collaboratively with issuers to address any problems in establishing dedicated distributed data environments in 2014. HHS also proposes that it will assess the default risk adjustment charge. However, HHS notes that it may elect to pursue civil monetary penalties in conjunction with the imposition of the default risk adjustment charge if an issuer failed to comply with applicable data security or privacy standards, putting the interests of third parties at risk.

Reinsurance

HHS proposes that an issuer of a reinsurance-eligible plan may be subject to civil monetary penalties for failure to comply. HHS notes that it would reserve the right to pursue these penalties regardless of whether or not an issuer becomes ineligible for reinsurance payment as a result of failing to comply.

Default Risk Adjustment Charge (§153.740)

HHS proposes that if an issuer of a risk adjustment-covered plan fails to (1) establish a dedicated distributed data environment or (2) provide HHS with access to risk adjustment data in such environment by April 30 of the year following the applicable benefit year (such that HHS cannot apply its federally certified risk adjustment methodology to calculate the plan's risk adjustment payment transfer amount in a timely fashion), then HHS would assess a default risk adjustment charge.

HHS notes that delaying the calculation of risk adjustment payment transfers in a market in a state until all risk adjustment-covered plans submit complete risk adjustment data would weaken the integrity of the April 30 data submission deadline and jeopardize related deadlines for the risk corridors and medical loss ratio (MLR) programs. HHS intends to provide future guidance on any applicable review processes available to those issuers for whom the agency proposes to assess a default charge.

HHS is considering two methods for calculating the default risk adjustment charge. One option would be to use the highest per member per month (PMPM) charge among risk adjustment-covered plans in a risk pool in the market in the plan's geographic rating area. The second option would be to use a PMPM default charge that is two standard deviations above the mean charge in the market in the plan's geographic rating area.

Items for Comment

HHS seeks comment on:

- The proposed approach for default risk adjustment charges.
- The proposed methods for determining default risk adjustment charges, as well as other appropriate methods and sources of data HHS could use to determine enrollment data for non-compliant issuers.
- Whether to allocate a non-compliant issuer's default charge to issuers in the market as part of payments and charges in the concurrent benefit year, during a subsequent benefit year, or sometime between annual payments and charges processes.

Part 155: Exchange Establishment and Other Related Standards

1. Subpart A–General Provisions

Definitions (§155.20)

- HHS notes that it previously interpreted Section 1311(b) of the ACA to mean that a state Exchange must elect to carry out both the individual and Small Business Health Options Program (SHOP) functions. Because some states have expressed interest in operating only a SHOP Exchange, HHS has revised its interpretation to allow a state to only operate a SHOP. Therefore, HHS proposes that if the state will establish only a SHOP Exchange, and will not operate the individual market Exchange, HHS must establish and operate the individual market Exchange. HHS proposes to modify the definition for "Exchange" to reflect this new flexibility for states.
- HHS proposes that the definition of "Exchange" would mean a governmental agency or non-profit entity that meets the applicable standards and makes QHPs available to qualified individuals and/or qualified employers. HHS clarifies that it intends the phrase "meets the applicable standards of this part" to refer to any applicable standard of Part 155, "*Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act*," and the special rules applicable to regional Exchanges. HHS further clarifies that there must be an individual market Exchange and a SHOP Exchange in each state.
- HHS proposes to define "issuer customer service representative" to mean an employee, contractor, or agent of a QHP issuer that provides assistance to applicants and enrollees, but is not licensed as an agent, broker, or producer under state law.
- HHS proposes to specify that, for a plan offered outside the Exchange to be considered the same plan as one that is certified as a QHP and offered through the Exchange, the following items must be identical: benefits package, provider network, service areas, and cost-sharing structure. HHS notes that this proposed approach would relieve an issuer of a plan that has been certified as a QHP by the Exchange from the requirement to charge the same premium for the QHP sold to consumers outside the Exchange. HHS also proposes to clarify that a plan sold to consumers outside the Exchange would only be

subject to the risk corridors program if it is the same as a QHP actually offered by that issuer inside the Exchange.

Items for Comment

- HHS invites general comments, including whether HHS should amend provisions to provide states with the flexibility to establish and operate only a SHOP.
- HHS requests comment on all aspects of the proposed approach, particularly on issues that may be raised by this approach for state requirements for product or policy form filings, including filings for coverage riders (whether mandatory or optional), state-required benefits, and state-required service areas (including tiered networks within service areas).
- HHS seeks comment on whether the criteria for ensuring a QHP is identical to a plan sold outside the Exchange—benefits, provider network, service areas, and cost-sharing structure—are the proper criteria, and whether additional criteria such as allowances for *de minimus* variations that do not change plan actuarial value should be included, or whether no criteria are necessary because it is clear from state oversight processes when a plan is the same plan or a different plan. HHS seeks comment on how this proposed approach would affect what is considered a new plan offering and the potential impact of this proposal on plan renewals.
- HHS seeks comment on the operational feasibility of the proposed requirements for QHPs and plans sold outside the Exchanges, particularly with regard to issuers in the small group market.

2. Subpart B–General Standards Related to the Establishment of an Exchange

Establishment and Approval of a State Exchange (§§155.100, 155.105, and 155.140)

HHS proposes an amendment to permit a state to operate a state-based SHOP Exchange only, where the individual market Exchange would be operated as a federally facilitated Exchange (FFE). HHS has not proposed that a state be allowed to operate an individual market Exchange while HHS is responsible for the operation of a federally facilitated SHOP (FF-SHOP) Exchange in the state.

HHS proposes that a state that has timely applied for certification of an Exchange for 2014 and that has received conditional approval for its application would be able to modify its Blueprint to exclude the operation of the individual market Exchange functions for 2014.

Items for Comment

HHS seeks comment on the approach to allow a state to establish a state-based SHOP Exchange only with an FFE but not allow a state to establish a state-based individual Exchange with an FF-SHOP.

3. Subpart C–General Functions of the Exchange

Functions of an Exchange

In this section, HHS proposes that a state operating only an Exchange that provides for the establishment of a SHOP need only perform the minimum functions described in subpart H and all applicable provisions of other subparts referenced therein.

Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§155.220)

HHS established general Exchange standards that agents and brokers must meet in order to assist individuals in enrolling in QHPs and applying for advance payments of the premium tax credit (APTCs) and cost-sharing reductions (CSRs), including registration, training, compliance with the privacy and security standards adopted by the Exchange, compliance with applicable state law, and execution of an agreement with the Exchange.

Web Broker Policies and Procedures

This section establishes standards that apply when an agent or broker uses its publicly facing website to assist individuals in selecting or enrolling in a QHP. HHS proposes to amend display and disclosure requirements for web-based brokers to meet all standards contained in §155.205(b)(1) and 155.205(c). HHS proposes to limit a web-based broker's obligation to display and disclose the QHP information to all the information provided to the web broker by the Exchange or directly by the issuer. HHS notes that some of the required data, such as quality rating and enrollee satisfaction survey results, may not be available in the first of Exchange operations, in which case web brokers would not be required to display this information. HHS proposes that, to address situations where the web broker is unable to display certain QHP information, the web broker must display a link to the Exchange website so the consumer may obtain the additional information.

HHS also proposes to add new language that would require web brokers' websites in an FFE to prominently display language notifying consumers that: (a) the web broker's website is not an FFE website; (b) the web broker's website might not display all QHP data available on the Exchange website; (c) the web broker has entered into an agreement with HHS; and (d) the web broker agrees to comply with standards related to §155.220.

HHS expects to make available an application programming interface ("API") that would permit web brokers to use their public-facing websites to assist consumers in enrolling through individual market QHPs offered through an FFE ("FFE API"). HHS proposes that an FFE API would allow an individual seeking to enroll in a QHP to initiate his or her shopping experience on a web broker's website, connect securely to an FFE website to complete the eligibility application and determination process, and return securely to the web broker's website to compare and select a QHP.

HHS proposes requiring web brokers who make websites available to other agents or brokers to require, as a condition of the agreement or contract, that the agent or broker accessing and using the web broker's website complies with standards related to §155.220. HHS proposes that the web broker would be required to provide to HHS a list of agents and brokers who are under such arrangements, and that the web broker be required to comply with the policies that the web broker would be required to develop under §155.220(d)(4), as proposed below.

Agent and Broker Policies and Procedures on Privacy and Security in an FFE

HHS proposes to require agents and brokers assisting or enrolling consumers in the individual market of an FFE to establish policies and procedures implementing the privacy and security standards (to train their employees, representatives, contractors, and agents with regard to those policies and procedures on a periodic basis) and to ensure that their employees, representatives, contractors, and agents comply with those policies and procedures.

Standards for Agent and Broker Agreement Termination in an FFE

HHS proposes to require agents and brokers who wish to terminate their agreement with an FFE to send to HHS a 30-day advance written notice of the intent to terminate the agreement and the intended date of termination. If the notice does not specify a date of termination, or the date is not acceptable to HHS, HHS may set a date that will be no less than 30 days from the date of the agent or broker's notice of termination.

HHS proposes to establish new standards for agents and brokers in the FFEs, so that agents and brokers that register with an FFE have a clear understanding of the rights and standards governing their participation in an FFE. HHS proposes the standards under which it may terminate an agent's or broker's agreement with an FFE with cause. HHS proposed that it may pursue termination with notice of an agent's or broker's agreement with an FFE if HHS identifies a specific finding of noncompliance or pattern of compliance that is sufficiently severe. In such case, HHS would take necessary steps to prohibit an agent or broker from assisting or enrolling individuals in an individual market QHP offered through an FFE or prohibit a web broker from securely exchanging information with HHS.

HHS proposes that an agent or broker would be considered noncompliant if HHS finds that the agent or broker violated: (1) any standard related to §155.220 ("*Ability of States to Permit Agents*

and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs"); (2) any term or condition of its agreement with the FFE, including but not limited to the FFE privacy and security standards; (3) any applicable state law; or (4) any other applicable federal law. If HHS finds noncompliance or patterns of noncompliance to be sufficiently severe, such a finding would form the basis for a termination with cause. HHS proposes that termination with cause would result in the loss of the ability to assist individuals enroll in QHPs and transact data with HHS, including transactions through the FFE API.

HHS proposes to establish a one-level process through which an agent or broker may request reconsideration of HHS's decision to terminate the agreement for cause. An agent or broker must submit a request for reconsideration to an appropriate HHS designee (referred to as a "reconsideration entity") within 30 calendar days of the date of the notice. The reconsideration entity would provide the agent or broker with a written reconsideration decision within 30 calendar days of the date it receives the request for reconsideration. This written decision would constitute HHS's final determination.

Items for Comment

HHS seeks comment on:

- Whether the obligation to display and disclose QHP information for web brokers should be limited to the extent an FFE (and not a state-based Exchange) can provide such information.
- How to ensure that web brokers display QHP information received by an Exchange or QHP issuers in a manner consistent with the QHP information displayed on an Exchange website.
- The standards and protocols when a web broker is unable to display certain QHP information, such as requiring the web broker to display a link to the Exchange website so consumers may obtain additional QHP and other information.
- The circumstances and proposed approach with regard to web brokers making their website available to other brokers and agents. Additionally, HHS seeks comment on whether these arrangements should be prohibited outright, and on whether there are other options to consider.
- The appropriate frequency of retraining requirements with regard to privacy and security for employees of brokers and agents assisting or enrolling consumers in the individual market of an FFE.
- Its proposed procedures related to a broker's or agent's termination from an FFE. Furthermore, HHS seeks comment on other circumstances that should result in an HHS termination with cause.

