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REFORM Update

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The Department of Health and Human Services (DHHS) recently released final regulations addressing premium stabilization programs and certain aspects related to the Health Insurance Marketplace. Proposed regulations were addressed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2014/Reform_Update_80.pdf.

The Centers for Medicare and Medicaid Services (CMS) will be responsible for the reinsurance fee billing and payment process. The final rules did not address the process of reporting headcounts or how payment should be remitted. CMS has indicated that additional details will be released later this year. However, they intend for the process to be managed electronically at www.pay.gov. The contributing entity will be required to register on the site, submit the average number of covered lives and then remit the appropriate fee. Remember, self-funded employers will have to pay this fee on behalf of their plans. The carrier will be responsible for paying the fee for fully-insured plans.

CMS will offer training on the process beginning late in June. Employers impacted can register to receive information on the training at https://www.regtap.info/.

The final regulations adopt most of the changes introduced by the proposed regulations issued last year. A handful of changes apply to the reinsurance program. The following summarizes the key provisions included in the final regulations:

- The term “major medical coverage” was defined. This is health coverage for a broad range of medical services and treatments, providing minimum value, incurred in various settings. The definition of major medical coverage in the final regulations was amended to include catastrophic medical coverage in the individual or small group market, subject to the actuarial value requirements.
- CMS expects to collect the reinsurance payment only once per covered life. If an individual has dual coverage, the primary payer will be expected to submit the reinsurance fee for that covered life. Primary and secondary payment status is determined by each plan sponsor and each plan’s coordination of benefit provisions. A plan sponsor can rely on the other plan sponsor’s representation of primary payment status to exclude an individual with dual coverage in the calculation of covered lives. However, the primary payer must be subject to the reinsurance fee for this exclusion to apply.
- The program modifications for 2014 were adopted. The attachment point will be $45,000, and the coinsurance rate will be 80 percent. The cap on reinsurance benefits is $250,000.
- Reinsurance contributions should be used for claims in the current year. If the funds collected exceed the benefits claimed, CMS will increase the coinsurance level to make sure that funds are used for current year claims. If funds remain after reinsurance claims are paid at 100 percent, the excess will roll into the next benefit year.

- The two-part payment process was adopted. The reinsurance fees for each calendar year will be due as follows:

	First Part	Second Part
2014 Fee	$52.50 per covered life due in January 2015	$10.50 per covered life due in fourth quarter 2015
2015 Fee	$33.00 per covered life due in January 2016	$11.00 per covered life due in fourth quarter 2016
2016 Fee	Estimated to be $26 per covered life; payment split has not been determined	

- Self-funded, self-administered health plans are excluded from paying the reinsurance fee in 2015 and 2016. The new regulations allow a small percentage of all benefits and services to be provided by an unaffiliated service vendor. A small percentage is defined as up to 5%. For example, the plan may use a third party for provider network development and related services.
- Clarification on who is responsible for making the reinsurance contributions for a self-funded health plan was provided. The self-funded plan is the contributing entity, so the plan (i.e., plan sponsor) is obligated to pay the reinsurance fees. The plan may use a third-party administrator for the transfer of the reinsurance contributions.
- The plan parameters for the 2015 benefit year were confirmed. The attachment point will be $70,000, and the coinsurance rate will be 50 percent. The cap on reinsurance benefits is $250,000.

In addition, the final rules also adopt a number of changes to Marketplace operations:

- The time needed to launch a state-based Marketplace was reduced. A state needs to submit a blueprint for Marketplace operations at least 6.5 months prior to the first effective date of Marketplace coverage.
- The open enrollment period for 2015 coverage was changed. Open enrollment will run from November 15, 2014 to February 15, 2015. However, for coverage to be effective on January 1, 2015, it must be elected by December 15, 2014.
- Small group health plans may charge composite rates based upon member rates and family composition. The Affordable Care Act standardized health insurance ratings across all states. The rules require per-member rating based on age, geographic locations and, possibly, tobacco use. For group coverage, insurers can add the per-member rates for all covered individuals and develop a composite rate that is charged to each employee or family under the plan. Insurance carriers have the option to choose between per-member and composite rating. Composite rates are developed based on expected enrollment at the beginning of the plan year. Rates will be updated annually at renewal. The final rules include these clarifications:
    - Two composite rate tiers are allowed, one for individuals aged 21 and older and the other for individuals under age 21. Children under age 21 are capped at three per household.

  - The tobacco rating must still be applied on a per-member basis.
  - Composite rating is prohibited if employee choice is offered in the Small Business Health Options Program (SHOP). Employee choice means the employer offers to cover a metal tier, and the employees can pick any plan available within that metal tier.
  - States may approve more than two rating tiers with the approval of CMS.
- The annual cost-sharing limit for stand-alone pediatric dental coverage was increased. The limit is $350 for one child and $700 for two or more children in 2015. The final regulations also retained the requirement to offer two actuarial value levels for stand-alone dental plans (70% or 85%).
- The proposed privacy and security measures were adopted, and will apply to any non-Marketplace entities that need personally identifiable information for operational purposes. In most cases, Marketplace entities are obligated by the Health Insurance Portability and Accountability Act (HIPAA) to protect personal information.

Finally, the 2015 out-of-pocket maximum limits that apply to non-grandfathered group health plans were confirmed. They are:

- Single coverage - $6,600
- Family coverage - $13,200

These amounts are higher than the maximum out-of-pocket limits that apply to qualifying high deductible health plans (HDHPs). The IRS specifies the annual plan parameters for HDHPs that can be paired with tax-advantaged health savings accounts (HSAs). Employers must be careful to set out-of-pockets limits for HDHPs based on the requirements of the IRS, and not on the out-of-pocket maximums listed above. The HDHP plan parameters for 2015 can be found at http://www.mcgrawwentworth.com/Special_Alert/2014/Special_Alert_Issue_5.pdf.

Concluding Thoughts

The final rules adopted, with minor changes, many of the provisions in the proposed rules released in December 2013.

Employers are anxious for more details regarding how average covered lives will be reported, how the reinsurance fee will be billed, and how it should be paid. Those details are expected soon. To address concerns, CMS will be offering a training program on the reinsurance fee. Sign up at https://www.regtap.info/ to get updates on training sessions.