American Hospital Association

Regulatory Advisory

July 3, 2014

Update on 2015 Regulatory Actions for ACA Marketplace and Medicare Advantage

AT A GLANCE

At Issue

Mid-April marked the end of the first open enrollment period of the Affordable Care Act (ACA) during which more than 8 million people enrolled in coverage through the federal and state health insurance marketplaces. The second enrollment period for the health insurance marketplaces will start Nov. 15 for coverage that begins on Jan. 1, 2015. Over the past several months, the Department of Health and Human Services (HHS) has been busy issuing rules and guidance for the 2015 plan year. The AHA expects that, in future years, HHS will devote the first quarter of each calendar year to the issuance of all the necessary insurance, marketplace and health plan changes needed to prepare for the upcoming year of coverage. We anticipate that the timing and process for ACA marketplace guidance will be similar to that of the Medicare Advantage program for which the Centers for Medicare & Medicaid Services (CMS) also issued annual guidance earlier this year.

This advisory summarizes the key ACA marketplace and Medicare Advantage policy changes for 2015 and links to other AHA advisories and federal regulations on these topics. We examine the following areas:

- New requirements for health insurance enrollment navigators and assisters;
- Certification standards for Qualified Health Plans (QHPs) sold through the Federally Facilitated Marketplaces, including network adequacy standards;
- Changes to the ACA premium stabilization programs, such as the health plan risk corridor, risk adjuster and reinsurance;
- Clarification regarding third-party payment of new health insurance marketplace premium subsidies;
- Guidance on employer responsibility to report employee health care coverage to the Internal Revenue Service;
- Changes in employer COBRA notification; and
- Updates to the Medicare Advantage program for the 2015 plan year.

Implications for Hospitals:

These are complex rules and guidance, and the implications for hospitals and hospital systems as caregivers, employers, and in some cases insurers, will vary. The attached table is a compendium of the key rules and guidance. It provides a brief summary, identifies key hospital-related issues and includes web links to associated regulatory documents.

What You Can Do:

- ✓ Share this advisory with key staff members in payer contracting, human resources and government relations so that they can evaluate any potential impact on your organization's operations.
- ✓ If your hospital or system operates a health plan, share this advisory with your health plan leadership.
- ✓ For decisions relegated to state governments, please contact your state hospital association for additional information on the status of those state-specific issues.

Further Questions:

If you have questions, contact Jeff Goldman, vice president for coverage, at 202-626-4639, or jgoldman@aha.org; Molly Collins Offner, director for policy, at (202) 626-2326 or mcollins@aha.org; or Ellen Pryga, director for policy, at (202) 626-2267 or epryga@aha.org

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Health insurers of Qualified Health Plans (QHP) are expected to begin submitting plans and prices shortly after these rules and guidance go into effect. By issuing guidance early in the calendar year, health insurers will have time to decide the types of plans

and the premiums for the health plans they intend to offer in the health insurance marketplaces. Some of these policy changes will be reflected in formal rulemaking, while others will be reflected in sub-regulatory guidance known as Frequently Asked Questions (FAQs) and still others will be embedded in issuer call letters. Issuer call letters are annual updates on technical and operational procedures for health plan insurers, also known as "issuers," that serve as the basis for the development of health plan policies sold in the general marketplace.

NEXT STEPS

Share this advisory with key staff members involved in payer contracting, human resources and government relations so that they can evaluate any potential impact on your organization's operations. If your hospital or system operates a health plan, share this advisory with your health plan leadership. The AHA will issue additional analysis on future rules and guidance.

For decisions relegated to state governments, check with your state hospital association for additional information on the status of those state-specific issues.

FURTHER QUESTIONS

If you have questions, please contact Jeff Goldman, vice president for coverage, at 202-626-4639, or jgoldman@aha.org; Molly Collins Offner, director for policy, at (202) 626-2326 or mcollins@aha.org; or Ellen Pryga, director for policy, at (202) 626-2267 or epryga@aha.org.