- The information resolution approach it is considering implementing through future sub-regulatory guidance, specifically on whether it should consider any alternative proposals.
- The appropriate time length for a cure period and on whether it should include a provision permitting HHS to terminate an agent's or broker's agreement immediately and permanently for cause if findings of noncompliance are sufficiently egregious.
- The option that would allow it to immediately, but temporarily, suspend an agent or broker by prohibiting the agent or broker from assisting individuals to enroll in a QHP offered through the FFE and/or ability to securely exchange information with HHS, including through the FFE API, without advance notice.
- Its proposed rule for broker or agents seeking reconsideration of HHS's termination. HHS intends to provide further guidance on the manner and form in which agents and brokers should present requests for reconsideration, HHS's designation of an appropriate reconsideration entity, and additional procedures related to agent and broker revocation and reconsideration.
- The information required to carry out its oversight activities, and on any existing definitions, timeframes, or procedures, described in HHS's proposed rule relating to such activities.

Electronic Information Exchange with Covered Entities (§155.270)

HHS proposes to specify that to the extent an Exchange performs electronic transactions with a covered entity, an Exchange must use standards, implementation specifications, operating rules, and code sets that are adopted by the Secretary or that are otherwise approved by HHS. HHS further proposes to approve the HIX 820 transaction for transmitting payment-related information between the Exchange and a covered entity.

Items for Comment

HHS seeks comment on its proposed approach related to an Exchange performing electronic transactions with a covered entity.

Oversight and Monitoring of Privacy and Security Requirements (§155.280)

HHS proposes that it will monitor any individual or entity who would be subject to the privacy and security requirements as established and implemented by an Exchange. Furthermore, HHS would oversee and monitor the FFEs and non-Exchange entities associated with FFEs for compliance with the privacy and security standards established and implemented by the FFEs for compliance with such standards. State-based Exchanges will oversee and monitor non-Exchange entities associated with the state-based Exchange for compliance with the standards implemented by the state-based Exchange.

HHS proposes the oversight activities that HHS may conduct in order to ensure adherence to the privacy and security requirements. These may include, but are not limited to, audits, investigations, inspections, and any reasonable activities necessary for appropriate oversight of compliance with the Exchange privacy and security standards.

HHS proposes the following definitions of "incident" and "breach" as they apply to privacy and security:

- Incident: The act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data; unwanted disruption or denial of service; the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.
- Breach: The loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for any reason other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic.

HHS proposes that, in the event of an incident or breach, the entity where the incident or breach occurs would be responsible for reporting and managing it according to the entity's documented incident handling or breach notification procedures. FFEs, non-Exchange entities associated with FFEs, and state-based Exchanges must report all privacy and security incidents and breaches to HHS within one hour of discovering the incident or breach. HHS further proposes that a non-Exchange entity associated with a state-based Exchange must report all privacy and security incidents and breaches to the state Exchange with which they are associated.

Items for Comment

HHS seeks comment on its definitions of "incident" and "breach" as they relate to personally identifiably information and the proposed approach to the reporting of all privacy and security incidents and breaches.

4. Subpart D–Exchange Functions in the Individual Market: Eligibility Determinations

Eligibility Process (§155.310)

The intent of this proposed rule is to provide flexibility to states so that they may align incomplete application processes with Medicaid. HHS intends to work with states to implement these procedures and, in 2014, to accommodate states with processes established for handling incomplete applications that do not match the processes described.

HHS proposes that if an application filer does not provide sufficient information on an application for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange, or for insurance affordability programs (if the application includes a request for an eligibility determination for insurance affordability programs), the Exchange will provide notice through the eligibility determination notice. HHS proposes that the Exchange will provide the applicant with a period of no less than 15 days and no more than 90 days from the date a notice is sent to the applicant to provide necessary information.

HHS proposes that during this period, the Exchange will not proceed with the applicant's eligibility determination or provide APTCs or CSRs unless an application filer has provided sufficient information to determine his or eligibility for enrollment in a QHP through the Exchange, in which case the Exchange must make such a determination for enrollment in a QHP through the Exchange. HHS proposes a flexible timeframe of no less than 15 days and no more than 90 days. HHS notes that the online and telephonic applications are structured to minimize situations in which an applicant can fail to provide necessary information.

Items for Comment

HHS seeks comment on its approach to handling incomplete applications, including whether Exchange flexibility is appropriate; whether 15 days and 90 days are the right lower and upper limits; and whether additional language is needed to ensure coordination between the Exchange, Medicaid, and the Children's Health Insurance Program (CHIP).

Verification of Eligibility for Minimum Essential Coverage other than through an Eligible Employer-Sponsored Plan (§155.320)

HHS proposes to re-designate specified paragraphs to consolidate the standards for Exchange responsibilities in connection with verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan. HHS proposes to add the phrase "for verification purposes" to clarify that HHS would provide a response to the Exchange to verify the information transmitted from the Exchange to HHS about an applicant's eligibility for or enrollment in minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the Basic Health Program. HHS would work with the appropriate federal and state agencies to complete the appropriate computer matching agreements, data use agreements, and information exchange agreements that would comply with all appropriate federal privacy and security laws and regulations.

HHS also proposes to add language to provide that a health plan that is a government program providing public benefits is expressly authorized to disclose protected health information that relates to eligibility for or enrollment in the health plan to HHS for verification of applicant eligibility for minimum essential coverage. This includes verification for the purposes of the eligibility determination process for APTCs and CSRs.

HHS notes its intent for this provision to enable any health plan that is a government program to disclose the information necessary for HHS to be able to verify of minimum essential coverage as required to conduct eligibility determinations for insurance affordability programs.

Items for Comment

HHS seeks comment on this approach to verifying minimum essential coverage other than through an employer-sponsored plan.

Administration of APTCS and CSRs (§155.340)

In this section, HHS proposes that if the Exchange discovers that it did not reduce an enrollee's premium by the amount in accordance with regulations, then the Exchange will be required to refund to the enrollee any excess premium and must notify the enrollee of the improper allocation of the APTC no later than 30 days after the Exchange discovers it.

Items for Comment

HHS is considering requiring the Exchange to provide quarterly reports on the occurrences of improper allocation of the APTC beginning in the 2015 benefit year. HHS seeks comment as to whether it should establish a minimum error rate or threshold before an Exchange is required to report improper APTC allocations to HHS and what that rate or threshold should be. HHS also seeks comment as to whether these reports should be provided less frequently than quarterly.

