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REFORM UPDATE

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FINAL NOTICE OF BENEFITS AND PAYMENT PARAMETERS FOR 2016

The Department of Health and Human Services (DHHS) recently released the Final Notice of Benefit and Payment Parameters for 2016. The Notice contains updated information on a number of issues related to the Affordable Care Act (ACA), including:

- Reinsurance program
- Maximum out-of-pocket limits and cost-sharing parameters
- Minimum value
- Exchange operations

This *Reform Update* provides detail on the provisions addressed by the Final Notice.

REINSURANCE PROGRAM

The reinsurance program is intended to help stabilize premiums in the individual market. The individual market is dealing with uncertainty caused by the ACA's changes to coverage and rate setting in the individual insurance market. Both self-funded and insured group health plans will fund the reinsurance program to help stabilize the individual market. While insurance carriers pay the reinsurance fee for fully-insured plans, employers pay the fee for self-funded plans.

The reinsurance program is meant to be temporary, with contributions applying for 2014, 2015, and 2016. The Notice confirmed the annual reinsurance contributions per average covered life:

- 2015 - $44 (if split payments, $33 by January 15, 2016; $11 by November 15, 2016)
- 2016 - $27 (if split payments, $21.60 by January 2017; $5.40 by November 15, 2017)

The counting method options were not unchanged. Details on the counting methods can be found at http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_56.pdf.

The Notice confirms the process for insurance carriers and self-funded health plans to report average covered lives. Self-funded employers must report average covered lives through pay.gov by November 15. The general process remains the same as in 2014:

- **Step 1** – Register at pay.gov (you do not need to register again if you already did so last year).
- **Step 2** – Complete the Contribution Form.
  - This form will be updated for the 2015 calendar year, and will likely be made available in the fall.
- **Step 3** – Upload supporting documentation.
  - This is not employee-specific data.
  - The employer information should be in the required .CSV file format.
- **Step 4** – Schedule payments.
  - The employer will have the option to schedule a single payment, due by January 15, 2016.
  - If employer wants to pay in two installments, two Contribution Forms must be completed. However, the gross annual enrollment count on the forms is the same. The only difference is one form will be used to schedule the first installment, and the second form will be used to schedule the final installment.

Self-funded employers should schedule a reminder in September 2015 to begin the reporting process for the reinsurance program. In addition, the Final Notice confirms that self-funded expatriate plans will not be required to make reinsurance contributions for 2015 and 2016. (Fully-insured expatriate plans were already excluded from making reinsurance contributions.)

Next, the Notice made changes to the design of the reinsurance program for 2015. The attachment point for reinsurance claims has been decreased to $45,000 (it was initially set at $70,000). The 2016 reinsurance program parameters are:

- **Attachment factor:** $90,000
- **Coinsurance rate:** 50 percent
- **Reinsurance cap:** $250,000

The Notice also addressed an issue that perplexed employers. Employers may terminate, start or change plan funding during a year. This could result in a self-funded employer overpaying or underpaying the reinsurance fee, such as when an employer, using the snapshot or snapshot factor method, has a change in funding methods during a quarter. The Notice directs the employer to choose "count days" under these methods that have employees covered by the plan. Employers can then pro-rate that quarter's count of average covered lives based on the number of days that coverage was provided during that quarter.

Self-funded, self-administered medical plans will not be subject to the reinsurance fee in 2015 or 2016.

Finally, the Notice updated details on the risk corridor and risk adjustment premium stabilization programs, which directly affect insurance carriers. These programs are also designed to mitigate uncertainty in the individual markets following the launch of subsidized coverage in state Marketplaces.

MAXIMUM OUT-OF-POCKET LIMITS AND COST-SHARING PARAMETERS

The Notice provided the indexed maximum out-of-pocket limits that applied to non-grandfathered health plans as of the first day of the first plan year beginning on or after January 1, 2014. The 2015 and 2016 limits are as follows:

	2015	2016
Single	$6,600	$6,850
Family	$13,200	$13,700

All cost-sharing associated with essential health benefits must apply to the out-of-pocket limits. These limits apply only to the in-network level of benefits.

