

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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## **FACT SHEET**

FOR IMMEDIATE RELEASE

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### **Exchange and Insurance Market Standards for 2015 and Beyond and Final 2015 Letter to Issuers in the Federally-facilitated Marketplace**

#### **Overview**

Today, CMS is releasing a proposed rule for Exchange and Insurance Market Standards for 2015 and beyond as well as the Final 2015 Letter to Issuers in the Federally-facilitated Marketplaces (FFM). Virtually all of the policies in these documents were previously described in the preamble of the HHS Notice of Benefit and Payment Parameters for 2015 (March 11, 2014) and the Draft 2015 Letter (February 4, 2014). The guidance documents are the next procedural step in providing early guidance and certainty stakeholders need to provide affordable health coverage next year. They clarify policies to improve consumer protections, stabilize premiums, and continue the common-sense approach to implementing key policies. Specifically, these guidance documents propose or advance policies to:

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

Key policies outlined in today's proposed rule and Final Letter include:

**Standardizing Notices to Improve Consumer Education and Choices:** In order to provide clear information to consumers when insurers make changes to their policies, today, HHS issued proposed rules and draft standardized notices in a separate bulletin that issuers would be required to use when renewing or discontinuing plans. These proposed processes and notices will help to ensure consumers understand the changes and choices in the individual and group market.

**Implementing Quality Standards:** To help empower consumers, the proposed rule takes the next step in making quality information available to consumers while they shop for plans in the Marketplace. Building upon the existing Qualified Health Plan (QHP) certification requirements related to quality reporting and implementation of quality improvement strategies, we propose to require insurers to submit data to support the calculation of the quality ratings. HHS would specify the form, manner, reporting level, and timeline in future technical guidance. Marketplaces would also be directed to display the HHS-calculated quality ratings and enrollee satisfaction survey results in a clear and standardized manner.

**Providing Additional Options for SHOP in 2015:** We propose to align the start of annual employer election periods in all SHOPs for plan years beginning in 2015 with the start of open enrollment in the individual Marketplace for the 2015 benefit year to minimize confusion and maximize efficiency. The guidance also takes the next step in implementing SHOP "employee choice" in which an employer could allow employees to choose any health plan within a metal tier rather than one plan, which is what generally happens today. To smooth this transition, we propose to allow State regulatory agencies to recommend to HHS that a SHOP modify the employee choice provision in 2015 if doing so would preserve and promote affordable insurance for employees and small businesses. The annual letter also describes other simplifications for employers in the FF-SHOP such as premium aggregation in which the employer gets one bill from SHOP for all employees, regardless of where their workers get covered.

**Strengthening Standards for Navigators and Other Assistants:** In order to ensure that Navigators and other assistants are not restricted from carrying out their responsibilities to help consumers enroll in insurance coverage while meeting stringent quality, security, and privacy standards, our proposal specifies which types of state law provisions applicable to assistants would conflict with Federal law. HHS developed these clarifications after consultation with stakeholders (including States, non-profit community-based organizations, hospitals, and community health centers), as well as its ongoing monitoring of state laws and their effects on assister programs. Today's rule also proposes to codify many of the standards already in practice that are applicable to the different consumer assistance entities and individuals. For example, the proposed rules would prohibit assistants from specified solicitation activities such as making cold calls to provide application assistance and offering cash or gifts other than those that are nominal as an inducement to apply or enroll in coverage. The rules would also ensure that assistants cannot charge for the services and must be recertified annually.

**Improves Premium Stabilization Policies for 2015:** To maximize the effectiveness of the transitional reinsurance program in stabilizing individual market premiums, we seek comment on allocating reinsurance contributions collected first to reinsurance payments and administrative expenses and second to the U.S. Treasury. We propose to raise the ceiling on allowable administrative costs and raise the floor on profits by 2 percentage points in the risk corridors formula. This adjustment would be applied uniformly in all States for 2015 to help with additional transition costs and uncertainty. We aim to implement the risk corridor programs in a budget neutral way. The proposed rule includes a clarification about sequestration, with HHS aiming to make payments of sequestered fiscal year 2015 funding for the reinsurance and risk adjustment programs, which would have otherwise been paid in the summer of 2015, as soon as practicably possible in fiscal year 2016, which begins on October 1, 2015. And, we propose various amendments to the medical loss ratio (MLR) provisions, including standards that would modify the timeframe for which issuers can include their ICD-10 conversion costs in their MLR calculation and account for the special circumstances of issuers during the changes taking place in 2014 (e.g., unanticipated costs due to high call center volume in January 2014). The core requirements of the MLR program, for example that insurers spend at least 80 percent (small group market), or 85 percent (large group market) of premiums on health care and quality improvement, are generally not affected by these proposed adjustments.

**Provide Operational Guidance and Promoting Access to Care in the FFM:** Also today, HHS is finalizing the 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM). A draft of this letter was released in February for public comment, and the final letter is largely similar to the proposed. The Letter builds on previously released guidance and provides issuers convenient access to operational standards needed for the qualified health plan (QHP) certification process. This information will help issuers submit plans to operate on the Marketplace and will also help them in understanding consumer support functions. It also encourages improved consumer protections regarding essential community providers, network adequacy, access to needed prescription drugs, and coverage of care during transitions. While primarily aimed at FFM issuers, the letter provides useful information to states, issuers and other stakeholders.

The 2015 Exchange and Insurance Market Standards Proposed Rule can be accessed here: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf>

The Bulletin can be accessed here: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-discontinuance-renewal-notices-03-14-14.pdf>

The Final 2015 Annual Letter can be accessed here: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>

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