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REFORM Update

Issue Eighty February 2014

February 10, 2014

The Centers for Medicare and Medicaid Services (CMS) recently released proposed rules addressing the premium stabilization programs and certain operational aspects of the Health Insurance Marketplace. The government has requested feedback on a number of provisions.

The regulations discuss procedural changes to the risk adjustment and risk corridor programs addressed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_56.pdf. These affect insurance carriers, and will not have a direct impact on employers.

The new regulations also include a proposed actuarial value (AV) calculator for 2015. This calculator can be found at http://www.cms.gov/site-search/search-results.html?q=av%20calculator. Employers can use the calculator to determine if their plan meets the minimum value level, providing at least 60 percent coverage for essential health benefits.

This *Reform Update* will summarize the proposed guidance relating to:

- The reinsurance program
- Marketplace (or Exchange) operations
- Student health insurance programs
- Maximum out-of-pocket and deductible limits for 2015

Some of these provisions may change in the future based on feedback from key stakeholders.

Reinsurance Program

The three-year reinsurance program launches in 2014. It is intended to help stabilize premiums in the individual Marketplace due to uncertainty about how the requirements of the Affordable Care Act (ACA) will change the insurance market. Both self-funded and insured group health plans will fund the reinsurance program.

The details for the 2014 reinsurance program were reviewed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_56.pdf. The latest guidance publishes the parameters for reinsurance in 2015. The new regulations also propose modifications to the program.

Clarification on the Meaning of Major Medical Coverage

The initial regulations provided a broad description for coverage that would constitute major medical coverage subject to reinsurance contributions. The contributions are meant to apply to comprehensive medical coverage, covering a wide range of medical services and provider settings. The proposed regulations define major medical coverage as “health coverage for a broad range of services and treatments provided in various settings that provides minimum value.”

These regulations advise that it is the government's intent that reinsurance contributions do not need to be made more than once on the same covered life. Certain group health plans have complex arrangements that may result in multiple reinsurance payments for the same individual. CMS intends to provide more clarity on this issue in future regulations. These regulations do state that no reinsurance contributions are required from employer-sponsored group health coverage where:

1. The coverage applies to individuals who are enrolled in individual health insurance coverage for which reinsurance contributions are required of the individual insurance carrier.
2. The coverage is supplemental or secondary to the group health coverage for which reinsurance contributions must be made for the same covered lives.

The second situation would apply in the event of dual coverage. For example, a married couple is offered coverage by each of their employers. They both elect two-person coverage. In this case, the plan that pays on a primary basis would count one covered life. There would be only one reinsurance payment made per covered life.

Comments are being sought on this issue, specifically:

- Which entity should be responsible for the reinsurance contribution?
- How can payment responsibility be determined?
- What arrangements should be required between entities to assure efficient coordination in determining reinsurance payment responsibility?
- What other situations should be addressed to achieve the goal of preventing more than one reinsurance contribution per covered life?

2014 Program Modifications

For 2014, the rules propose a change in the reinsurance parameters, because the Marketplace website did not launch as cleanly as anticipated. The government is concerned that they will not enroll enough young people to help offset the risk and expense of older members in the Marketplace. As a result, the government proposes lowering specific reinsurance plan parameters:

Provision	2014 Original Plan Parameter	2014 Newly Proposed Parameter
Attachment Point	$60,000	$45,000
Coinsurance Rate	80 percent	80 percent
Reinsurance Cap	$250,000	$250,000

If the contributions collected for the reinsurance program exceed the reinsurance benefits requested for the benefit year, then the government will increase the coinsurance percentage so the contributions collected in one year will be used for benefits in that year.

In addition, the government has heard the concern about payment timing. Initially, the regulations required contributing entities to submit annual average member counts by November 15. The Department of Health and Human Services (HHS) would calculate the reinsurance fees owed and bill the entity by December 15. The contributing entity would be required to pay the bill within 30 days of receipt.

The proposed regulations modify the payment timing, but the timing for the notification of covered lives remains the same. The government proposes to split the payment and allow it to be paid in two installments. For 2014, the $63 charge per covered life would be split into two installments.

- The first installment of $52.50 would be due in January 2015
- The second installment of $10.50 would be due during the fourth quarter of 2015

The government is seeking comments on this split payment approach. Specifically, they want feedback on whether a contributing entity should have the option of making the entire contribution with the first installment instead of splitting the payment into two installments.

The regulations also include a clarification on the Form 5500 method for calculating average covered lives. A self-funded group health plan may use the enrollment figures found in the Form 5500 even if the plan year is different from the calendar year. A self-funded plan would use the current year's Form 5500 to calculate average covered lives.

