2016 Cost-Sharing Limits, Reinsurance Fee, and Other Changes Related to the Exchange

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On February 27, 2015, the Department of Health and Human Services ("HHS") changed cost-sharing and transitional reinsurance program fee limits and released standards for health insurers and the Exchange (a.k.a. the Health Insurance Marketplace). This article identifies a few items of note for employers.

2016 Cost-sharing Limits

For 2016, the maximum annual out-of-pocket limits for non-grandfathered plans are $6,850 for individual coverage and $13,700 for family coverage. These limits generally apply with respect to any essential health benefits ("EHBs") offered under the group health plan. The final regulations established that starting with the 2016 plan year, the self-only annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Transitional Reinsurance Program

The reinsurance fee for 2016 is $27 per covered individual. 2016 is the final year for the transitional reinsurance program. Generally, enrollment counts for the reinsurance fee are due by November 15 of the benefit year. Payment is due by January 15 of the following year (and November 15 of the following year if paying in two installments). The regulations make clear that when these dates fall on a Saturday, Sunday, or holiday, submission of this information and/or payment is due by the next business day.

For 2015:

- Enrollment counts are due by November 16, 2015.
- The fee of $44/per covered life:
  - if making a single payment, is due by January 15, 2016; or
  - if paying in two installments, the first payment of $33/covered life is due by January 15, 2016 and the second payment of $11/covered life is due by November 15, 2016.

For 2016:

- Enrollment counts are due by November 15, 2016.
- The fee of $27/covered life:
  - if making a single payment, is due by January 16, 2017; or

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- if paying in two installments, the first payment of $21.60 per covered life is due by January 16, 2017 and the second and final payment of $5.40 per covered life is due by November 15, 2017.

The regulations clarify the application of the snapshot count and snapshot factor counting methods to a plan that is established or terminated, or that changes funding mechanisms, in the middle of a quarter. Specifically, if the plan had enrollees on any day during a quarter and if the contributing entity uses either the snapshot count or snapshot factor method, it must choose a set of counting dates for the counting period such that the plan has enrollees on each of the dates, if possible. The enrollment count for a date during a quarter in which the plan was in existence for only part of the quarter can be reduced by a factor reflecting the amount of time during the quarter for which the plan or coverage was not in existence.

Consistent with the proposed regulations, the final regulation provides that self-funded expatriate plans are not required to pay the reinsurance fee for 2015 and 2016 benefit years. Insured expatriate plans do not make reinsurance contributions. Self-insured plans that do not use a TPA do not make reinsurance contributions in the 2015 and 2016 benefit years. The final regulations clarify that a TPA is an entity that is not under common ownership with the self-insured group health plan or its sponsor that provides administrative functions in connection with the core administrative services. Common ownership should be determined under Code Sec. 414(b) and (c).

Open Enrollment Period for the Exchange

For benefit year January 1, 2016, the annual enrollment period for the Exchange begins November 1, 2015 and extends through January 31, 2016. For the benefit year beginning on January 1, 2016, the Exchange must ensure coverage is effective:

- January 1, 2016 for plan selections received by the Exchange on or before December 15, 2015;

- February 1, 2015 for plan selections received by the Exchange from December 16, 2015 through January 15, 2016; and

- March 1, 2016 for plan selections received by the Exchange from January 16, 2016 through January 31, 2016.

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Small Business Health Options Program (SHOP)

In an effort to streamline the administration of the SHOP, the regulations allow the SHOP to assist employers in the management of COBRA continuation of coverage. The regulations provide that the SHOP is permitted to collect COBRA premium from any person enrolled in COBRA coverage through the SHOP consistent with applicable and the terms of the group health plan. The regulations also align the SHOP rules with the COBRA rules, including COBRA eligibility for dependents and former dependents. Note that SHOP does not have capabilities to manage the entire COBRA process (e.g., send out the notices).

Minimum Value Plans

In November 2014, in Notice 2014-69, HHS, the Treasury, and the Internal Revenue Service (collectively, the "Departments") announced their intent to issue regulations clarifying that a group health plan will not provide minimum value (MV) if it excludes substantial coverage for in-patient hospitalization services or physician services (or both) (referred to as a "Narrow MV Plan"). There is a very narrow exception to this general rule if, and only if, an employer with a plan year that begins on or before March 1, 2015 has entered into a binding written commitment to adopt or has begun enrolling employees in a Narrow MV Plan prior to November 4, 2014, in which case it will not be subject to the Employer Penalty for the 2015 plan year.

Consistent with Notice 2014-69 and proposed regulations, these regulations finalized the requirement that an employer-sponsored plan must provide substantial inpatient hospital services and physician services, as well as meet the quantitative standard of the actuarial value of benefits plan (cover 60% of the total allowed costs) in order to provide MV.

Pediatric Age

The regulations provide that pediatric benefits must be provided at least until the end of the month in which the enrollee turns 19.

Habilitative Services

Habilitative services and rehabilitative services are part of the EHB package. The final regulations adopt a uniform definition of habilitative services to clarify the difference between habilitative and rehabilitative services. Habilitative services are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Rehabilitative services, are provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost due to illness, injury or disabling condition.

The final regulations adopt the definition of habilitative services from the Uniform Glossary of Health Coverage and Medical terms, effective for plan years beginning in 2016, and require carriers to have separate visit limits on habilitative services and rehabilitative services for plan years beginning in 2017.

Medical Loss Ratio

The final rule clarifies that that federal and state employment taxes should not be excluded from premium in the MLR and rebate calculations. It also provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

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