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HHS Proposes 2016 Reinsurance Contribution Rate and OOP Maximums

The Department of Health & Human Services has proposed a 2016 transitional reinsurance rate of $27 and provided additional guidance in several key areas of the reinsurance program. HHS has also proposed 2016 out-of-pocket maximums of $6,850 for self-only coverage and $13,700 for other than self-only coverage, and provided guidance on the marketplace open enrollment periods for 2016 and later years.

Background

Each year the Department of Health & Human Services (HHS) releases the HHS Notice of Benefit and Payment Parameters that provides important guidance related to the Affordable Care Act (ACA) marketplaces and various ACA provisions. On November 21, HHS released the proposed rule for 2016 as well as a fact sheet that summarizes the guidance. While this guidance is primarily focused on the ACA marketplaces and insurers offering programs, it includes areas that affect large employer and self-insured group health plans, such as:

- Transitional reinsurance program fees, counting methods, submission process, and other provisions
- ACA out-of-pocket maximums
- 2016 marketplace open enrollment period

ACA Indexed Dollar Amounts

A table summarizing the various ACA indexed dollar amounts by year is included at the end of this publication.

The guidance also discusses minimum value plans and the requirement that those plans include substantial coverage of inpatient hospital services and physician services. We will discuss that topic in a future *For Your Information*.

Transitional Reinsurance Program

The primary purpose of the transitional reinsurance program is to help stabilize premiums in the individual health insurance market from 2014 to 2016 by protecting insurers against the potential need to raise premiums due to the implementation of the ACA market reform rules.

2016 Reinsurance Contribution Rate

The total amount to be collected under the reinsurance program from insurers and self-insured group health plans is $25 billion over three years. $20 billion of the amount collected will fund the reinsurance pool, while the remaining $5 billion will be paid to the US Treasury.

HHS previously released the reinsurance contribution rate for 2014 and 2015. The regulations now provide the 2016 rate of $27 per enrollee.

Reinsurance Program Funding and Contribution Rates

Year	Reinsurance Pool	US Treasury	Total	Reinsurance Rate
2014	$ 10 billion	$ 2 billion	$ 12 billion	$ 63
2015	$ 6 billion	$ 2 billion	$ 8 billion	$ 44
2016	$ 4 billion	$ 1 billion	$ 5 billion	$ 27
Total	$ 20 billion	$ 5 billion	$ 25 billion	

Comment. Plan sponsors can now determine the amount of reinsurance fees that will be paid for 2016. Since HHS has estimated the number of enrollees that the fees will apply to over the three years, the total amount of fees collected will either exceed or not cover the targeted $25 billion. The guidance does not discuss how HHS will adjust these payments after the three years to collect $25 billion. Employers may be required to make additional payments if the above rates do not collect the amount required; or they may receive refunds.

Consistency in Counting Methods

The counting methods for determining the number of covered lives are similar to those provided for determining the Patient-Centered Outcomes Research Institute (PCORI) fee. (See our December 6, 2012 *For Your Information* for an overview of the counting methods.) Under all of the alternatives except the Form 5500 Method, the number of covered lives for the year will be determined based on the first nine months of the applicable calendar year. A contributing entity can use a different counting method for purposes of the reinsurance contribution than it uses for the PCORI fee.

The proposed regulations would require that insurers use the same counting method for all enrollees in a state for the 2015 and 2016 years. However, the regulations do not include a similar requirement for self-insured group health plans because "… in many instances, a plan sponsor's multiple group health plans may be administered by different entities, making uniformity of counting methods potentially more difficult." The regulations request comments on this proposal.

Counting Methods:

- Actual count method
- Snapshot count method
- Snapshot factor method
- Form 5500 method

Comment. Using different counting methods for different self-insured plans can help to reduce the amount of the reinsurance fees. The "snapshot factor method" typically produces significantly lower fees for plans covering active employees, while the "snapshot count method" usually produces the lowest fees for pre-Medicare retirees. If active employees and retirees are in different plans, varying the approach can optimize the amount of the fees. Employers who have already submitted their enrollment data to HHS, but need to correct or revise the number of covered lives, can make that update through the pay.gov site. Employers can also use different counting methods for different years.

Reinsurance Contribution Submission Process

The proposed regulations include several changes to the contribution submission process that have generally already been implemented:

- Enrollment counts must be submitted to HHS no later than November 15 of the year for which contributions are due in 2014, 2015, and 2016. Where that date is not a business day, the submission deadline will be the next business day.
- Reinsurance contributions must be remitted by January 15 and November 15 in 2015, 2016, and 2017. Where that date is not a business day, the remittance deadline will be the next business day.
- The reinsurance contribution can be in one payment or two separate payments.
- HHS will notify contributing entities of the contribution amount when the annual enrollment count is entered into pay.gov. There will not be any separate notification or invoice.

