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Health Care Reform Alert

November 25, 2014

Proposed Regulations on 2016 Benefit and Payment Parameters

On November 21, the Department of Health and Human Services (HHS) issued proposed regulations that address a variety of Patient Protection and Affordable Care Act (PPACA) benefit provisions for 2016 affecting both the group and individual markets. There is a 30-day comment period on these proposed regulations. Here is an overview of some of the key provisions.

CHANGES AFFECTING GROUP HEALTH PLANS

2016 Reinsurance Fee Contribution Amount

The Reinsurance Fee applies to insured and self-funded group health plans for calendar years 2014 through 2016. The 2015 fee amount of $44 was announced previously. The proposed fee for 2016 is $27 per covered individual.

Insured expatriate plans do not have to pay the reinsurance fee. The regulations propose that self-insured expatriate plans also not be required to pay the reinsurance fee for 2015 and 2016.

Cost-Sharing Limits

The proposed plan year cost-sharing maximums for 2016 are $6,850 for self-only coverage and $13,700 for family coverage. Insurers are permitted, but not required, to count out-of-network costs toward the annual cost-sharing limits.

Lower Cost-Sharing Limits for Certain Individuals

Lower cost-sharing limits are proposed for certain individuals with lower incomes. For individuals with household incomes between 100% and 200% of the federal poverty level,

the proposed maximum is $4,250 for self-only coverage and $4,500 for family coverage. For individuals with incomes between 200% and 250% of the federal poverty level, the proposed maximums are $5,450 for self-only coverage and $10,900 for family coverage.

Minimum Value

To meet the minimum value requirement, a plan must include substantial coverage of both inpatient hospital services and physician services in addition to meeting the requirement to cover at least 60% of allowed costs.

A proposed minimum value calculator for 2016 was issued, including links to the **draft actuarial value calculator** and the **draft calculator methodology**.

Medical Loss Ratio (MLR) Rebates

Currently, individuals enrolled in insured group health plans subject to ERISA must receive the benefit of any MLR rebates within three months of receipt by the group policyholder. The proposed regulations would apply this same three-month timing to individuals enrolled in non-federal governmental plans and other group health plans not subject to ERISA.

The proposed regulations also clarify how certain types of expenses should be treated in calculating the medical loss ratio.

New Essential Health Benefit Benchmark Plan Selection

The proposed rules would require all states to select new benchmark plans for 2017 based on plans available in 2014.

Hardship Exemptions from the Individual Mandate

Individuals who live in states that chose not to expand Medicaid, who have household incomes below 138% of the federal poverty level, are under age 65 and do not qualify for Medicaid or Medicare, will automatically qualify for a hardship exemption from the Individual Mandate. They will not be required to apply for Medicaid and be denied, or to obtain a hardship exemption certificate from the Marketplace.

Any individual whose gross income is below the federal income tax filing threshold can qualify for a hardship exemption from the Individual Mandate. This exemption can be claimed through the tax filing process.

CHANGES AFFECTING INDIVIDUAL INSURANCE PLANS

Marketplace Annual Enrollment

For the 2016 calendar year and beyond, the annual enrollment period for individual policies, both on and off the Marketplace, is proposed to be October 1 through December 15. Individuals enrolled in employer-sponsored non-calendar year plans would have a 60-day special enrollment period corresponding to their plan's annual enrollment period.

Currently, individuals who do not take action during the annual open enrollment period are re-enrolled in their current plan, even if that plan has a significant premium increase. The proposed regulations would allow states to pursue re-enrollment alternatives for 2016 that could default individuals into a lower-cost plan rather than their current plan.

Rate Review

Proposed premium rate increases in the individual and small group markets of 10% or more (or above a threshold specified by a state) are reviewed by state regulators or HHS to determine whether they are reasonable. Currently this happens at a “product” level, for example all an insurer’s PPO products, which could include many types of plans. The proposed rule would require the rate review at a “plan” level (for example, the insurer’s silver level plan).

User Fees

The fee insurers pay to sell individual policies through the Marketplace is proposed to remain at 3.5% of the monthly premium.

Formulary Drug Lists

Health plans must publish an up-to-date drug formulary, or list of covered drugs, including any tiering structure or restrictions on how a drug can be obtained. This list must be easily accessible to enrollees, the state, the Marketplace, HHS and the general public.

The regulations propose the establishment of more detailed procedures for requesting coverage of drugs not included in the formulary. This includes a standard review process and an external review if the health plan denies the initial request. Expenses with respect to drugs obtained through this exception process must count toward the annual cost-sharing limits.

Provider Directories

Health plans must publish an up-to-date, accurate and complete provider directory, including information on which doctors and other health care professionals are accepting new patients. This information must be easily accessible to enrollees, the state, the Marketplace, HHS and the general public.

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