IMPORTANT NOTICE REGARDING HEALTHCARE REFORM

Update # 28 **December, 2013**

Proposed HHS Notice of Benefit and Payment Parameters for 2015

The proposed HHS Notice of Benefit and Payment Parameters released last week include payment parameters applicable to the 2015 benefit year.

Key policies in the proposed rule include:

Promoting Stable Individual Market Premiums
HHS is proposing to decrease the reinsurance attachment point from $60,000 to $45,000 for the 2014 benefit year due to updated estimates that allow for greater payments from the contribution fund. The annual reinsurance contribution rate for 2014 is $63.00 per enrollee.

For 2015, HHS is proposing an attachment point of $70,000, a reinsurance cap of $250,000, and a coinsurance rate of 50 percent. The annual reinsurance contribution rate is proposed at $44.00 per enrollee, to be paid by health insurance issuers and certain self-insured group health plans. This contribution rate would fund the required $6 billion reinsurance payments pool, $2 billion payable to the U.S. Treasury, and $25.4 million to HHS for estimated reinsurance administrative expenses. HHS also stated if reinsurance contributions collected for a benefit year exceed the requests for reinsurance payments for the benefit year, they would increase the coinsurance rate on reinsurance payments (or make other modifications to reinsurance parameters) to ensure that all of the contributions collected for that benefit year are expended for claims for that benefit year.

Alleviating the Burden of Reinsurance Contributions
HHS is proposing to modify the contribution collection schedule for the reinsurance program, so that they would collect reinsurance contribution amounts for reinsurance payments and administrative expenses earlier in the calendar year, however, collect the reinsurance contribution amounts for payments to the U.S. Treasury in the last quarter of the calendar year. For example, the $63.00 per enrollee reinsurance contribution for 2014 would be collected in two installments, i.e., $52.50 in January 2015, and $10.50 in the fourth quarter of 2015. HHS is proposing to exclude from this contribution obligation any self-insured group health plan that does not use a third party administrator for claims processing or adjudication, or plan enrollment for 2015 and 2016.

Adjusting for the Transitional Plan Policy
On November 14, 2013, the Federal government announced a policy under which it will it will not consider certain individual and small group health insurance coverage renewed between January 1, 2014, and October 1, 2014, under certain conditions, to be out of compliance with certain 2014 market rules, and requested that States adopt a similar policy. Because issuers' premium estimates assumed that individuals currently enrolled in the transitional plans would participate in the Affordable Care Act qualified plans, the transitional policy may lead to unanticipated changes in premium revenue for issuers of plans that comply with the 2014 market rules. HHS announced that they are considering a number of approaches to potentially mitigate these effects, including a proposal for a State-by-State adjustment to how administrative costs and profits are calculated under the risk corridors program. The adjustment would be larger in States in which enrollment in transitional plans is greater. HHS is seeking comments on whether this, or alternative ideas, are warranted.

Amendments to Open Enrollment Period for 2015
HHS is proposing changing the annual open enrollment period for the 2015 benefit year to begin on November 15, 2014 and extend through January 15, 2015. This is intended to give issuers additional time before they would

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need to set their 2015 rates and submit their qualified health plan applications, give States and HHS more time to prepare for open enrollment, and give consumers until January 15, 2015 to shop for coverage.

New Blueprint Timelines
HHS is also proposing to give States more time to transition into a State-based Marketplace after 2014 by moving the approval or conditional approval deadline for States back from January 1st to June 15th for the following year.

Protecting Individuals from Excessive Out-of-Pocket Expenses
The Affordable Care Act sets limits on cost sharing to protect individuals from excessive out-of-pocket expenses. The statute requires that these limits be updated annually based on the percent increase in average per capita premiums for health insurance coverage. HHS is proposing to calculate this percent increase using the projections of average per enrollee private health insurance premiums from the National Health Expenditure Accounts (NHEA), which is calculated by the CMS Office of the Actuary. Based on HHS estimates, these figures appear to be the most comprehensive, accurate, and transparent figures available in the timeframe they are required to follow to set this percentage each year. This should include a premium adjustment percentage for 2015 of 6.0%, which would result in a maximum annual limitation on cost sharing for 2015 for self-only coverage of $6,750, and a maximum annual limitation on deductibles for 2015 for health plans in the small group market for self-only coverage of $2,150

Annual Limitation on Cost Sharing for Stand-alone Dental Plans (SADPs)
HHS is proposing setting a national stand-alone dental plan maximum out-of-pocket (MOOP). The policy would reduce the MOOP to $300 for one covered child and $400 for two or more covered children. Given the limited cost sharing variations possible with decreased annual limits on cost sharing, the rule proposes that the AV standard be removed for stand-alone dental plans.