Comment. The November 15, 2014 deadline for submitted enrollment counts was previously extended to December 5, 2014. (See our November 17, 2014 *For Your Information*.)

Self-Insured Expatriate Plans

Previous guidance excluded insured expatriate group health plans from the reinsurance contributions. The proposed regulations would also exempt self-insured expatriate coverage from the reinsurance contributions for 2015 and 2016. An expatriate health plan is defined as limiting enrollment to primary insureds who reside outside of their home country for at least six months of the plan year, and any covered dependents. HHS has asked for comments on this proposed change.

Self-Administered, Self-Insured Plans

Self-administered, self-insured plans are exempt from the reinsurance fee for 2015 and 2016 (but not 2014). (See our March 25, 2014 *For Your Information*.) Self-administered plans are those that do not use a third party administrator (TPA) for claims processing or adjudication (including internal appeals) or plan enrollment services. For this purpose, the TPA is an entity that is not under common ownership with the self-insured group health plan

or its sponsor. HHS is proposing that common ownership be defined according to section 414(b) and (c) of the Internal Revenue Code. The guidance notes that this is the same common ownership rules that apply to the employer shared responsibility requirements under the ACA.

Out-of-Pocket Maximums

Effective for plan years beginning on or after January 1, 2014, the ACA imposes annual out-of-pocket (OOP) maximums 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. (See our March 11, 2014 *For Your Information*.)

In 2015, the OOP limits are $6,600 for self-only coverage and $13,200 for other than self-only coverage. HHS has proposed 2016 OOP maximums of $6,850 for self-only coverage and $13,700 for other than self-only coverage. The guidance also proposes to amend 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.

Family OOPs

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. This is a proposed clarification, and not stated expressly in the regulations.

> **Comment.** Employers should review their OOP limits for family coverage 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. That design is no longer allowed, unless the family OOP is no greater than the ACA maximum for the individual OOP.

Marketplace Annual Open Enrollment Period

The annual open enrollment for individual polices both inside and outside the ACA marketplaces for benefit years beginning or after January 1, 2016 will be October 1 through December 15 of the prior calendar year. Coverage will begin on January 1st of the year following open enrollment.

> **Comment.** The open enrollment period for 2016 will be October 1, 2015 through December 15, 2015. The current open enrollment period for the 2015 year is November 15, 2014 through February 15, 2015.

ACA Indexed Dollar Amounts

The table below summarizes the ACA indexed dollars limits for 2016 and prior years

ACA Indexed Dollar Amounts							
	Out-of-pocket Maximums (1,5)					Employer Shared Responsibility Annual Assessments (1,4,6,7)	
	Self-only	Other than Self-only	PCORI Fee (2,5)	Transitional Reinsurance Fee (6)	Health FSA Salary Reduction Cap (3,5)	4980H(a) – Failure to Offer Coverage	4980H(b) – Failure to Offer Affordable, Minimum Value Coverage
2016	$ 6,850	$ 13,700	Not available	$ 27	Not available	Not available	Not available
2015	$ 6,600	$ 13,200	Not available	$ 44	$ 2,550	$2,080 (Est.)	$3,120 (Est.)
2014	$ 6,350	$ 12,700	$ 2.08	$ 63	$ 2,500	$ 2,000	$ 3,000
2013	N/A	N/A	$ 2.00	N/A	$ 2,500	N/A	N/A
2012	N/A	N/A	$ 1.00	N/A	N/A	N/A	N/A

Notes:

(1) Indexed to increase in average per capita premium for US health insurance coverage in prior calendar year. Out-of-pocket maximum does not apply to grandfathered plans or retiree-only plans
(2) Indexed to increases in national health expenditures
(3) Indexed for CPI-U
(4) One-twelfth of annual amount assessed on monthly basis. No assessments for 2014
(5) Applies on a plan year basis
(6) Applies on a calendar year basis
(7) 2015 assessment amounts have not been released. Estimate based on increase in average per capita premium for US health insurance coverage in 2014 as determined by HHS
N/A – Not applicable

In Closing

The proposed clarification regarding the self-only out-of-pocket cost-share maximum requires immediate attention by plan sponsors to confirm that their plans are in compliance. In addition, the proposed guidance provides plan sponsors welcome early notice to begin planning for 2016. As noted, HHS has requested comments on several of the items covered by this guidance.

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