Health Care Reform
Bulletin

HHS Issues Final Notice of Benefit and Payment Parameters for 2016

Provided by JRG Advisors, LLC

Quick Facts

- On Feb. 27, 2015, HHS published its final Notice of Benefit and Payment Parameters for 2016.
- The annual contribution rate for the reinsurance program in 2016 is $27 per enrollee.
- The final rule adjusts the annual enrollment period for the 2016 benefit year.
- The cost-sharing limit for non-grandfathered plans increased for 2016 under the final rule.

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

On Feb. 27, 2015, the Department of Health and Human Services (HHS) published its final **Notice of Benefit and Payment Parameters for 2016**. This final rule describes benefit and payment parameters applicable to the 2016 benefit year, including standards relating to:

- The reinsurance program's annual contribution rate for 2016;
- The 2016 open enrollment period; and
- The 2016 annual limitations on cost-sharing.

Annual Reinsurance 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—2016). This 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 was **$63 per enrollee**.
- For 2015, HHS lowered the annual contribution rate to **$44 per enrollee**.
- For 2016, HHS lowered the annual contribution rate even more, to **$27 per enrollee**.

Open Enrollment Period for 2016

The final rule sets the annual open enrollment period for non-grandfathered policies in the individual market, both inside and outside of the Exchange, for the 2016 benefit year and beyond. Under the proposed Notice of Benefit and Payment Parameters for 2016, the annual open enrollment period would have run from Oct. 1, 2015, through Dec. 15, 2015. However, the final rule modified this schedule, so that **the annual open enrollment period for 2016 will begin on Nov. 1, 2015, and run through Jan. 31, 2016**.

The final rule does not change the schedule for the Exchange's open enrollment period for 2015, which ended on Feb. 15, 2015.

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

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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 final rule, the out-of-pocket maximum increased for 2016 to **$6,850 for self-only coverage** and **$13,700 for family coverage**.

HHS also clarified in the final 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 may, but are not required to, count out-of-network cost-sharing against the annual out-of-pocket maximum.

Finally, HHS clarified in the final rule that the annual limitation on cost-sharing for self-only coverage applies to all individuals, regardless of whether the individual is covered by a self-only plan or family coverage. In both of these cases, an individual's cost sharing for essential health benefits may never exceed the self-only annual limitation on cost-sharing.

For example, if a family plan has an annual limitation on cost-sharing of $10,000, and one individual in the family plan incurs $20,000 in expenses from a hospital stay, that particular individual would only be responsible for paying the cost-sharing related to the costs of the hospital stay covered as essential health benefits, up to the annual limit on cost-sharing for self-only coverage (assuming an annual limitation of $6,850 for 2016, the maximum for that year).

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 a plan's MV, 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 final 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 final rule provides that, if an individual must pay more than **8.13 percent of his or her household income** for MEC, that 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 to enrollees.

The final rule requires 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 final rule includes technical clarifications to ensure that issuers correctly exclude federal and state employment taxes, as well as the cost-sharing reduction payments issuers receive from HHS, from MLR and rebate calculations.

Small Business Health Options Program (SHOP)
The final rule includes provisions to streamline administration of the SHOP. For example, the final rule:

- Allows SHOPs to assist employers in the administration of continuation coverage (COBRA) enrolled in through a SHOP;
- Allows 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;
- Modifies 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 (this policy is limited to the federally facilitated SHOP, effective for plan years beginning on or after Jan. 1, 2016; states may decide how to calculate minimum participation rates for state SHOPs and the non-SHOP small group market);
- Aligns SHOP qualified health plan (QHP) certification in SHOPs that certify QHPs on a calendar year basis with rolling enrollment in the SHOP, so that employers can start coverage through the SHOP at the beginning of any month, with coverage lasting for 12 months;
- Finalizes an exception to the rule regarding 12-month plan years in the SHOP for states with merged individual and small group risk pools under federal law;
- Specifies 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; and
- Specifies that, effective Jan. 1, 2016, certain termination notices will be provided by the SHOP.

Source: Department of Health and Human Services