2015 Contributions and Timing

The reinsurance contribution for 2015 will be less than the 2014 amount. The program is targeted to collect $8 billion in 2015.

The total **annual** contribution about will be $44 per average covered life. The payment would again be split into two installments:

- The first installment of $33.00 would be due in January 2016
- The second installment of $11.00 would be due during the fourth quarter of 2016

Contributing Entities

The new proposed regulations modify which organizations in 2015 and 2016 will be considered contributing entities.

In 2014, contributing entities were:

1. Group health insurance carriers
2. Third-party administrators (TPAs) on behalf of self-insured group health plans
3. Self-insured, self-administered health plans

In 2015 and 2016, self-insured, self-administered health plans will be excluded from making reinsurance contributions. The regulations are very clear that these plans must not use a third-party administrator for any of their core administrative functions. These functions include:

- Adjudicating, adjusting and settling claims
- Management or processing of claim appeals
- Processing and communicating enrollment information to plan participants

Few self-funded plans are truly self-administered, so this is a narrow exclusion.

Reinsurance Program in 2015

The parameters for the reinsurance program in 2015 will be as follows:

Provision	2015 Plan Parameter
Attachment Point	$70,000
Coinsurance Rate	50%
Reinsurance Cap	$250,000

The proposed regulations allow HHS to audit contributing entities, which will have 30 days to provide a corrective action plan addressing any issues.

Marketplace (or Exchange) Operations

A number of changes to Marketplace operations were proposed in this round of regulations.

These new regulations reduced the time states must provide to launch a state-run Marketplace. Initially, the law required the blueprint for the Marketplace to be approved 12 months in advance of the coverage effective date of the first individual policies sold. The government has subsequently reduced that timeframe to 6.5 months.

The new regulations also change the open enrollment period for 2015. Open enrollment in the Marketplace is scheduled to run from October 15 to December 7 each year. Any coverage elected during that time would be effective on January 1. For 2015 only, however, the open enrollment period will run from November 15 to January 15. This change is in response to the turbulent launch of the federal Marketplace. By pushing back open enrollment, carriers will be able to get an additional month of claim experience to calculate rates for 2015. For coverage elected on or before December 15, 2014, coverage will be effective on January 1, 2015. Coverage will be effective February 1, 2015 for elections made between December 16, 2014 and January 15, 2015.

Federally-Facilitated Exchanges (FFE) also charge a user fee to insurance carriers sponsoring Qualified Health Plans (QHPs) in the Marketplace. In 2014, the user fee was 3.5 percent of total premium. In 2015, the user fee will remain at 3.5 percent of total premium. The rules also include details on how insurance carriers can offset this fee if they provide contraceptive coverage directly to members of an eligible religious-affiliated organization.

FFEs also require that insurance carriers offering multiple QHPs within a state Marketplace provide a meaningful difference among the products offered. Otherwise, a single insurer offering similar multiple plans will stifle competition. These rules contain the parameters for determining if plan variations constitute meaningful differences.

The initial Marketplace regulations established an annual cost-sharing limit for stand-alone dental plans providing the pediatric dental coverage that is an essential health benefit. This cost-sharing limit is widely misunderstood. It was set at $700 for one child and $1,400 for one or more children in 2014. Given the widespread confusion and comments received, these cost-sharing limits will be set on a national basis and reduced to $300 for one child and $400 for one or more children in 2015. These limits apply solely to

stand-alone pediatric dental policies offered to meet the essential health benefit requirement. Employers are only affected if their insurance carriers need to meet the essential health benefit requirements. Insurance carriers offering individual coverage and small group coverage must offer coverage for essential health benefits. Small group health plans are defined by the states in 2014 and 2015. Small groups can be under either 50 or 100 lives. As of 2016, however, small groups will be less than 100 lives.

Changes to the Small Business Health Options Program (SHOP)

Small group coverage in the Marketplace was required to be member-rated. These new proposed regulations recognize that many carriers issue uniform premiums based on a specific family composition. A carrier can convert a per-member rate into average enrollee premiums. The proposed rule states that if an insurer does offer a composite rate instead of member rating, the insurer cannot vary the composite rates during the plan year, even if the composition/demographics of the group changes. At the annual renewal, the insurer would recalculate the group's composite premium based on plan enrollment at that time. This approach allows premiums and contributions to remain stable throughout the plan year.

The allowance for composite rating will apply to small group plans offered on or off the SHOP. The possibility for composite rating will be permitted for plan years beginning in 2015, but insurance carriers can allow it in 2014.

The only time composite rating would not be available would be if an employer decided in 2015 to offer a metal tier and allowed employees to select any insurance plan offered in that tier. The composite rate is not available in this situation.