QHPs AND MARKETPLACE ISSUES	
Exchange and Insurance Market Standards Rule	
On May 27, the Department of Health and Human Services (HHS) published its final rule that determines policy and market standards for the new health insurance marketplaces for 2015. The new health insurance marketplaces, also known as exchanges, are central to the coverage expansion objectives of the ACA. Through these marketplaces individuals and small businesses may purchase coverage from private insurance companies. Federal subsidies that help make the insurance more affordable are available to qualifying individuals who purchase coverage through the marketplace. Under the ACA, there are: • people specially trained to help individuals sign up for insurance in the marketplaces, known as navigators and non-navigator assistors. • specific programs put in place to stabilize the changing insurance market landscape that are intended to help keep the cost of insurance premiums in check. • quality reporting requirements health plan insurers must meet in order to sell Qualified Health Plans (QHPs) in the new marketplaces. Each of these is included in this final rule, putting in place the final pieces in preparation for the 2015 insurance marketplace.	
Federal Issuance/AHA Resources	**Synopsis**
http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/marketstandards-5-16-2014.html http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/downloads/Final-Master-FAQs-5-16-14.pdf	**Marketplace Assisters:** The final rule authorizes civil money penalties (CMPs) for navigators, non-navigator assistance personnel, and certified application counselors and certified application counselor designated organizations in Federally Facilitated Marketplaces and State Partnership Marketplaces that do not comply with applicable federal requirements. HHS notes that it intends to work with these entities to prevent noncompliance issues or address them before they rise to the level of a CMP. In addition, the rule codifies and strengthens many of the standards already in practice that are applicable to the different consumer assistance entities and individuals. For example, the rule prohibits assisters from specified solicitation activities, such as offering cash or gifts other than those that are nominal as an inducement to enroll in coverage. The rule also stipulates that assisters cannot charge for services they are certified by the marketplace to provide and that they must be recertified annually. The AHA urged the Centers for Medicare & Medicaid Services (CMS) to limit CMPs, in general, to egregious violations of selected requirements where no other enforcement

	mechanisms exist. To a large extent, CMS, in this final rule, has narrowed the application of CMPs to serious violations. Hospitals should carefully review the CMP sections that apply to the various assister programs to make certain their programs are in compliance. **Risk Corridors:** The final rule makes adjustments to the temporary risk corridor program to address health plan insurers' additional administrative costs, and risk pool effects related to a number of unforeseen policy decisions, such as the states' extensions of renewals of non-ACA compliant plans; the extension of the initial open enrollment period; the extended phase out of the high-risk pools; and other unanticipated administrative costs. The adjustments raise the ceiling on allowable administrative costs and raise the floor on profits by 2-percentage points in the risk corridors formula. This adjustment will be applied uniformly in all states for 2015 to help with unexpected administrative costs. The AHA recommended that risk corridor changes be limited so that the adjustments reflect the actual increased costs experienced by the health plan insurers. *(For in-depth background, see Health Plan Management on pg. 7.)* **Medical Loss Ratio (MLR) and ICD-10:** The rule requires that the MLR formula not to take into account any additional risk corridor payments resulting from risk corridor adjustments. The rule modifies the timeframe during which health plan insurers can include their ICD-10 conversion costs in their MLR calculation. **Transitional Reinsurance Program:** If the reinsurance fees collected are insufficient for the purposes of making reinsurance payments, the rule requires reinsurance contributions to be distributed first to the payment of reinsurance claims, second for administrative expenses and finally to the Treasury The AHA supported this new prioritization, but recommended that, if possible, funds be allocated first to claims and administrative costs as proposed, but then rolled over to the next year's reinsurance pool, potentially postponing payment to the Treasury until the end of the three-year program. *(For in-depth background, see Health Plan Management on pg. 7.)* **Quality Rating System for QHPs:** CMS clarifies that the quality rating system for marketplace plans will use data from both state and federal exchanges to calculate ratings. Ratings for plans must be displayed on both the federal and state websites in 2016, with details on state data display and reporting level requirements expected in future guidance. The AHA generally supported the approach taken in the final rule, but