Small Group Participation in Risk Adjustment and Risk Corridors
HHS is proposing that a group plan should be classified as a small group plan for purposes of risk adjustment (provides payments to health insurance issuers that disproportionately attract higher-risk populations) according to the employee counting method applicable under State law, as long as the method accounts for part-time employees. If the State counting method does not take into account part-time employees, the full-time equivalent method described in section 4980H(c)(2)(E) of the Internal Revenue Code, which is the method used for the Federally-facilitated SHOP. HHS is also proposing that a plan be classified as a small group plan for purposes of risk corridors (protects against inaccurate rate-setting by sharing risk gains and losses on allowable costs between HHS and qualified health plans to help ensure stable health insurance premiums) according to the employee counting method applicable under State law even if the State definition does not take non-full-time employees into account.

Simplifying Composite Rating
HHS is proposing that beginning in 2015, if an issuer in the small group market (including the SHOP) offers a composite (average enrollee) premium, the composite premium would not change during the plan year, even if the composition of the group changes.

Protecting Personally Identifiable Information (PII)
HHS is proposing additional Marketplace flexibility regarding applicant eligibility and enrollment information to promote the efficient operations of the Marketplace. The proposed use and disclosure would be subject to review

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and approval criteria, consent from the individual providing the information, and to the strict privacy and security standards in §155.260(b). HHS also proposes to allow Exchanges to adjust privacy and security standards for non-Exchange entities so that the standards align more closely to the functions and operating environment under which the non-Exchange entity is performing; so long as these standards provide the same level of protection as current §155.260 affords.

Protecting Enrollees in QHPs

HHS is proposing to implement patient safety standards over time to provide consumers with access to health care that meets adequate safety and quality standards. For the initial two years, they are proposing to align QHP issuer standards with the Medicare Hospital Condition of Participation requirements for a quality assessment and performance improvement program and discharge planning. Additionally, as a means of ensuring that all QHPs offered through the Federally-facilitated Marketplace (FFM) are in the interest of qualified individuals and qualified employers, HHS is proposing that in order to be certified as a QHP in the FFM, a plan generally must be considered "meaningfully different" from all other plans offered by the same issuer.

Protecting Federal Funds

HHS is proposing oversight provisions applicable to the premium stabilization programs, including authority for HHS to conduct audits of issuers and entities in the HHS operated risk adjustment and reinsurance programs, as well as audits of State operated reinsurance programs and standards regarding risk adjustment data validation. They are also proposing to clarify that HHS has the authority to net payments to issuers against amounts owed to them by the issuer for any related entity streamlining operations.

Fully Implementing Employee Choice in the Federally-facilitated SHOPs (FF-SHOPs)

Last, HHS is proposing several provisions that would take effect after employee choice and premium aggregation become available in FF-SHOPs. They are proposing that employers in the FF-SHOPs would make premium payments according to a timeline and process set by HHS. This would include setting a standard premium prorating methodology for the FF-SHOPs such that groups would be charged only for the portion of the month for which they are enrolled, and a policy that FF-SHOP issuers must effectuate coverage for a group unless the FF-SHOP sends a cancellation notice to the issuer. This would allow employers in the FF-SHOPs to offer employees either a single stand-alone dental plan or a choice of all stand-alone dental plans available in an FF-SHOP, and allow FF-SHOPs to permit employers to contribute differently to the premiums of full-time and non-full-time employees. HHS proposes to not allow composite rating in the FF-SHOPs when an employer elects to offer employees a choice of plans at one AV level since having employees spread across multiple plans would make composite rating complex.

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