Guidance for Changes in 2015

Reinsurance Fee, Cost-Sharing Limits, and Other Changes

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The Department of Health and Human Services ("HHS") recently issued proposed regulations addressing a number of provisions under the Affordable Care Act ("ACA"). Some of this guidance will impact employer-sponsored group health plans.

Transitional Reinsurance Fee

The regulations estimate that the transitional reinsurance fee for 2015 will be $44 per covered life. This is a reduction from the $63 per covered life fee that applies for 2014. The transitional reinsurance fee for 2016 has not been announced.

As a reminder, the fee is assessed on all covered lives (e.g., any employee, spouse, domestic partner, children, and COBRA beneficiaries). Contributing entities must pay the reinsurance fee. Contributing entities are:

- A health insurance issuer (carrier) for insured coverage;
- For 2014, a self-insured group health plan whether or not it uses a third party administrator; and
- For 2015 and 2016 benefit years, a self-insured group health plan that uses a third party administrator in connection with claims processing, adjudication (including management of appeals), or plan enrollment. This is a notable change from the 2014 requirements, as self-insured, self-administered major medical plans will be exempt from the transitional reinsurance fee for 2015 and 2016 (but not 2014). Most employer-sponsored self-insured health plans are administered by a third party and will not qualify for this relief.

A self-insured group health plan that is a contributing entity is responsible for the reinsurance contributions, although it may elect to use a third party administrator for transfer of the reinsurance contributions.

In addition, the proposed rule modifies the previously announced payment scheme. Now, contributing entities must pay the fee in two installments. This is a departure from the previously announced payment model in which a single lump-sum payment was due. However, HHS is considering whether to allow a single lump-sum payment option.

For now, the two-payment installment means:

- For the 2014 benefit year ($63 per covered life fee), entities will pay $52.50 per covered life within 30 days after the date of first notification by HHS (expected in the fourth quarter 2014) and the remaining $10.50 per covered life will be invoiced by the fourth quarter of 2015 and payable in late fourth quarter 2015.

- For the 2015 benefit year ($44 per covered life proposed fee), entities will pay $33 per covered life within 30 days after the date of first notification by HHS (expected in the fourth quarter of 2015) and the remaining $11 per covered life fee will be invoiced by the fourth quarter of 2016 and payable late in the fourth quarter of 2016.

Further, the new regulations clarified that the transitional reinsurance fee applies to "major medical coverage," which is newly defined for these purposes as health coverage for services and treatments provided in various settings that provides a minimum value, using the same criteria applicable to the employer penalty. So, to the extent that the plan's share of the total allowed cost of benefits is at least 60%, which is calculated on a broad set of services using an HHS-issued minimum value calculator, a yet to be issued design-based safe harbor checklist, or actuarial certification, the transitional reinsurance fee will apply for that plan.

The proposed rule clarifies that no reinsurance contributions will be required in the case of employer-provided group health plan coverage where such coverage:

- applies to individuals who are also enrolled in individual market health insurance for which reinsurance contributions are required; or

- is supplemental or secondary to group health coverage for which reinsurance contributions must be made for the same covered lives.

Finally, the guidance makes clear that reinsurance contributions are not owed by the carrier or self-insured plan on individuals with primary residence in a territory that does not operate a reinsurance program.

Maximum Annual Limitation on Cost-Sharing

All non-grandfathered group health plans must comply with annual cost-sharing limitations on out-of-pocket maximums. The dollar amounts are adjusted annually. For 2015, the maximum annual limitation on cost-sharing will be $6,750 for self-only coverage and $13,500 for family coverage (coverage other than self-only).

Maximum Annual Limitation on Deductibles – Small Group

Non-grandfathered insured small group health plans are subject to certain deductible limits that are adjusted annually. A "small" employer is an employer that employed an average of not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. For plan years beginning before January 1, 2016, a state may elect to substitute "50" for "100." All states currently define the small group health insurance market as employers with 2-50 employees, with the exception of WA, CO, HI, MS, FL, NC, DE, CT, RI, MA, NH, ME, and VT that use the definition of employers with 1-50 employees. This may change prior to January 1, 2016.

For 2015, the annual deductible in the small group market may not exceed $2,150 for self-only coverage and $4,300 for family coverage (coverage other than self-only).

Composite Rating – Small Group

HHS restated that nothing prevents an issuer from converting per-member rates into average enrollee premium amounts (calculated composite premiums), provided that the total group premium is the same total amount calculated using the permitted rating factors per member. Insurance carriers are subject to new underwriting rules with respect to small, insured groups. Rating variations are restricted to (a) benefit coverage elected (plan and tier), (b) geographic area, (c) age (limited to a ratio of 3 to 1 for adults), and (d) tobacco use (limited to a ratio of 1.5 to 1).

Composite premiums are average rates for a particular group of participants. Therefore, any change in employee census would result in a change in the average rate. To address the mid-year composite premium fluctuations, HHS proposed a new policy for plan years beginning on or after January 1, 2015. The policy requires issuers that offer a composite premium for small groups to ensure that the amount does not vary for any plan participant during the plan year. The issuer is required to accept the group's composite premium, calculated at the beginning of the plan year, for any new participant who enrolls during the plan year. Issuers are encouraged to adopt this policy for plan years beginning in 2014.

HHS is considering a uniform tiered-composite rating structure for the small group market for future years.

Risk Adjustment Fee – Small Groups

Beginning January 1, 2014, there is a new permanent fee imposed on health insurance carriers with respect to small, insured, non-grandfathered plans. For calendar year 2014, HHS established a per capita annual user fee rate of $0.96, which will apply as a risk adjusted user fee of $0.08 per enrollee per month. HHS proposed for calendar year 2015 an increased per capita fee rate of $1.00 risk adjusted user fee per enrollee per year.

Exchange Marketplace Open Enrollment

HHS proposes changing the annual open enrollment period for the 2015 benefit year to begin on November 15, 2014 and extend through January 15, 2015.