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HHS Finalizes 2016 OOP Maximums and Transitional Reinsurance Contribution Rates

The Department of Health & Human Services has finalized the 2016 out-of-pocket maximums of $6,850 for self-only coverage and $13,700 for other than self-only coverage, including a significant clarification in the treatment of family deductibles and OOP limits. HHS also finalized the 2016 transitional reinsurance rate of $27 per covered life and guidance on the requirement that to satisfy minimum value a plan must include substantial coverage of inpatient hospital services and physician services.

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. Late last year HHS released the proposed rule for 2016. (See our December 3, 2014 *For Your Information*.) HHS published the final rule on February 27, and also released a fact sheet that summarizes the guidance. While this guidance is primarily focused on the ACA marketplaces and insurers, it includes areas that affect large employer and self-insured group health plans, including:

- ACA out-of-pocket maximums
- Transitional reinsurance program fees, counting methods, submission process, and other provisions
- Minimum value and inclusion of substantial coverage of inpatient hospital services and physician services
- 2016 marketplace open enrollment period

ACA Indexed Dollar Amounts

We've included a table summarizing the various ACA indexed dollar amounts by year starting on page 5.

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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 finalized the 2016 OOP maximums of $6,850 for self-only coverage and $13,700 for other than self-only coverage. The final guidance does not include a change in the proposed regulations that would have clarified 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. The regulators noted that after review of comments received, the proposed rule is not being finalized at this time. However, the regulators also stated in the preamble that the annual limitation on cost-sharing applies on an annual basis, i.e., not subject to mid-year change, regardless of whether it is a calendar or non-calendar year plan.

Family OOPs and Deductibles

Importantly, HHS also finalized the clarification of the treatment of other than self-only (family) OOPs that was included in the proposed guidance. Under this guidance, an "embedded" individual OOP is required for family coverage. In other words, the annual OOP maximum under ACA for self-only coverage applies regardless of whether the individual has self-only or family coverage. For example, if a plan has a family OOP of $10,000 and an individual in the family has $20,000 in expenses, that individual can only be responsible for cost-sharing up to the ACA maximum of $6,850 in 2016, even though the overall OOP under the plan for the family is $10,000. This clarification is not expressly stated in the regulations and is effective for plan years starting in 2016.

A Cost-Sharing FAQ was posted by HHS on March 24, 2015 that further clarifies the treatment of deductibles under the OOP requirements. Under the policy, the plan must also apply the annual limitation on cost-sharing for self-only coverage to deductibles for each individual in the plan, even if this amount is below the family deductible. If the family deductible exceeds the maximum self-only OOP limit allowed under ACA, then the individual's cost-sharing must be capped at the ACA OOP limit. For example, if a plan has a $10,000 family deductible, and an individual in the family has $20,000 in expenses, the maximum deductible and OOP that can be applied to that individual is $6,850 in 2016.

> **Comment.** This clarification in the treatment of family OOPs and deductibles under ACA is a significant change that will affect many employer health plans. In informal discussions HHS confirmed that this provision applies to large employer and self-insured plans. Employers should review their deductibles and OOP limits for family coverage to determine if any plan design changes are required.
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> High-deductible plans with health savings accounts (HSAs) often apply a single overall family deductible, and /or family OOP maximum, without an underlying or embedded self-only deductible or OOP maximum. That design is no longer allowed, unless the family deductible and OOP are no greater than the ACA maximum for the self-only OOP (i.e., a family deductible and OOP limit no greater than $6,850 in 2016). If the family deductible in 2016 exceeds the self-only $6,850 OOP limit, then an embedded self-only deductible and OOP is required.

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 rates of $63 for 2014 and $44 for 2015. The regulations now finalize the 2016 rate of $27 per enrollee.

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 final regulations require that insurers use the same counting method for all enrollees in a state for each of the 2015 and 2016 years. However, the regulations do not include a similar requirement for self-insured group health plans because a plan sponsor may have multiple group health plans — insured and self-insured — within a state that are administered by different entities.

> **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.

Reinsurance Contribution Submission Process

The 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 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 by January 15 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.

Self-Insured Expatriate Plans

Previous guidance excluded insured expatriate group health plans from the reinsurance contributions. The final regulations 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.

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 has finalized the proposal that common ownership be defined according to Section 414(b) and (c) of the Internal Revenue Code. The guidance notes that these are the same common ownership rules that apply to the employer shared responsibility requirements under the ACA.

Minimum Value

If an employer offers a health plan that fails to provide a "minimum value" (MV) of at least 60%, or that is unaffordable, its employees who enroll in a marketplace plan may be eligible for low-income subsidies. Under the ACA's "employer shared responsibility" provisions, a large employer who offers coverage to substantially all of its full-time employees could be subject to a $3,000 annual assessment for each full-time employee who receives subsidized marketplace coverage. HHS regulations provide several approaches that employers can use to determine if a health plan provides MV, including the use of an MV Calculator that is available on the HHS website. (See our May 24, 2013 *For Your Information*.)

HHS and the Treasury noted that some group health plans were being offered to employees that provided no coverage of inpatient hospital services, but still satisfied the 60% MV requirement using the MV Calculator. These plan designs had two advantages for employers:

- Employer plan costs for the employer would be minimized because (1) inpatient coverage was excluded, and (2) a substantial percentage of employees would not enroll in the plan.
- If the plan was also affordable, the employer would avoid the $3,000 shared responsibility assessment because employees who were eligible for the employer plan would not be eligible for marketplace subsidies.

Regulators were concerned that these plan designs negatively affected employees by not covering hospital services and denying access to marketplace subsidies. On November 4, 2014, the Treasury, in coordination with HHS, released Notice 2014-69. The notice advised that HHS and Treasury would release regulations "providing that plans that fail to provide substantial coverage of inpatient hospital or physician services do not provide MV." The notice provided transition relief for employers that already enrolled employees in such plans, or adopted such plans before November 4, 2014, as long as the plan year began no later than March 1, 2015. Those employers would not be subject to the employer shared responsibility assessment for that plan year for failing to offer a plan that provides MV. However, employees enrolled in a plan that did not provide substantial coverage of inpatient hospital services or physician services would still be eligible for the premium tax credit. These HHS regulations finalize that approach.

Comment. The HHS regulations do not specify what level of hospital or physician coverage must be provided to be "substantial." The preamble to the regulations states that HHS intends to provide further clarity on the requirement as circumstances warrant. While this provides employers with plan design flexibility, it does leave uncertainty about whether plans satisfy the "substantial" coverage requirement.

Marketplace Annual Open Enrollment Period

The annual open enrollment for individual polices both inside and outside the ACA marketplaces, and for both federal and state-based marketplaces, for 2016 will be November 1, 2015 through January 31, 2016.

Comment. The open enrollment period for 2015 was November 15, 2014 through February 15, 2015. The 2016 open enrollment period starts two weeks earlier, but is the same length as the 2015 year.

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	$2,160 (Est.)	$3,240 (Est.)
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 and 2016 assessment amounts have not been released. Estimates are based on increase in average per capita premium for US health insurance coverage as determined by HHS
N/A – Not applicable

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In Closing

Employers, particularly those offering HSA-compatible, high-deductible health plans, should review the new requirements for family OOP and deductible limits for compliance with these new rules. Any necessary changes will need to be adopted and communicated before the 2016 plan year. Employers who offer plans with limited or no coverage of inpatient hospital services should review those program designs and expand coverage in order to comply with these new requirements.

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