	continues to urge CMS to move to individual QHP-specific data as quickly as possible so that consumers have better information to select a plan. **Expedited Exceptions Process for Certain Drugs:** The final rule requires that health plans providing Essential Health Benefits (EHB) include an expedited exceptions process for access to certain clinically appropriate drugs not covered by the plan. As part of this expedited process, health plans must make coverage determinations within no more than 24 hours after receiving the request, and must continue to provide the drug throughout the duration of the enrollee's medical issue defined as when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. **Small Business Health Options Program (SHOP) and Employee Choice:** The rule also aligns the start of the annual employer election periods in the federally-facilitated SHOP with the start of open enrollment in the individual market exchange, and lists the conditions under which a SHOP would be permitted to delay employee choice in 2015. **Consumer Notice of Discontinued Insurance Product:** The final rule requires health plan insurers to use standardized notices when renewing coverage or discontinuing insurance products. These requirements will help ensure that consumers understand the changes and choices in the individual and small group markets.
Qualified Health Plans Certification for 2015 in Federally Facilitated Marketplaces	
Health plans sold in the health insurance marketplaces, must meet a number of standards to be certified as QHPs. In states that chose not to establish their own marketplace, CMS certifies the QHPs in the Federally Facilitated Marketplaces (FFMs). States that chose to establish state-based marketplaces conduct the certification process for QHPs sold in their state. Early each year, CMS will issue guidance on changes to QHP certification process or requirements for QHPs for the next plan year, thus allowing adequate time for issuers to incorporate these changes prior to submission for certification. The following is a synopsis of the key issues for hospitals contained in CMS's March 14 guidance for commercial insurance companies (issuers) that plan to offer QHPs in the FFMs in the benefit year 2015.	
Federal Issuance/AHA Resources	**Synopsis**
http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf	**QHP Application Timing:** QHPs applications were due at the end of June and certification agreements will be finalized between Oct. 10 and Nov. 3.

	Certification Standards: Issuers of QHPs must be licensed and in good standing and meet state solvency standards in each state in which they plan to offer a QHP. **Service Area:** The services area must cover the entire geographic area of a county, or group of counties or partial counties defined by the marketplace. The marketplace must ensure that the service area of the QHP is established without regard to race, ethnicity, language, health status, medically underserved populations or populations that are high utilizers or high cost. QHPs cannot change their service area after their initial data submission except by petition to CMS; service area changes are not permitted after the final data are submitted. **Network Adequacy:** For benefit year 2015, CMS will assess provider networks using a "reasonableness access" standard. CMS does not specify the "reasonableness standard" in the guidance, but does state that the agency will focus on areas where network adequacy issues have been historically raised, including hospital systems (not defined in the guidance); mental health providers; oncology providers; and primary care providers. If CMS determines that the provider network is inadequate, the agency will notify the issuer, and the issuer will have an opportunity to respond prior to a final certification determination. CMS will provide additional technical guidance as part of the certification/recertification instructions regarding the collection method for a plan's provider list. CMS also signaled that the agency would consider time and distance standards in possible future rulemaking regarding network adequacy. In addition, QHPs also will be evaluated for their sufficient inclusion of Essential Community Providers (ECPs). ECPs serve predominately low-income and medically underserved populations and the ACA requires that QHPs include ECP providers and defines them according to the Public Health Service Act eligibility criteria for the 340B Drug Pricing Program. CMS identifies specific ECP guidelines for the 2105 benefit year: • Issuers must demonstrate that 30 percent of available ECPs in each QHP service area participate in the network. • If issuers cannot meet the 30 percent ECP guideline, the issuer in its certification application must provide a satisfactory narrative justification. • Issuers must offer contracts in good faith to at least one ECP in each ECP category in each county in the service area where an ECP is available. (ECP categories are: Federally Qualified Health Centers, Ryan White Providers, Family Planning Providers, Indian Health Providers, Hospitals (DSH and DSH-