5. Subpart E–Exchange Functions: Enrollment in QHPs

Allowing Issuer Customer Service Representatives to Assist with Eligibility Applications (§155.415)

HHS is proposing to allow Exchanges (at their option and to the extent permitted by state law) to permit issuer customer service representatives who do not meet the definition of an agent or broker to assist qualified individuals in the individual market with applying for an eligibility determination/redetermination through the Exchange, applying for insurance affordability programs, and facilitating the selection of a QHP offered by the issuer represented.

Special Enrollment Periods (§155.420)

In this section, HHS clarifies that special enrollment will be available when an Exchange determines that a consumer has been incorrectly or inappropriately enrolled in coverage due to misconduct of a non-Exchange entity. HHS proposes to limit this special enrollment opportunity to the individual market (and will not apply to the SHOP market). This special enrollment would include instances in which individuals are not enrolled in QHP coverage as desired, are not enrolled in their selected QHP, or have been determined eligible for, but are not receiving,

APTCs and CSRs. Non-Exchange entities under this proposed rule include Navigators, non-Navigator consumer assistance personnel, certified application counselors, agents or brokers, issuer customer service representatives, or a QHP conducting direct enrollment.

HHS further proposes that all requests for special enrollment periods should be evaluated by the Exchange as part of the eligibility determination process. HHS notes that it expects to develop further guidance and standard operating procedures for making determinations that would trigger this special enrollment period.

Items for Comment

HHS seeks comment on all of the proposed rules related to the new category of special enrollment.

6. Subpart H–Exchange Functions: SHOP

Standards for the Establishment of SHOP (§155.700)

HHS proposes to broaden the definition of "SHOP application filer" to mean an applicant, an authorized representative, an agent or broker, or an employer filing for its employees.

Functions of a SHOP (§155.705)

In this section, HHS proposes that a SHOP require QHP issuers to make changes to rates at a uniform time no more often than quarterly. Issuers in the FFE will be required to submit rates to HHS 60 days in advance of the effective date.

HHS further proposes that, in Exchanges where the state or federal government operates both the individual and SHOP Exchanges, the SHOP would provide data related to the eligibility and enrollment for a qualified employee to the individual market Exchange that corresponds to the service area in which the SHOP is operating. The intent of this proposal is to ensure that the Exchange can use SHOP data for purposes of verifying eligibility for qualifying coverage in an employer-sponsored plan. States operating a SHOP only are exempt from this requirement.

Application Standards for SHOP (§155.730)

HHS proposes amending the application filing standards for SHOP to remove the requirement for paper and telephone applications. HHS also clarifies that an employer or employee application may be filed by a "SHOP application filer."

Termination of Coverage (§155.735)

HHS proposes that each SHOP would be required to develop uniform standards for the termination of QHP coverage.

- SHOP will be required to set policies regarding advanced notice of employer-requested terminations and when coverage will end.
    - HHS is proposing that employer-requested terminations in the FF-SHOP are effective only on the last day of a month and that notice of termination would have to be received on or before the 15th of the month.
- SHOP will be required to establish standards for termination due to non-payment, including defining grace periods, due dates for premium payments, employer and employee notices, and reinstatement policies.
    - For the FF-SHOP, HHS proposes that payment for a group's coverage would be due to the FF-SHOP by the first day of the coverage month and that the employer would have a 31-day grace period. Employers would have 30 days from the termination date to request reinstatement in the FF-SHOP. HHS further proposes that the employer would pay the FF-SHOP all outstanding premiums and the next month's premium prior to reinstatement.
- SHOP will be required to establish consistent policies across QHP issuers on the process and effective dates for termination of employee and dependent coverage in the following circumstances: the employee/dependent is no longer eligible, the employee requests termination, the QHP in which the employee is enrolled terminates or is decertified, the employee changes QHPs during open or special enrollment, or the enrollee's coverage is rescinded.
    - For the FF-SHOP, these terminations would be effective on the last day of the month in which the FF-SHOP receives notice of the event. HHS also proposes that a dependent losing covering when he/she turns 26 would have to be covered on the parent's plan through the end of the month.

These termination policies will be effective January 1, 2015. SHOPs offering employee choice and premium aggregation prior to January 1, 2015, would need to comply with these standards by the time they are operational.

7. Subpart M–Oversight and Financial Integrity Standards for State Exchanges

General Financial Integrity and Oversight Requirements (§155.1200)

The ACA requires Exchanges to keep accurate accounting of all activities, receipts, and expenditures and to submit this information in an annual report to HHS. In this section, HHS

proposes that state Exchanges maintain an accounting of all of their receipts and expenditures in accordance with generally accepted accounting principles and develop and implement a process for monitoring. HHS further proposes that state Exchanges submit an annual report on April 1 of each year that includes a financial statement. States must also submit eligibility and enrollment reports that will include eligibility determination errors, non-discrimination safeguards, accessibility of information, and fraud and abuse incidents. In addition, states must submit performance monitoring data that include financial sustainability, operational efficiency, and consumer satisfaction.

The ACA further requires an annual audit of state Exchanges. HHS proposes that state Exchanges engage an independent qualifying audit entity that meets accepted professional and business standards and follows generally accepted governmental auditing standards. This audit entity will perform an independent external financial and programmatic audit of the Exchange. HHS proposes that this audit requirement may be satisfied through an audit by an independent state government entity. The Exchange must submit the results of the audit with its annual report.

Items for Comment

HHS seeks comment on:

- The approach, content, format, and timing of these financial integrity and oversight reports.
- The proposed annual audits and other activities that state Exchanges should be specifically required to audit.

Maintenance of Records (§155.1210)

The ACA gives the Inspector General authority to investigate, examine properties and records, and require periodic reports from Exchanges. HHS notes that it anticipates conducting a limited number of targeted audits each year, informed by the external audit and annual report. Exchanges, their contractors, subcontractors, and agents will be required to maintain records for ten years, including documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices. These records must include finances, eligibility verifications and determinations, enrollment transactions, appeals, plan variation certifications, QHP contracting and benefit review data, consumer outreach, and Navigator grant oversight.

Items for Comment

HHS requests comment on auditing procedures and the length of document retention requirements.