The Notice included an important clarification on the out-of-pocket limit requirements. Many group health plans apply the family cost-sharing limit to the entire family. If an employee elected family coverage and one member of the family incurred significant medical expenses, then the out-of-pocket family limit was still applied, even though only one family member was using the plan.

DHHS will now require group health plans to embed the single cost-sharing annual limit into the family limit. In the above example, the family member who is using the plan would meet his or her out-of-pocket maximum when the single out-of-pocket limit is reached.

At this point, it is not clear if this applies to self-funded plans. Hopefully, the Department of Labor (DOL) will provide additional clarification in the future.

This requirement to embed the single out-of-pocket maximum is effective for plan years beginning on and after January 1, 2016.

MINIMUM VALUE

The Notice described the new requirements for determining minimum value. Plans still have to provide an actuarial value of at least 60 percent. The final regulations now require the medical plan to reflect the benefits historically provided under medical employer-sponsored coverage. This includes substantial coverage of both inpatient hospital services and physician services.

A new minimum value calculator was released for 2016, and can be found at http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html. Please note that you will need to scroll down to the Plan Management section to find the link to the actual calculator.

EXCHANGE OPERATIONS

A number of issues regarding the state Exchanges were addressed. The Notice establishes the open enrollment period for the 2016 benefit year for individual policies offered on or off state Exchanges, also called Marketplaces. Open enrollment will run from November 1, 2015 until January 31, 2016. If an individual enrolls by December 15, 2015, coverage will be effective on January 1, 2016.

Health insurers in the individual and small group markets are required to offer essential health benefits for non-grandfathered health plans. States are required to establish a benchmark plan within certain parameters. The Notice indicates that states may establish a new benchmark plan for 2017 based on plans available in 2014.

The Notice defines habilitative services to match the definition from the Uniform Glossary of Health Coverage and Medical Terms that is included by reference in the Summary of Benefits and Coverage. The new definition applies for plan years beginning in 2016. Insurance carriers will also be required to have separate visit limits on habilitative and rehabilitative services beginning with the 2017 plan year.

Pediatric benefits must be provided until the end of the month in which the enrollee turns 19.

One of the challenges when the Marketplaces launched was inadequate or incorrect information about network providers. The Notice clarifies that Qualifying Health Plans (QHPs) must publish an up-to-date, accurate and complete provider directory. The directory must clearly identify who is accepting new patients, and be easily accessible to plan enrollees, prospective enrollees, the state, the Marketplace, DHHS and the Office of Personnel Management (OPM). This means the general public must be able to view all of the current network providers on the plan's public website through a clearly identifiable link.

The Notice specified the provisions for streamlining administration of the Small Business Health Options Program (SHOP):

- The SHOP can assist employers in the administration of COBRA when coverage is provided through the SHOP. For example, the SHOP can collect COBRA premiums on behalf of any employer. DHHS is also investigating the feasibility of the SHOP taking on more COBRA responsibilities, such as providing the required COBRA notices to plan participants.
- The SHOP can renew an employee's offer of coverage when an employee remains eligible to participate in the SHOP, as long as the employee has taken no action to modify coverage or withdraw from the SHOP.
- A qualified employer that fails to pay premium for SHOP coverage in a timely manner can have its prior coverage reinstated only once per calendar year.

Finally, the Notice confirms the 2016 user fee charged to insurance carriers offering QHPs will remain at 3.5 percent of premiums in 2016.

CONCLUDING THOUGHTS

Every year, DHHS will release the Final Notice of Benefit and Payment Parameters. It is the process by which they annually address issues related to the Exchanges, premium stabilization programs and other key aspects of the ACA. Much of the guidance included with this Final Notice affects insurance carriers. However, key provisions will have an impact on employers as well.

It is important to note the annually indexed out-of-pocket maximums for 2016 and the requirement to embed the single out-of-pocket maximum in the family out-of-pocket maximum for 2016. You should speak with your health plan vendor to make sure this change is made to your benefit plan. It is not common to embed out-of-pocket maximums. Also self-funded employers should wait for a clarification from the Departments on whether the requirement to embed the single out of pocket maximum will apply to their plans.

Finally, self-funded plans should create a reminder in late September or early October to start the process of reporting average covered lives and scheduling reinsurance payments.