	eligible hospitals, children's hospitals, rural referral centers, sole community hospitals, free-standing cancer centers, critical access hospitals), and other facilities such as sexually transmitted disease and tuberculosis clinics. • Issuers must offer contracts in good faith to all available Indian Health providers. • Issuers must list contract offers extended to ECPs and Indian Health providers and provide verification requested by CMS in their QHP certification application. • CMS provides examples in the guidelines of how issuers can meet these ECP requirements. CMS guidance also provides an alternative standard for issuers that provide a majority of covered services through physicians employed by the issuer or a single medical group.
Health Plan Management – HHS Notice of Benefit and Payment Parameters – Final Rule	
On March 11, HHS published its final rule, HHS Notice of Benefit and Payment Parameters, which implements payment parameters and oversight provisions related to ACA's premium stabilization programs. The premium stabilization programs consist of three programs that collectively are designed to mitigate risk for health plans as the ACA insurance reforms are implemented. The three programs, known as the 3Rs, are transitional reinsurance, temporary risk corridors and permanent risk adjustment. The final rule is applicable to the 2015 benefit year and includes several other provisions on the open enrollment period for 2015 and patient safety standards for hospitals contracting with QHP issuers. The following synopsis of the rule highlights key provisions for hospitals and hospitals with health plans.	
Federal Issuance/AHA Resources	**Synopsis**
http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf	**Premium Stabilization Program:** The premium stabilization program is a three-prong approach to minimizing the risk for health plans as ACA insurance reforms take hold. *Reinsurance*. The reinsurance program is a transitional program that is intended to help insurers in the individual market offset some of the costs of enrollees with high medical expenses. The program generally follows typical stop-loss reinsurance, except that the attachment point (the point at which the reinsurance begins to cover a portion of the claim) is relatively low compared to commercial reinsurance. The program is designed to reduce the degree of reinsurance protection across the three-year life of the program as health plan issuers become more accustomed to setting rates in the new reformed insurance market. It is funded through a per capita assessment on health insurers and third-party administrators for self-insured plans. The ACA specifies that in 2014 $10 billion in reinsurance contributions (assessments) is to be collected, $6

	billion in 2015 and $4 billion in 2016. For 2015 and 2016, reinsurance contributions will not be collected from self-administered, self-insured plans. For purposes of this provision of the final rule, a plan is considered "self-administered" as long as it does not use a third-party administrator for claims processing, claims adjudication and enrollment. The final rule does permit a plan to be considered self-administered when only "de minimus" services are provided by a third-party administrator, such as for provider networks; to administer pharmacy benefits or excepted benefits; or for "de minimus" administrative services. This exception does not apply for 2014. The AHA objected to this exception as arbitrary. In our comments to the proposed rule, we noted that there are no real distinctions in self-funded plans that are self-administered and self-funded plans that use third-party administrators. For 2014, the contribution fee was $67 annually per capita and the reinsurance pool was scheduled to reimburse insurers 80 percent of the cost of an enrollee's claim that exceeded an attachment point of $60,000, up to a cap of $250,000 per claim. The final rule lowered the attachment point for 2014 to $45,000. The AHA, in its comments to the proposed rule, objected to lowering the attachment point for 2014 because there remained too much uncertainty in enrollment and a lower attachment point might result in fewer available reinsurance dollars to offset higher cost cases. For 2015, the final rule sets the reinsurance contribution rate at $44 annually per capita with an attachment point at $70,000, up to a cap of $250,000 per claim and a 50 percent issuer coinsurance rate. For 2014 and 2015, if the reinsurance contribution collected for a benefit year exceeds the requests for reinsurance payments for the benefit year, the final rule instructs HHS to increase the coinsurance rate to 100 percent before rolling over any excess funds to the next year. *Risk Corridor.* The risk corridor program is intended to address the difficulty of initially making accurate actuarial projections under the new insurance reforms. It operates in tandem with the medical loss ratio (MLR) program. The final rule includes changes to the MLR calculation to account for the additional administrative costs and adverse selection effects resulting from the Administration's enrollment extension transition policy announced in November 2013 that allows non-ACA compliant policies to be renewed in the individual and small group market. For 2014, the final rule changed the definition of allowable issuer costs by increasing the profit margin floor and the administrative cost ceiling. This will increase the risk corridor payments to offset lower

