Bernie Lowe & Associates, Inc.
"Beyond the Product"

Health Care Reform Update

IMPORTANT NOTICE REGARDING HEALTHCARE REFORM

Update #44 **March, 2015**

Final 2016 Notice of Benefit and Payment Parameters

On February 20, 2015 the Department of Health and Human Services (HHS) issued final regulations on the 2016 Notice of Benefit and Payment Parameters. The regulations address a variety of Patient Protection and Affordable Care Act (PPACA) benefit provisions for 2016 affecting both the group and individual markets. While HHS clarified a few items from the proposed rule, namely the open enrollment period, minimum value, and medical loss ratio, many of the provision requirements remain the same.

Here is a brief overview of the major items.

2016 Cost Sharing Limits

In 2015, the OOP limits are $6,600 for self-only coverage and $13,200 for other than self-only coverage.

The ACA imposes annual out-of-pocket maximums (OOP) on the amount that an enrollee in a non-grandfathered health plan, including self-insured and large group health plans, must pay for essential health benefits (EHB) through cost sharing. For 2016, HHS has confirmed that the OOP maximums will be $6,850 for self-only coverage and $13,700 for other than self-only coverage. (In 2015, the OOP limits are $6,600 for self-only coverage and $13,200 for other than self-only coverage.)

The guidance also amends the regulations to clarify that non-calendar year plans are subject to the annual limitation on cost sharing that is specific to the calendar year in which the plan year begins. That limit will apply as the maximum OOP for the entire plan year.

HHS also clarified in the guidance that the annual OOP for self-only coverage applies regardless of whether the individual has self-only or other than self-only (family) coverage. For example, if a plan has an other than self-only OOP of $10,000 and an individual has $20,000 in expenses, that individual would only be responsible for cost sharing up to the maximum $6,850 limit in 2016.

OOP limits for family coverage should be reviewed to determine if this clarification requires any plan design changes. High-deductible plans with HSAs often apply a single overall OOP maximum on the family, without an underlying self-only OOP maximum.

It is important to note that if an other than self-only OOP is $6,850 or lower, the regulations allow for the deductible to be aggregated.

Minimum Value Standards

The final rule establishes new standards by which employer-sponsored plans meet the minimum value requirement. HHS now requires employer plans to provide "substantial" coverage of inpatient and physician services. This will apply to employer sponsored plans on the effective date of the final notice, and these plans will not meet minimum value unless they provide this specific coverage. Separate further guidance is expected to provide more clarification around the definition of "substantial."

Reinsurance Fee

The final rule confirms that the 2016 Reinsurance Fee is $27 per person. In addition, self-funded group health plans that do not use a third-party administrator will be exempt from making reinsurance contributions in the 2015 and

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2016 benefit years. The final rule also confirms that self-insured expatriate plans are also not required to make reinsurance contributions for the 2015 and 2016 benefit years.

Open Enrollment Period
For the 2016 calendar year, the open enrollment period for non-grandfathered policies in the individual market, inside and outside the Marketplace, will run from November 1, 2015 through January 31, 2016, with various plan effective dates depending on when an individual enrolls.

Essential Health Benefit Benchmark Plans
It is confirmed that states may select new benchmark plans for 2017, based on plans available in 2014.

Reduced Maximum Annual Limitation on Cost Sharing
Individuals with household incomes between 100-200 percent of the Federal Poverty Level (FPL) have a reduced maximum annual limitation on cost sharing for self-only coverage of $2,250. Individuals with incomes between 200-250 percent FPL have a reduced maximum annual limitation on cost sharing for self-only coverage of $5,450.

Medical Loss Ratio (MLR) Program
The final rule clarifies that Federal and State employment taxes should be included in premium for the MLR and rebate calculations. In addition, subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates, or a rebate distribution, within three months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do. This provision is effective January 1, 2016 for the 2016 MLR reporting year, which must be submitted in 2017.

2016 Federal Marketplace User Fee
The user fee paid by insurers that offer plans on the federally facilitated Marketplace is confirmed at 3.5 percent of monthly premiums, consistent with previous guidance.

Compliance Standards for Federal Marketplace
Under the final rule, HHS has the authority to approve and oversee vendors that provide training to agents and brokers in federally facilitated Marketplaces. HHS may recognize the successful completion of a Marketplace training program by agents and brokers. To become an HHS-approved vendor, the organization must demonstrate that it meets specified criteria outlined on the application process established by HHS. HHS is also finalizing the proposal to extend the good faith compliance policy for Qualified Health Plan (QHP) issuers participating in federally facilitated Marketplaces. In addition, the final 2016 Letter to Issuers in the federally facilitated Marketplace was published, which provides key guidance for issuers seeking to offer plans in this Marketplace.

Final Regulations can be found at: **Notice of Benefit and Payment Parameters for 2016**