



Health Care Reform **Bulletin**

HHS Issues Proposed Benefit and Payment Parameters for 2016

Provided by Clarke & Company Benefits, LLC

- Quick Facts**
- On Nov. 21, 2014, HHS released its 2016 Notice of Benefit and Payment Parameters Proposed Rule.
 - The proposed annual contribution rate for the reinsurance program is \$27 per enrollee.
 - The proposed rule identifies the annual enrollment period for the 2016 benefit year.
 - The cost-sharing limit for non-grandfathered plans will increase for 2016 under the proposed rule.

The 2016 Notice of Benefit and Payment Parameters Proposed Rule includes a variety of changes for 2016, including updates to the cost-sharing limit for non-grandfathered health plans.

On Nov. 21, 2014, the Department of Health and Human Services (HHS) released its [2016 Notice of Benefit and Payment Parameters Proposed Rule](#). The proposed rule describes benefit and payment parameters applicable to the 2016 benefit year, including standards relating to the:

- Reinsurance program's annual contribution rate;
- Open enrollment period for 2016; and
- Annual limitations on cost-sharing.

HHS may make changes to the proposed rule before finalizing it. However, the proposed rule is a good indicator of the benefit and payment parameters that HHS may adopt for 2016.

Reinsurance Program – Annual Contribution Rate

The Affordable Care Act (ACA) created a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014 through 2016). The program imposes a fee on health insurance issuers and self-insured group health plans.

The reinsurance program's fees are based on a national contribution rate, which HHS announces annually.

- For 2014, the annual contribution rate is **\$63 per enrollee**.
- For 2015, HHS lowered the annual contribution rate to **\$44 per enrollee**.
- For 2016, HHS proposed to lower the annual contribution rate even more, to **\$27 per enrollee**.

Open Enrollment Period for 2016

The proposed rule identifies the annual open enrollment period for non-grandfathered policies in the individual market, inside and outside of the Exchange, for the 2016 benefit year and beyond. Under the proposed rule, the annual open enrollment period would begin on Oct. 1 and run through Dec. 15 of the year prior to the benefit year. Thus, under the proposed guidance, the open enrollment period for 2016 would begin on Oct. 1, 2015, and run through Dec. 15, 2015.

The proposed rule does not change the schedule for the Exchange's open enrollment period for 2015, which began on Nov. 15, 2014, and goes until Feb. 15, 2015.



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Annual Limitations on Cost-sharing

Effective for plan years beginning on or after Jan. 1, 2014, the ACA requires non-grandfathered health plans to comply with an overall annual limit, or an out-of-pocket maximum, on essential health benefits.

The ACA requires that the out-of-pocket maximum be updated annually based on the percent increase in average premiums per person for health insurance coverage.

- For 2015, the out-of-pocket maximum is **\$6,600 for self-only coverage** and **\$13,200 for family coverage**.
- Under the proposed rule, the out-of-pocket maximum would increase for 2016 to **\$6,850 for self-only coverage** and **\$13,700 for family coverage**.

HHS also clarifies in the proposed rule that the out-of-pocket maximum applies for the **plan year** and not the calendar year for non-calendar year plans. Also, plans and issuers are permitted, but not required, to count out-of-network cost-sharing against the annual out-of-pocket maximum.

Minimum Value—Closed Loophole for Low-cost Employer Plans

Under the ACA, minimum value (MV) of an employer-sponsored plan is significant for a number of purposes. Beginning in 2015, certain large employers may be penalized if the health plans they offer do not provide MV. Also, an individual who is offered employer-sponsored coverage that is affordable and provides MV may not receive a subsidy for coverage through an Exchange. HHS and the Internal Revenue Service (IRS) have provided four methods for determining the MV of a plan, including an online [MV Calculator](#).

On Nov. 4, 2014, the IRS issued [Notice 2014-69](#) to clarify that plans that do not provide inpatient hospitalizations or physician services (referred to as Non-hospital/Non-physician Services Plans) do not provide the MV intended by the ACA.

Consistent with Notice 2014-69, the proposed rule provides that, in order to provide MV, a plan must not only cover a predicted 60 percent of the allowed costs under the plan, but it must also provide a benefits package that reflects benefits historically provided under “major medical” employer coverage.

Specifically, to satisfy the MV requirement, coverage must include substantial coverage of both inpatient hospital services and physician services.

Individual Mandate: Affordability Exemption

Under the ACA, individuals who lack access to affordable minimum essential coverage (MEC) are exempt from the individual mandate. For purposes of this exemption, coverage is affordable for an employee if the required contribution for the lowest-cost, self-only coverage does not exceed **8 percent of household income**.

This required contribution percentage is adjusted annually after 2014. For 2015, coverage is unaffordable for purposes of the individual mandate exemption if it exceeds **8.05 percent of household income**.

For 2016, the proposed rule provides that, if an individual must pay more than **8.13 percent of his or her household income** for MEC, the individual is exempt from the individual mandate penalty.

Medical Loss Ratio Rebates

The ACA’s medical loss ratio (MLR) rules require health insurance issuers to spend 80 to 85 percent of their premium dollars on medical care and health care quality improvement activities, or pay rebates.

The proposed rule would require that subscribers of nonfederal governmental or other group health plans not subject to ERISA receive the benefit of MLR rebates within **three months** of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do. In addition, the proposed rule includes technical clarifications to ensure that issuers correctly



exclude from MLR and rebate calculations the federal and state employment taxes, as well as the cost-sharing reduction payments issuers receive from HHS.

Small Business Health Options Program (SHOP)

This proposed rule includes provisions to streamline the administration of the SHOP. For example, the proposed rule would:

- Permit SHOPS to assist employers in the administration of continuation coverage (COBRA) enrolled in through a SHOP;
- Permit a SHOP to elect to renew an employer's offer of coverage where the employer remains eligible to participate in the SHOP, and has taken no action to modify its offer of coverage or withdraw from the SHOP during its annual election period, so long as the offered coverage remains available through the SHOP;
- Modify the calculation of minimum participation rates in the SHOP to align with the current practice of issuers in many states and to include other types of coverage in the calculation of the group's rate; and
- Specify that a qualified employer that fails to pay its premium for federally facilitated SHOP coverage in a timely manner can be reinstated in its prior coverage only once per calendar year.

Source: Department of Health and Human Services