	premium revenue and increased administrative costs. This will benefit plans with allowable costs of at least 80 percent. The modification of the risk corridor program will apply only for 2014 because insurers will be able to adjust their premiums for 2015 to fit their risk pool. *Risk Adjustment*. The risk adjustment program is permanent and intended to protect health plans operating in the individual and small group markets from attracting a higher than average health risk population after consideration of the allowable rating variables: family size/composition, tobacco use, geographic areas and age. Under the risk adjustment program, assessments are collected from plans with favorable selection and then distributed to plans with adverse selection. The final rule establishes a user fee of $.96 per member per year to be charged to individual and small group insurers covered by the risk adjustment program. The risk adjustment program will use the same methodology in 2015 used in 2014, except that a new adjustment will be put in place to recognize the higher utilization and reduced cost sharing for Medicaid premium assistance plans that are being implemented in several states, such as Arkansas and Iowa. The final rule also indicates that HHS will be providing further guidance on the inclusion of ICD-10 codes and ICD-9 codes for risk adjustment purposes. **Open Enrollment Period for 2015:** The final rule sets the open enrollment period for the benefit year 2015 to begin Nov. 15, 2014 and end Feb. 15, 2015. The additional month in 2015 gives issuers and the marketplaces more time to prepare before they need to begin accepting plan selections for 2015. **Establishment of Patient Safety Standards for QHP Issuers:** The ACA specifies that QHPs may contract with hospitals with more than 50 beds only if the hospital meets certain patient safety standards. Under these standards, a hospital must have a patient safety evaluation system, a relationship with a patient safety organization and operate a comprehensive hospital discharge program. These patient safety standards for issuers will be phased in. Phase one begins Jan. 1, 2015 and is effective for two years; it specifies that a QHP may contract with a hospital of more than 50 beds only if the hospital is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN). The final rule clarifies that only the CCN is required for documentation purposes. The AHA supported this approach in its comments to the proposed rule.

Third-party Payment and Premium Subsidies	
The ACA health insurance marketplaces give individuals, especially those who were previously uninsured, an opportunity to purchase health insurance coverage from one of a number of QHPs. Recognizing that an individual's share of the cost of a premium or for services received may be prohibitive, even with a federal premium subsidy, hospitals and health systems have expressed interest in providing subsidies for the purchase of premiums and cost sharing and have inquired whether there are any legal barriers to providing assistance if they wish to do so.	
Federal Issuance/AHA Resources	**Synopsis**
http://www.aha.org/hospital-members/advocacy-issues/tools-resources/advisory/2014/140408-legal-adv.pdf http://www.aha.org/hospital-members/advocacy-issues/tools-resources/advisory/2014/060514-legal-adv.pdf http://www.aha.org/advocacy-issues/letter/2014/140428-let-aha-cha.pdf	On March 19, CMS released an interim final rule requiring issuers of QHPs "to accept premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program, other Federal and State government programs that provide premium and cost-sharing support for specific individuals, and Indian tribes, tribal organizations, and urban Indian Organizations." However, the rule does not prevent QHPs from having "contractual provisions" prohibiting the acceptance of premiums and cost-sharing from third-party payers other than those specified in the regulation, and CMS continues to discourage third-party payments by hospitals, other health care providers, and other commercial entities, and encourages QHPs to reject such payments. In May 21 letters to the AHA and the Catholic Health Association of the United States, then-Secretary Kathleen Sebelius confirmed that payments from private, not-for-profit foundations to QHPs on behalf of individuals who enroll in coverage via the health insurance marketplaces are not prohibited. The clarification came in response to the associations' request to confirm that HHS was ***not*** discouraging hospital-affiliated or other charitable foundations from subsidizing premiums or cost-sharing expenses. The March rule related to third-party payments had created uncertainty about the favorable view expressed in the earlier Frequently Asked Questions (FAQs) documents regarding foundation subsidies. The secretary's letter clears the way for hospitals to support hospital-affiliated or other charitable foundations in providing subsidies for premiums or cost-sharing expenses for individuals in need of assistance who purchase coverage through the Health Insurance Marketplaces, so long as they follow the guidelines in CMS's Feb. 7 FAQ. The criteria in the guidelines include payments made on behalf of QHP enrollees based on financial need and that the premium or any cost sharing payments cover the entire policy year. Refer to AHA's Legal Advisories issued on April 8 and June 5 for further information.