Part 156: Health Insurance Issuer Standards

1. Subpart A–General Provisions

Definitions (§156.20)

HHS proposes to add definitions of the following:

- Delegated entity: Any party (including an agent or broker) that enters into an agreement with a QHP issuer to provide administrative or health care services to qualified individuals, qualified employers, or qualified employees and their dependent.
- Downstream entity: Any party (including an agent or broker) that enters into an agreement with a delegated entity or another downstream entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer.
- Enrollee satisfaction survey vendors: An organization that has relevant survey administration experience, organizational survey capacity, and quality control procedures for survey administration.
- Registered user of the survey data warehouse: Enrollee satisfaction survey vendors, QHP issuers, and Exchanges authorized to access CMS's secure data warehouse.

Single Risk Pool (§156.80)

HHS proposes that issuers in individual or merged markets would be permitted to make changes to their market-wide adjusted index rate and plan-specific pricing on an annual basis. Issuers in the small group market would be permitted to make these changes on a quarterly basis, beginning with the rates effective for the third quarter of 2014. Issuers in the FF-SHOP would be required to set rates for non-grandfathered plans in the small group market on an annual basis until the FF-SHOP is capable of processing quarterly rates.

2. Subpart C–QHP Minimum Certification Standards

Additional Standards Specific to SHOP (§156.285)

HHS proposes to amend §156.285 to ensure that all QHP issuers offering in the SHOP comply with the proposed termination of coverage requirements as a condition of certification for plan years beginning on or after January 1, 2015. SHOPs implementing employee choice and premium aggregation prior to January 1, 2015, would have to meet this requirement by their operational date.

3. Subpart D–FFE QHP Issuer Standards

Changes of Ownership of QHP Issuers in the FFE (§156.330)

HHS proposes that issuers will be required to notify HHS of changes in ownership of QHP issuers in the FFE 30 days prior to the date of the change, and the new owner must agree to adhere to all applicable statutes and regulations.

Items for Comment

HHS requests comment on this 30-day notice requirement and the information requested.

Standards for Downstream and Delegated Entities (§156.340)

HHS is proposing standards for downstream and delegated entities in the FFE similar to existing standards for Medicare Advantage organizations. HHS proposes that QHP issuers maintain responsibility for their compliance and the compliance of downstream and delegated entities. Because a QHP issuer generally cannot enforce an agreement to which it is not a party, HHS proposes that all agreements governing the relationships among a QHP issuer and its delegated and downstream entities contain specific provisions describing each entity's obligations to fulfill the QHP issuer's responsibilities.

4. Subpart E–Health Insurance Issuer Responsibilities for APTCs and CSRs

HHS proposes requirements and timeframes for refunds to eligible enrollees and providers when a QHP issuer incorrectly applies APTCs or CSRs, or incorrectly assigns an individual to a plan variation (or standard plan without CSRs), resulting in the enrollee or the provider paying a portion of the cost sharing or premium amount that should otherwise have been reduced.

Definitions (§156.400)

- HHS proposes to supplement existing definitions of a "most generous" and a "more generous" plan by clarifying that the definitions of a "least generous" and a "less generous" plan variation have the opposite meanings of the existing definitions of a "most generous" or a "more generous" plan variation. Specifically, HHS proposes that, as between two plan variations (or a plan variation and a standard plan without CSRs), the plan variation or standard plan without CSRs designed for the category of individuals first listed in 45 CFR 155.305(g)(3) [special rules for family policies] would be deemed the less generous one.
- HHS also proposes a technical modification to change "QHP or plan variation" to "standard plan or plan variation" to clarify that a plan variation is not distinct from a QHP.

Improper Plan Assignment and Application of CSRs (§156.410(c)-(d))

To address misapplication of CSRs due to an enrollee, HHS proposes:

- If a QHP issuer fails to ensure that an individual assigned to a QHP plan variation receives the CSRs required under the applicable plan variation (taking into account the requirement regarding cost sharing previously paid under other plan variations of the same QHP under §156.425(b)), then the QHP would notify the enrollee of the improper application of the CSRs and refund any excess cost sharing paid by or for the enrollee within 30 calendar days.
- If a QHP issuer provides an enrollee assigned to a plan variation more CSRs than required under the applicable plan variation (taking into account §156.425(b) concerning continuity of deductibles and out-of-pocket amounts, if applicable), then the QHP issuer will not be eligible for reimbursement of any excess CSRs provided to the enrollee and may not seek reimbursement from the enrollee or the provider.
- If a QHP issuer improperly assigns an enrollee to a plan variation (or standard plan without CSRs), or the QHP issuer does not change the enrollee's assignment due to a change in eligibility, as required, then the QHP issuer would reassign the enrollee to the applicable plan variation (or standard plan without CSRs) and notify the enrollee of the improper assignment no later than 30 calendar days after discovery.
- If a QHP issuer reassigns an enrollee from a more generous to a less generous plan variation of a QHP (or a standard plan without CSRs) to correct an improper assignment on the part of the issuer, the QHP issuer will not be eligible for, and may not seek from the enrollee or provider, reimbursement for any of the excess CSRs provided to or for the enrollee following the effective date of eligibility required by the Exchange.
- If a QHP issuer reassigns an enrollee from a less generous plan variation (or a standard plan without CSRs) to a more generous plan variation of a QHP to correct an improper assignment on the part of the issuer, then the QHP issuer would recalculate the individual's liability for cost sharing paid between the effective date of eligibility and the date on which the issuer effectuated the change. The QHP issuer would refund any excess cost sharing paid by or for the enrollee within 30 calendar days of discovery.

Items for Comment

HHS seeks comment on:

- The above-described approach, including the 30-calendar-day timeframe for QHP issuers to reassign an individual to the correct plan variation and refund any excess cost sharing paid by or for the enrollee.

- Whether the timeframe should depend on the point in the month the issuer discovers the improper assignment, considering the amount of time issuers may require to effectuate the reassignment, as well as the impact on enrollees due to a delay in reassignment.

