DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Subject: Frequently Asked Questions on Health Insurance Marketplaces

Oversight of Premium Stabilization Programs, Advance Payments of the Premium Tax Credit, and Cost-sharing Reductions

Q1: What oversight activities does the Centers for Medicare & Medicaid Services (CMS) intend to propose with respect to the state-operated risk adjustment and reinsurance programs, cost-sharing reductions, and advance payments of the premium tax credit?

A1: We intend to propose monitoring and oversight measures related to the premium stabilization programs applicable to both states and issuers. With respect to state-operated risk adjustment programs, we intend to propose a standard under which the state would maintain an accurate accounting for each benefit year of risk adjustment expenditures, receipts, and administrative expenses, and the state would provide to CMS and make public an annual summary of the program. We also intend to propose that each state-operated risk adjustment program provide for an annual external financial and programmatic audit, and maintain relevant records for ten years.

We intend to propose oversight standards applicable to states operating reinsurance programs that are substantially similar to those discussed above for state-operated risk adjustment programs.

With respect to advance payments of the premium tax credit and cost-sharing reductions, we intend to propose standards for reimbursement to eligible enrollees, and providers as applicable, when a QHP issuer incorrectly applies cost-sharing reductions or advance payments of the premium tax credit with respect to an enrollee. We also intend to propose standards relating to record retention, annual reporting, and audits.

Q2: How will CMS ensure that issuers of a risk-adjustment covered plan or reinsurance-eligible plan establish a distributed data environment?

A2: We intend to propose enforcement of distributed data environment standards through civil money penalties. In addition, with respect to risk adjustment, we intend to propose a default risk charge that would apply to plans that fail to establish a secure, distributed data environment or otherwise fail to provide risk adjustment data required for the calculation of risk adjustment payment transfers.

Issuer Oversight

Q3: How does the Federally Facilitated Marketplace intend to enforce issuers' ongoing compliance with Marketplace-specific standards?

A3: We expect that state departments of insurance will continue to oversee issuers in the health insurance market pursuant to the respective states' existing law and regulations. We intend to coordinate with state monitoring and oversight efforts to avoid duplicating such efforts, to the extent feasible and appropriate. As mentioned in prior FAQs, (http://www.cciio.cms.gov/resources/factsheets/aca_implementation_faqs.html), we intend to

continue assisting issuers to maintain compliance with Marketplace standards. To that end, we expect to release guidance reflecting this approach in the near future.

Q4: Under what circumstances are issuers in the Federally-facilitated Marketplace subject to enforcement actions, including decertification of their QHPs?

A4: We intend to take an enforcement approach that would take into consideration various factors, including any past or concurrent state determinations and indications of the issuer's good faith efforts in maintaining compliance with standards specific to the Federally-facilitated Marketplace. We note the need to coordinate with states on issuer oversight to avoid duplicative enforcement or investigative actions for the same issue, to the extent feasible and appropriate. We will generally look to the states to enforce standards applicable to issuers in the Federally-facilitated Marketplace. Where a state has elected not to enforce a standard or lacks the regulatory or enforcement authority to do so, we intend to propose enforcement of Federally-facilitated Marketplace-specific standards through civil money penalties (CMPs) and decertification. Absent any extraordinary circumstances, we expect decertification would be uncommon. We also intend for issuers to be able to appeal the issuance of CMPs or decertifications.

State-based Marketplace Reporting Requirements

Q5: Will State-based Marketplaces be required to provide reports to CMS on Marketplace activities?

A5: Yes, we intend to propose requiring State-based Marketplaces to submit reports to CMS at least annually, including but not limited to financial statements and summary-level statistical reports regarding eligibility determinations, enrollments, appeals, eligibility determination errors, privacy and security safeguards, and fraud and abuse determinations. Additionally, we intend for State-based Marketplaces to submit performance monitoring data including financial sustainability, operational efficiency, consumer satisfaction, and quality of care data.

Q6: Are there any recordkeeping requirements for State-based Marketplaces?

A6: Yes, we intend to propose that State-based Marketplaces will be required to maintain for a minimum of 10 years records related to external audits, annual financial reports, error rate testing, consumer complaints, and other data sources in anticipation of targeted audits.

Q7: What types of audits will State-based Marketplaces be required to conduct?

A7: We intend to propose that State-based Marketplaces engage an independent qualified auditing entity to perform an independent audit of their annual financial statements and a review of the process/internal controls associated with their eligibility determinations and enrollments. We further intend to propose that State-based Marketplaces will be required to provide the results of this financial and programmatic audit to CMS.