OTHER COVERAGE RELATED ISSUES

Basic Health Program for 2015

The ACA gives states the option of creating a Basic Health Program (BHP), a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the new health insurance marketplaces. Through the BHP, states can provide coverage to individuals who do not qualify for Medicaid, or the Children's Health Insurance Program (CHIP), and have income between 133 percent and 200 percent of the federal poverty level (FPL). Individuals who are lawfully present non-citizens who have income that does not exceed 133 percent of FPL but who are unable to qualify for Medicaid due to such non-citizen status, also are eligible to enroll.

BHP benefits include at least the 10 essential health benefits specified in the ACA. The monthly premium and cost sharing charged to eligible individuals will not exceed what an eligible individual would have paid if he or she were to receive coverage from a QHP through the marketplace. A state that operates a BHP will receive federal funding equal to 95 percent of the amount of the premium tax credits and the cost-sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the marketplace.

Federal Issuance/AHA Resources	Synopsis
http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05299.pdf http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05257.pdf http://www.aha.org/advocacy-issues/tools-resources/advisory/2014/140108-regulatory-adv.pdf	On March 12, CMS published its final rule that provides the framework under which a certified BHP may be established and operated beginning on Jan. 1, 2015. In addition, CMS also published final methodology for determining payments to states under the BHP for 2015. To date, a handful of states have expressed interest in a BHP or are moving forward with plans to establish a BHP, including California, Minnesota, New York, Oregon and Washington.

Internal Revenue Service Guidance on Employer Responsibility and Reporting, Individual Responsibility and Minimum Essential Coverage	
The ACA requires that beginning Jan. 1, 2014, all U.S. citizens and legal residents maintain minimum essential coverage, defined as any plan offered through the individual market; public programs such as Medicare, Medicaid, TRICARE and the Veteran's Health Care Program; and employer-sponsored health plans. Insurers and employers are required to report coverage status to the Internal Revenue Service (IRS). On March 5, the IRS released two final rules implementing these reporting obligations that had previously been delayed by one year. The rules are effective for reports to be filed in 2016 for reporting year 2015. The following is a brief synopsis of these final rules.	
Federal Issuance/AHA Resources	**Synopsis**
http://www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05051.pdf http://www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05050.pdf http://www.aha.org/hospital-members/advocacy-issues/tools-resources/advisory/2014/140423-regulatory-adv.pdf	**Individual Responsibility and Minimum Essential Coverage:** The IRS final rule implements section 6055 of the Internal Revenue Code (IRC), which requires health insurers, self-insured employers, and other entities that provide minimum essential insurance coverage to individuals to report to the IRS. The reports must include information about the type and period of coverage and provide statements containing this information to individuals provided coverage. Insurers that provide coverage through QHPs on the insurance marketplace do not have to file a report. **Employer Responsibility and Reporting:** This IRS final rule implements section 6056 of the IRC pertaining to the reporting requirements that apply to large employers with at least 50 full-time or full-time equivalent employees. These reports must include information concerning the health care coverage that these employers provide their employees to demonstrate compliance with the employer responsibility provisions of the ACA. Employers also are required to provide statements to their employees regarding available employer-sponsored coverage so that the employees may determine whether they may claim premium tax credits under the ACA.