HHS is also considering requiring that QHP issuers provide HHS and the Exchange quarterly reports detailing any improper applications of CSRs and instances when it did not refund any excess cost sharing paid by or for an enrollee or was reimbursed for excess cost sharing provided in violation of proposed §156.410(d)(1). HHS seeks comment on this approach, including 1) whether these reports should be provided less frequently and 2) whether HHS should establish a minimum error rate or threshold before a QHP issuer is required to submit such reports, as well as what an appropriate error rate or threshold should be.

Failure to Reduce an Enrollee's Premium to Account for Advance Payments of the Premium Tax Credit (§156.460(c))

This proposed rule would require a QHP issuer that discovers it had not reduced the portion of the premium charged to or for an enrollee by the amount of the APTC to refund to the enrollee any excess premium paid and notify the enrollee of the improper reduction no later than 30 calendar days after discovery. The proposed rule permits the QHP issuer to provide the refund by reducing the enrollee's portion of the premium in the following month, as long as the reduction is provided no later than 30 calendar days after discovery. HHS is also considering requiring QHP issuers to provide quarterly reports to HHS and the Exchange detailing the occurrence of instances of improper applications of APTCs. Such a reporting requirement would commence in 2015 and would be similar to the reporting requirements pertaining to the misapplication of CSRs discussed above.

Items for Comment

HHS seeks comment on the proposed approach, including:

- The timeframe for issuers to refund any excess premiums to enrollees.
- The timeframe for providing the quarterly report to HHS and the Exchange.
- Whether HHS should also establish a minimum rate or threshold before a QHP issuer is required to notify HHS of any such instances and what an appropriate rate or threshold would be.

Oversight of the Administration of CSRs and APTCs (§156.480)

The proposed rules specify that HHS must oversee QHP issuer compliance in the areas of APTCs and CSRs. HHS further proposes:

- To extend the standards set forth in proposed §156.705 concerning maintenance of records to a QHP issuer in the individual market on a state Exchange in relation to CSRs and APTCs.
- To require QHP issuers to ensure that any delegated and downstream entities adhere to these requirements, in parallel with the proposed standards for QHP issuers in the FFE. HHS notes that a QHP issuer and its delegated and downstream entities may satisfy this standard by maintaining the relevant records for a period of 10 years and ensuring that they are accessible if needed in the event of an investigation or audit.
- That QHP issuers participating in state Exchanges and the FFE be subject to reporting and oversight requirements that are intended to assist in monitoring a QHP issuer's compliance with federal standards with regard to APTCs and CSRs.
- That issuers that offer a QHP in the individual market through a state Exchange or an FFE report to HHS, annually, summary statistics on the administration of APTCs and CSRs. Information to be reported will include:
    - The total amount of cost-sharing paid under each plan variation, including the amount paid by the individual and amount reduced by CSRs.
    - An annual error rate of the misapplication of the APTCs and CSRs by plan variation.
    - The total number of enrollees who received a refund as well as the total and average refunds made to enrollees and providers by plan variation resulting from underpayments.
- That HHS or its designee may audit an issuer that offers a QHP in the individual market through a state Exchange or the FFE to assess its compliance with responsibilities with respect to APTCs and CSRs.

Items for Comment

HHS seeks comment on:

- The above-described approach, including how HHS may coordinate with states to address non-compliance with federal requirements regarding APTCs and CSRs.
- The proposed reporting requirements, including the operational readiness of issuers to report these data and the proposed approach to audits.
- How federal oversight activities may be coordinated with state Exchange oversight activities to avoid duplication of effort.

5. Subpart H–Oversight and Financial Integrity Requirements for QHP Issuers in the FFE

Maintenance of Records for the FFE (§156.705)

HHS proposes records retention standards similar to those already established for the Medicare Advantage program. Specifically, HHS proposes that issuers offering QHPs in an FFE maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices for ten years. This includes financial statements, financial reports filed with other federal programs or state authorities, QHP contracting data, and consumer outreach and navigator grant oversight information.

Activities necessary to safeguard the financial and programmatic integrity of the FFEs include periodic auditing of the QHP issuer's financial records related to its participation in the FFE and compliance reviews and other monitoring of a QHP issuer's compliance. These proposed standards pertain only to Exchange-specific areas of concern (for example, matters pertaining to APTCs and CSRs) within the FFE, as HHS would expect states to oversee the maintenance of records pertaining to other aspects of QHP issuer operations as required under state law.

Items for Comment

HHS seeks comments on all aspects of the above proposals, including the type and scope of records proposed to be maintained by QHP issuers participating in the FFE.

Compliance Reviews of QHP Issuers in the FFE (§156.715)

The proposed rule specifies that:

- Issuers offering QHPs in an FFE will be subject to compliance reviews by HHS.
- Findings from compliance reviews may be used in conjunction with other findings related to the QHP issuer's compliance with certification standards.
- HHS will have discretion to conduct either an onsite or desk review.
- HHS may review the records of the QHP issuer pertaining to its activities within the FFE.

Items for Comment

HHS seeks comment on other areas that should be included in the compliance reviews. The proposed rules also provide that HHS may conduct compliance reviews of a QHP issuer's operations during any plan benefit year for up to ten years from the last day of that plan benefit year. However, when a QHP is no longer available through an FFE, HHS would be able to

conduct a compliance review of the last plan benefit year of that QHP only up to ten years from the last day that the QHP's certification was effective. HHS invites comments on this proposal.

6. Subpart I–Enforcement Remedies in FFEs

Available Remedies; Scope (§156.800)

The proposed rules specify that HHS may determine that a QHP offered through an FFE will be decertified and no longer offered through an FFE under specified circumstances, including where the QHP no longer meets the conditions of the general certification criteria. Civil monetary penalties and decertification are proposed as the two formal enforcement actions that HHS may take against issuers of QHPs offered in an FFE.

Items for Comment

HHS solicits comments on the proposed use of the civil monetary penalties and QHP decertification as compliance tools and how HHS can collaborate with states on enforcement actions.

