Summary Program Integrity Regulation

The Department of Health and Human Services published a proposed regulation covering program integrity provisions for Exchanges, SHOPs, and Premium Stabilization Programs in the Federal Register on June 19, 2013. This regulation makes modifications to 45 CFR Parts 144, 147, 153, 155, and 156 and is open for comment through July 19th.

Oversight and Enforcement

- Records must be maintained for 10 years by Exchanges, State-based Risk Adjustment entities, Qualified Health Plans, and associated contractors. Records must be made available to federal agencies at their request.
- HHS may audit state-based Exchanges, risk adjustment and reinsurance entities and QHPs.
- State-based Exchanges, risk adjustment, and reinsurance entities must contract for an independent audit and make the results publically available. These entities must report to HHS on the results of the audit.
- State Exchanges, QHPs, and State operated Risk Adjustment and Reinsurance must submit reports in a form and manner specified by HHS. QHP reports may be quarterly and annually. Exchange reports are required annually.
- Exchanges and associated entities must report incidents or breaches to HHS within one hour of the occurrence of the event.
- HHS may conduct compliance reviews with QHPs and assess Civil Monetary Penalties (CMP) against QHPs or decertify them for transgressions.
- HHS operated programs (Reinsurance, Risk Adjustment, FFEs) are not subject to the same reporting requirements as state operated programs.

Exchanges

- 155.310(k) If and Exchange does not receive sufficient information on an application then a notice will be issued to the applicant indicating that the eligibility determination cannot be completed and listing the needed information. Applicant will have a period of 15 to 90 days to respond. This process will apply to the Federal Exchange as well.
- If an Exchange discovers it did not reduce a plan premium by the full amount of the accepted APTC it must refund the enrollee any excess premium paid and notify the enrollee within 30 days. Refund may be provided directly to enrollee or rolled to the next month.
- State Exchange must develop and implement process for monitoring all Exchange-related activities for effectiveness, efficiency, integrity, transparency and accountability.

SHOP

- States may elect to operate only the SHOP but not the individual Exchange. States may not elect to operate only the individual Exchange.
- Separate SHOPs will have separate Navigator Programs.
- SHOPs are not required to accept paper or phone applications.

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- SHOPs must develop uniform standards for coverage termination by 2015.
- Non-payment in the SHOP, employer has 31 day grace period to pay and 30 days from date of termination to reinstate coverage.
- Individuals that lose dependent coverage by turning 26 must be covered through the end of the month.

Agents and Brokers

- All agents and brokers using the Exchange must register with CMS.
- Web-brokers may display only the QHP information provided to the Web-broker through the Exchange or issuer.
    - Must display all available information and provide a list of all available QHPs for consumers to view.
    - Where Web-broker is unable to display all information on a QHP they must display a link to the Exchange website.
    - Web-broker site must indicate prominently that it is not the FFE, that it may not show all available information on QHPs, that the web-broker has an agreement with HHS, and that the web-broker agrees to comply with applicable federal standards.
- Proposed rule contemplates banning relationships between web-brokers and other agents that are not registered with CMS.
- Agents and Brokers using the FFE must establish policies and procedures implementing FFE privacy and security standards.
- Agents and brokers must notify FFE 30 days in advance if they intend to terminate their relationship with the FFE.
- FFE may terminate Agents or Brokers agreement with FFE for cause. FFE intends to collaborate with state DOIs on enforcement. Agent or broker may submit request/appeal for reconsideration of termination.

Health Plan Requirements

- QHPs offering on and off of the Exchange must be identical in benefits package, provider network, service areas, and cost-sharing.
    - Plans offered off of the Exchange will only be subject to Risk Corridors if it exactly the same as the plan offered on the Exchange
- Health plan customer service representatives are authorized to assist with application for coverage and insurance affordability programs and facilitating plan selection and enrollment.
- Issuers must notify HHS within 30 days of ownership change.
- QHP is responsible for compliance with standards of any downstream or delegated entities and must have agreements in place that specify delegated activities and associated record retention and reporting responsibilities. Agreements must be in place by January 1, 2015.
- Issuers that inappropriately apply APTC or CSR must notify the enrollee and refund the consumer. If the inappropriate application was in the Consumer's favor, the issuer may not recoup the funds. Quarterly error reports from the QHP to HHS and the Exchange are proposed.

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- QHPs may be subject to CMP for errors in applying APTC and CSR. Maximum CMP amount for this transgression is $100 per day for each individual adversely affected.
- QHPs must resolve complaints 'cases' forwarded to them through the HHS complaint tracking system within 15 days of receipt of case or less than 72 hours after receipt of case for urgent cases. QHP issuer must document resolution in HHS casework tracking system.
- QHPs must contract with HHS approved enrollee satisfaction survey vendors to complete enrollee satisfaction surveys.
- QHP must receive and review HHS payment and collections report and respond within 15 days.
- QHP issuers directly enrolling individuals in qualified health plans must notify consumers of other available options.
- QHP issuers must accept a variety of payment options including paper checks, cashier's checks, money orders, and replenishable pre-paid debit cards.

Reinsurance

- 153.20 Partially self-insured plans will be liable for reinsurance contributions if the partially self-insured coverage is major medical coverage, otherwise the insured coverage will be liable for these contributions.
    - 153.400 For health coverage arrangements where two or more policies make up the major medical coverage, the reinsurance contribution is due form the policy that provides the greatest percentage of benefits. If the percentage is equal then it is from the policy with the highest premium.

Risk Adjustment

- Risk Adjustment transfer methodology modified to account for community rated states with family tiers. In family tiering states billable members would be based on the number of children that implicitly count towards the premium under a state's rating factors.

Federal Enforcement of Risk Adjustment and Reinsurance

- For health plans that do not provide data in a timely manner for federally operated risk adjustment or reinsurance programs HHS may impose CMP on such plans.
- Health plans that do not submit Risk Adjustment Data will be subject to the default Risk Adjustment Charge. This charge may be indexed to the highest charge in the market, or based on a charge two standard deviations higher than the average market charge.

Other

- 144.103 Policy Year is redefined as a calendar year consistent with other guidance.
    - 147.104(b)(2) All non-grandfathered coverage in the individual market must be offered on a calendar year basis as of January 1, 2015.
- 147.102(c) Rating area is determined in the small group market using the principal business address of the group policy holder and in the individual market using the address of the primary policy holder.

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    - *This may conflict with prior guidance concerning businesses and families residing in multiple states.*
- Stand-alone dental not subject to Risk Corridors
- For transactions between the FFE and covered entities there is a modified 820, the HIX 820. This modified 820 will be used by the FFE in all transactions.
- Health plans that are government programs providing public benefits are authorized to disclose PHI for the purposes of eligibility and enrollment and verification of minimum essential coverage.
- New special enrollment period added for individuals that are incorrectly enrolled or not enrolled due to actions of on the part of a non-Exchange entity.
- Issuers in the Small Group Market may change rates quarterly.

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