Privacy and Security

Q8: Will CMS create additional security standards for State-based Marketplaces and non-Marketplace entities such as Navigators, agents, brokers, and other assistance personnel?

A8: We intend to propose that compliance with the security standards defined in the Minimum Acceptable Risk Standards for Marketplaces (MARS-E) suite of documents be a requirement for all SBMs and non-marketplace entities associated with the Federally-facilitated Marketplace.

We also propose clarifying that the security standards apply to all information that is used for Marketplace functions and not only to personally identifiable information.

Cost-Sharing Reductions and Health Savings Accounts

Q9: How should plan variations for QHPs that are high-deductible health plans (HDHPs) designed to be paired with a health savings account (HSA) be structured?

A9: If an issuer seeks to offer a QHP designed to be eligible for pairing with an HSA in 2014, the issuer must comply with the cost-sharing reduction standards described in 45 CFR 156 subpart E. CMS recognizes that certain plan variations of a QHP may require a low or zero deductible, or that certain services be exempt from the deductible. This may result in the plan variation not meeting IRS standards for an HDHP and therefore not being eligible to be offered in conjunction with an HSA. We recommend that issuers and Marketplaces educate consumers about this issue, both during open enrollment and when an individual has a change in eligibility for cost-sharing reductions. An individual who would not be eligible for the tax advantages of an HSA because the plan variation to which he or she would be assigned does not qualify as an HDHP may purchase the plan without cost-sharing reductions.

Eligibility and Enrollment

Q10. Will issuers be required to obtain a Health Plan Identifier (HPID) to conduct enrollment and payment transactions with Federally-facilitated Marketplace?

A10. CMS intends to propose rulemaking and supplemental guidance on the use of HPIDs in enrollment and payment transactions between issuers and the Federally-facilitated Marketplace.

A standard for HPIDs was adopted by HHS in a September 5, 2012 final rule at 77 FR 54664,[1] and the system to enable insurance issuers to obtain an HPID has been available since March 28, 2013. All health plans are required to obtain HPIDs by November 5, 2014 (small plans have until November 5, 2015). All HIPAA covered entities—health care clearinghouses, covered health care providers, and health plans—are required to use HPIDs to identify health plans in standard transactions such as claims, referrals, and remittance advice by November 7, 2016.

Since an issuer can obtain and use an HPID in advance of the compliance dates specified in the September 5, 2012 final rule, beginning in October 2013, the Federally-facilitated Marketplace anticipates requiring the issuers to have obtained HPIDs. The Federally-facilitated Marketplace will use them to route the electronic transactions correctly. We expect the HPID will be used in the "envelope" of the enrollment and payment transactions to ensure that they successfully reach the right issuer or its designated trading partner. Issuers may be able to limit the number of HPIDs they obtain to those needed for routing purposes to do business with the Federally-facilitated Marketplace, as long as they do so in accordance with the HPID regulation. Each of the issuer's QHPs will be associated with an HPID, but the HPIDs need not be unique for each QHP. An issuer that is a controlling health plan (CHP), as defined by 45 CFR 162.103, could decide to use its HPID for all transactions.

[1] "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets; Final Rule" (77 FR 54664, September 5, 2012).

Third party entities, such as clearinghouses, are also able to obtain an Other Entity Identifier (OEID) at this time. If an issuer utilizes a third party for processing its transactions, issuers would be able to use the OEID of the contracted party to identify where transactions would be routed.

For more information on HPID, visit http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.

Issuer Withdrawal from the Small Group or Large Group Market

Q11: May an issuer elect to discontinue offering all products in the small group market in a state but continue to offer products in the large group market in that state (and vice versa)?

A11. Yes. Although the final rule[2] implementing PHS Act section 2703, as added by the Affordable Care Act, addressed the market withdrawal exception to guaranteed renewability only with reference to the individual and "group" market, we intend to propose amendments in future rulemaking that recognize the distinction between the large group and small group market segments for purposes of PHS Act section 2703. Accordingly, an issuer could, in accordance with applicable state law and subject to the other requirements of 45 CFR 147.106(d), satisfy the requirement in 45 CFR 147.106(d) to discontinue offering all coverage by doing so with respect to either the large group or small group market without being required to withdraw from both segments of the group market.

[2] "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review" (78 FR 13406, February 27, 2013).