Bases and Process for Imposing Civil Monetary Penalties in the FFE (§156.805)

HHS proposes to impose civil monetary penalties where there is misconduct in the FFE or substantial noncompliance with Exchange standards applicable to issuers offering QHPs in the FFE. In determining penalties, HHS will assess the scope or level of the violation, taking into account the issuer's previous record of compliance, the frequency of the violation, and any aggravating or mitigating factors. The maximum amount of penalty imposed for each violation is proposed to be $100 per day for each QHP issuer, for each individual adversely affected by the non-compliance.

Items for Comment

HHS seeks comment on the content and scope of the proposed bases and processes for imposing civil monetary penalties in the FFE.

Bases and Process for Decertification of a QHP Offered by an Issuer through the FFE (§156.810)

The rules propose that decertification should occur at the QHP level since certification is granted at the plan level. HHS proposes the following bases for decertification:

- If the issuer substantially fails to comply with federal laws and regulations applicable to FFE participation

- If the issuer operates in a manner that hinders the efficient and effective administration of the FFE
- Failure of a QHP to meet the requirements of the applicable certification criteria
- When there is evidence that the issuer has committed or participated in fraudulent or abusive activities affecting the Exchange
- When the QHP issuer substantially fails to meet federal standards related to enrollees' ability to access necessary medical items and services
- When a state recommends to HHS that the QHP should no longer be available in an FFE

HHS proposes that it may consider a previous or ongoing regulatory or enforcement action taken by a state against a QHP issuer as a factor in determining whether to decertify a QHP offered by that issuer. HHS also proposes that it may decertify a QHP offered by an issuer in an FFE based on a determination or action of a state as it relates to the issuer offering QHPs in an FFE, including, but not limited to, when a state places an issuer or its parent organization into receivership or when the state has recommended to HHS that a QHP should no longer be made available in an FFE.

HHS proposes two processes for decertification. HHS proposes a standard decertification process where the basis for decertification does not put the QHP enrollees' ability to access necessary medical items and services at risk or substantially compromise the integrity of the FFE. HHS also proposes an expedited decertification process where the basis for a decertification is one in which the QHP enrollees' ability to access necessary medical items or services is at risk or the integrity of an FFE is substantially compromised. The rules propose that, under the standard decertification process, the appeal would be available prior to the decertification; under the expedited decertification process, the appeal generally would be available post decertification.

Items for Comment

HHS invites comments on all of the proposed decertification procedures and whether the proposed bases for decertification are appropriate.

7. Subpart J–Administrative Review of QHP Issuer Sanctions in the FFE

Administrative Review in the FFE (§§156.901-156.963)

HHS has determined that QHP issuers in an FFE that are subject to an enforcement action authorized by the ACA and proposed subpart I of 45 CFR part 156 are entitled to the protections provided by the Administrative Procedure Act, including a hearing.

Civil Monetary Penalty

45 CFR §§150.401 through 150.463 sets forth an administrative hearing process for individuals and entities against whom a civil monetary penalty has been imposed in the individual and group health markets. Those regulations also establish the administrative review process for enforcement actions against individuals and entities for HIPAA violations, which have been expanded to apply to appeals of market-wide reform enforcement actions. An administrative law judge will decide whether there is a basis for assessing a civil monetary penalty and whether the amount assessed is reasonable. In order to appeal the penalty, an individual or entity must request a hearing within 30 days after the date of the issuance of a notice of assessment.

Items for Comment

HHS seeks comment on whether this process, as proposed, should include additional protections and whether certain provisions could be eliminated to expedite the administrative review process and reduce administrative burden. Comments are also sought on whether other models, such as the appeals process for civil monetary penalties under section 1128A of the Social Security Act [*Exclusion Of Certain Individuals And Entities From Participation In Medicare And State Health Care Programs*], would be more appropriate.

Decertification of QHPs

The proposed rules expand the proposed process for civil monetary penalty appeals to include appeals of decertifications of QHPs offered in the FFE. Under this approach, the issuer of a QHP that is being decertified would have the opportunity to request a hearing before an administrative law judge.

Items for Comment

HHS seeks comment on whether this appeals process should include additional protections or whether certain aspects of the approach could be eliminated to expedite the administrative review process and reduce administrative burden and whether other models would be more appropriate to use.

8. Subpart K–Cases Forwarded to QHPs and QHP Issuers in the FFE by HHS (§156.1010)

In this section, HHS proposes requirements for resolving cases sent from HHS to the QHP issuer operating in an FFE. The section first defines the word "case" as a "communication brought by a complainant that expresses dissatisfaction with a specific person or entity subject to State or Federal laws regulating insurance, concerning the person or entity's activities related to the offering of insurance, other than a communication with respect to an adverse benefit determination as defined in 45 CFR 147.136(a)(2)(i)." HHS explains that a "case" may include

concerns about the operations of a QHP issuer in the FFE—issues such as waiting times when calling the issuer's call center or failure to receive the Summary of Benefits and Coverage from a QHP issuer. The section does not, however, propose to regulate adverse determination inquires, which are subject to the regulations governing the internal claims appeals and external review process laid out by HHS.

HHS anticipates that many of the cases described in this section will first be presented to the state Department of Insurance and will therefore be addressed by the state in accordance with applicable state laws. To the extent that a state forwards a case to a QHP issuer operating in an FFE, the issuer must follow state law. HHS intends to work with each state to ensure that all applicable and appropriate state laws are addressed.

Under this section, QHP issuers operating in an FFE must investigate and resolve cases brought by complainants. HHS will forward cases to the issuer using a casework tracking system or some other means. Under such a tracking system, cases may be input by HHS staff, navigators, and assistors.

Cases that are forwarded to a QHP issuer operating in an FFE must be resolved within in 15 days of receipt of the case, unless the case involves the need for urgent care (a case "in which there is an immediate need for health services because a non-urgent standard could seriously jeopardize the enrollee's or potential enrollee's life, or health or ability to attain, maintain, or regain maximum function"), in which case it must be resolved within 72 hours of receipt. Where applicable state law has stricter standards, the issuer must follow state law.

