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Health Care Reform Alert

February 25, 2015

Final 2016 Notice of Benefit and Payment Parameters

On February 20, 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 an overview.

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**.**

2016 Cost Sharing Limits

The 2016 maximum annual out-of-pocket limits are confirmed at $6,850 for individual coverage and $13,700 for family coverage. Additionally, the out-of-pocket limit for individual coverage applies to all enrollees, even if they are enrolled in family coverage. For example, if the plan has an individual out-of-pocket maximum of $5,000 and a family out-of-pocket maximum of $10,000, then if any family member's out-of-pocket maximum reaches $5,000, services for that particular family member will be covered at

coinsurance.

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.

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."

Rate Reviews

Premium rate increases in the individual and small group markets of 10 percent or more (or above a threshold specified by a state) triggered at the "plan-level" will be reviewed by state regulators or HHS to determine whether they are reasonable. This is a change from the previous requirement that was triggered at a "product level."

Issuers seeking the increase are required to publicly disclose the proposed increases and the justification for them. Beginning with rates filed in 2016 for coverage effective on or after January 1, 2017, rate increases will be subject to review by HHS.

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 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.

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.

Resources

There are many other details confirmed in this final rule. A fact sheet on the final rule is available on the Centers for Medicare and Medicaid Services (CMS) website.

Read the CMS Fact Sheet

We encourage you to bookmark Cigna's health care reform website, www.InformedonReform.com, where we continuously update regulatory guidance and information as it becomes available.

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