The government has requested comments on their approach to composite rating. They would like feedback specifically on whether they should establish a default uniform and tiered composite rating structure. For example, should they require an employee-only tier, an adult dependent tier and a child dependent tier?

These rules make clear that the SHOP is prohibited from performing any individual eligibility determinations for premium tax credits or cost-sharing credits in the Marketplace. The SHOP is limited to collecting the information needed from employers and employees to determine eligibility or to process enrollment for coverage.

The SHOP will be permitted to offer stand-alone dental coverage to employers purchasing coverage through the SHOP. Employers can offer their employees a single stand-alone dental option or a choice of stand-alone dental plans offered in the Marketplace.

The government is also working on standardizing premium payment policies for group coverage purchased through the SHOP. The regulations include a standard methodology for handling partial coverage months. The proposed approach is to pro-rate premiums for the number of covered days in the month.

The regulations also propose allowing an employer to define up to four different contribution levels in the SHOP in 2015. This refers to the employer contribution provided to the employee to purchase coverage in the SHOP:

1. Full-time employee only
2. Full-time employee dependent
3. Non-full-time employee only

4. Non-full-time employee dependent

This approach could affect a small business' eligibility for a premium tax credit. A small business is eligible for the tax credit if it has 25 or fewer employees. The regulations suggest that employers eligible for the tax credit should consult with the IRS about permissible contributions structures.

Privacy and Security of Personally Identifiable Information (PII) in the Exchange

The ACA limits the use of information provided by coverage applicants. Information provided by an applicant may be used, only to the extent necessary, to ensure the efficient operation of the Marketplace. The initial regulations specifically define the circumstances in which the Marketplace may use or disclose personally identifiable information (PII):

- To determine eligibility and enrollment in a Qualified Health Plan
- To determine eligibility for insurance affordability programs
- To determine eligibility for exemptions to the individual mandate penalty

Based on comments received, this list may be too restrictive to ensure the efficient operation of the Marketplace. Therefore, these regulations allow the Secretary of HHS to permit other uses and disclosures of PII.

The Marketplace is required to implement privacy and security measures similar to those required by HIPAA. For example, the Marketplace must have contractual assurances that any non-Marketplace entity with whom they share PII will comply with the same privacy and security measures required of the Marketplace. The original regulations included a definition of non-Marketplace entities that specified "navigators, agents and brokers." These new regulations clarify that this limited list was not intended to be exhaustive. The privacy and security requirements apply to any non-Marketplace entity with which the Marketplace shares PII for operational purposes.

Student Health Insurance Programs

Brief details of how student health insurance programs are impacted by the ACA are included in these regulations. Student health insurance coverage is defined as individual insurance coverage. However, a health insurance carrier is not required to accept individuals who are not students or dependents of students. Since student health insurance is generally offered on a school-year basis, it is not required to offer open enrollment or coverage effective dates that align with the calendar year. All other individual insurance plans are required to offer open enrollment that aligns with annual open enrollment in the Marketplace. These regulations therefore amend the guaranteed availability requirements of the ACA to exclude student health insurance programs.

Maximum Out-of-Pocket and Deductible Limits for 2015

Effective as of the first day of the first plan year beginning on or after January 1, 2014, non-grandfathered group health plans were subject to maximum out-of-pocket limits. These maximum limits are annually indexed. The limits for 2014 are $6,350 for single coverage and $12,700 for family coverage. All member cost-sharing must accumulate toward the out-of-pocket maximum.

The new rules propose that the 2015 maximum out-of-pocket limits be raised to $6,750 for single coverage and $13,500 for family coverage.

Effective as of the first day of the first plan year beginning on or after January 1, 2014, small group non-grandfathered health plans were assessed a deductible limit. In 2014, the deductible limits were $2,000 for single coverage and $4,000 for family coverage.

The new rules propose that the 2015 deductible limits be raised to $2,150 for single coverage and $4,300 for family coverage.

The new rules also discuss modifications that should be made to individual silver plans in the Marketplace. Low-income individuals may qualify not only for premium assistance, but also for assistance with plan cost-sharing. Since premium assistance is based on the silver plan level, carriers must offer variations on silver plan coverage that provide better benefits. The income levels and actuarial value of the plan that should be provided are as follows:

Household Income as Percent of Federal Poverty Limit (FPL)	Actuarial Plan Value
100% - 149%	94%
150% - 199%	87%
200% - 250%	73%

Concluding Thoughts

These are proposed regulations. The government has requested very specific feedback on some of the proposed provisions. Employers are anxious about the process for the reinsurance fees. The process details have not been released, only the proposed timing. The government has designated several options for counting average covered lives. The options are discussed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_56.pdf. The process for submitting average covered lives will likely come this summer. At this point, employers can determine how they will count average covered lives.