For cases that HHS forwards to a QHP issuer operating in an FFE, the issuer must provide notice of the disposition to the complainant as soon as possible but no later than seven days after the case is resolved. Notification can be verbal or written. The issuer must, using the HHS tracking system or other means developed by HHS, provide an explanation of how the case was resolved, including a description of how and when the complainant was notified of the resolution.

9. Subpart L–Quality Standards

Establishment of Standards for HHS-Approved Enrollee Satisfaction Survey Vendors for Use by QHP Issuers in Exchanges (§156.1105)

Under §1311(c)(4) of the ACA, the Secretary of HHS must develop an enrollee satisfaction survey for each QHP offered through an Exchange that had over 500 enrollees in the previous year. The results of the evaluation must be publicly available on the Exchange's internet portal "in a manner that allows of easy comparison." HHS states that it intends to begin this public reporting in 2016. This section proposes processes that HHS would use to approve and oversee enrollee satisfaction survey vendors that administer the satisfaction surveys. HHS indicates that it will, through future rulemaking, direct QHP issuers to contract with HHS-approved vendors

and require surveys to be modeled on the CAHPS® Health Plan survey. Further, HHS intends to promulgate additional quality reporting standards for QHP issuers and Exchanges.

HHS believes that requiring issuers to use only HHS-approved vendors will ensure that results are "valid, reliable, and unbiased." Enrollee satisfaction survey vendors will have to be approved by mid-2014 so that issuers can contract with these vendors in a timely manner. Under this section, HHS proposes an application and approval process for the survey vendors, including the standards that vendors must meet in order to be approved by HHS. These standards are as follows:

- Submit an application form
- Ensure that appropriate staff participate in HHS survey vendor training
- Ensure and attest to the accuracy of their data collection, calculation, and submission processes
- Execute a standard data use agreement with HHS
- Adhere to the enrollee satisfaction survey protocols and technical specifications as laid out by HHS
- Develop and submit to HHS a quality assurance plan
- Adhere to privacy and security standards under the Exchange regulations
- Comply with all federal and state laws
- Become a registered user of the enrollee satisfaction data warehouse to submit files to HHS on behalf of the QHP issuers that the vendor works with
- Participate in and cooperate with HHS oversight for quality-related activities
- Comply with minimum business criteria established by HHS (in the preamble, HHS indicates that this criteria includes: having at least two years of experience with similar survey administration, possessing appropriate staff credentials and expertise to conduct survey administration, and having the ability to store secure data)

Vendors will be approved for one-year terms; they will have to submit annual renewal applications demonstrating that they meet all requirements. HHS will propose standards for revocation of approval through future rulemaking.

Items for Comment

HHS seeks comment on:

- The proposed approach to approving and monitoring enrollee satisfaction survey vendors.
- The minimum business criteria and any additional criteria HHS should consider.

10. Subpart M–QHP Issuer Responsibilities

Confirmation of HHS Payment and Collections Reports (§156.1210)

HHS intends to send each issuer a monthly payment and collections report that will specify the payments HHS owes to the issuer, and vice versa. For 2014, this report should include APTCs and CSRs that HHS is paying to the issuer for each policy and any FFE user fees as applicable. Issuers will have to review these reports and, within 15 calendar days of the date of the report, will have to either confirm that the report is accurate or describe any inaccuracy it identifies. HHS will work with issuers to resolve discrepancies. HHS notes the need to protect enrollees from unanticipated tax liability and believes that these proposed provisions will help ensure that correct APTC and CSR amounts are paid to issuers.

Direct Enrollment with the QHP Issuer in a Manner Considered to be through the Exchange (§156.1230)

HHS anticipates that many individuals will contact issuers directly for enrollment into QHPs and insurance affordability programs and acknowledges that many individuals currently use issuer websites to enroll into coverage. HHS therefore proposes that an Exchange can, at itsdiscretion, allow a QHP issuer to enroll an applicant into a QHP in a manner that is considered "enrollment through the Exchange" so long as the issuer complies with certain requirements. First, the issuer must follow the process for enrollment of qualified individuals explained in §156.265. Second, the issuer will be required to meet certain minimum consumer protections. Specifically, the issuer's website must provide the same methods of viewing QHPs as are required of the Exchange under §155.205; the website must clearly distinguish between QHPs and non-QHPs; the issuer must inform all applicants of the availability of other QHP products offered through the Exchange, including a link to the Exchange or information on how to access the Exchange; and the issuer's website must allow an applicant to attest to APTC amounts.

HHS further explains that if the Exchange permits a QHP issuer to assist individuals using its customer services representatives (see §155.410), then the issuer must enter into an agreement with the Exchange to allow such representatives to assist individuals with applying for eligibility determinations, redeterminations, or insurance affordability programs, and facilitating the selection of a QHP offered by the issuer. Under this agreement, the issuer must agree that its customer service representatives receive training on QHP and insurance affordability program eligibility, options, rules and regulations; comply with Exchange privacy and security standards; and comply with applicable state law related to sale, solicitation, and negotiation of health insurance products (this includes any state laws applicable to agent, broker, and producer licensure, confidentiality, and conflicts of interest).

Finally, under this section HHS states that a QHP issuer directly enrolling individuals must ensure that the premium it charges to a qualified individual or enrollee, apart from any APTC, is the same as was accepted by the Exchange when the issuer received QHP certification. If and

when an issuer identifies a discrepancy, it must retroactively correct the error no later than 30 calendar days after the identification.

Enrollment Process for Qualified Individuals (§156.1240)

This section addresses the issue of unbanked individuals (those who do not have bank accounts or credit cards) who will be seeking health coverage through an Exchange. Because these individuals should have the same rights to access health coverage as those with a bank account or credit card, HHS proposes that QHP issuers must, at a minimum, accept a variety of payment methods including, but not limited to, paper checks, cashier's check, money orders, and pre-paid debit cards. Issuers may allow for electronic funds transfers from a band account and automatic deduction from credit or debit cards.

Items for Comment

HHS seeks comment on:

- The particular length of times issuers should have to respond to the payment and collections report
- The proposed provisions of direct enrollment with QHP issuers in a manner considered to be through the Exchange
- The proposed methods of payment for unbanked individuals, and whether any other payment methods should be included

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