COBRA and Employer Notification	
The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) includes employer coverage continuation provisions that allow an individual with employer-sponsored coverage to continue that coverage for a period of time after it would otherwise have been lost. Such circumstances in which such coverage could be lost are when an individual is laid off from his/her job or a dependent ceases to be eligible for coverage. The individual pays 102 percent of the cost of the coverage to obtain COBRA-related coverage. On May 2, the Employee Benefits Services Administration (EBSA) of the Department of Labor issued guidance related to the notices employers must provide to their employees regarding the continuation of coverage under the COBRA and the interaction with the ACA.	
Federal Issuance/AHA Resources	**Synopsis**
http://www.ofr.gov/OFRUpload/OFRData/2014-10416_PI.pdf http://www.dol.gov/ebsa/faqs/faq-aca19.html http://www.dol.gov/ebsa/	EBSA released model notice forms for employers to use for providing COBRA notices to their employees. In addition, EBSA and HHS issued FAQs that address the relationship between COBRA and the ACA. The FAQs addressed several issues, including COBRA coverage does not limit eligibility for potentially more affordable marketplace coverage; families can qualify for a special enrollment period if their children qualify for CHIP; and how certain out of pocket costs for preventive services should be calculated.
MEDICARE ADVANTAGE UPDATE	
Medicare Advantage Program 2015 Call Letter	
The Medicare Advantage (MA) Program, or Medicare Part C, allows Medicare beneficiaries to receive health care benefits from private health plans rather than from the traditional fee-for-service (FFS) program. The private MA plans are paid a capitated rate rather than on a FFS basis, and thus have greater incentives to use care management techniques to improve efficiency and control costs. This improved efficiency allows MA plans to offer additional benefits or services to beneficiaries. On April 7, CMS released final capitation rates and payment policies for private MA and Part D prescription drug plans beginning in contract year 2015. The rate announcement and final call letter continue the ACA implementation of changes to the MA program by phasing in alignment of MA benchmarks with Medicare FFS costs.	

Federal Issuance/AHA Resources	Synopsis
http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-04-07.html	**Payment Methodology:** As required by the ACA, CMS established a new methodology for calculating each MA county rate as a percentage of FFS spending in each respective county. The ACA provides for a transitional period during which each county rate is calculated as a blend of the pre-ACA rate set under the law (known as the "applicable amount") and the new FFS-based ACA rate (known as the "specified amount"). For 2015, most counties will be fully transitioned to the new rate methodology, although some will continue to be based on a blended rate. **Payment Rates:** CMS estimates the overall net change to plan payments between 2014 and 2015 will be 0.4 percent, up from an estimated -1.9 percent for proposals in the Advance Notice. Individual plan payments will vary by plan based on, but not limited to, its location and star rating. Among other changes, CMS modified the phase-in schedule for the new risk adjustment model that began in calendar year 2014 and removed a proposal to exclude certain diagnoses from enrollees' risk assessments. It also delayed implementation of a new Part D risk adjustment model; refined the risk adjustment methodology to account for the impact of baby boomers; delayed changes to the star ratings system; and withdrew a proposal to require plans to provide additional coverage in the gap for generic and brand drugs. The final call letter requires plans to provide CMS with 90 days' notice of any significant changes to their provider networks, and allows enrollees to switch plans when their MA organization initiates significant mid-year provider network terminations without cause. CMS also limited the permissible increase in total beneficiary costs to $32 per month and maintained existing limits on beneficiaries' maximum out-of-pocket spending. However, MA organizations are encouraged to allow enrollees' dollar contributions toward these limits to be transferable when they move to any plan offered by the same organization.