SEYFARTH SHAW

Health Care Reform Management Alert Series

Important Changes to Minimum Value and Out-of-Pocket Maximum Rules Embedded in Marketplace Guidance

Issue 90

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This is the ninetieth issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series). This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

Earlier this year, the Department of Health and Human Services (HHS) issued its Notice of Benefit and Payment Parameters for 2016 (the "Final Rule"). The Final Rule addresses a variety of provisions under the Affordable Care Act (ACA) for 2016 that impact both the group and individual markets, as well as certain provisions that impact self-funded plans. This alert only highlights those changes impacting employer group health plans (and, except where otherwise noted, these changes would only impact the "small group" fully-insured market, which generally includes 50 or fewer covered lives). While HHS clarified a few items from the proposed rule it issued late in 2014 – namely the open enrollment period, minimum value, and medical loss ratio – many of the provision requirements remain the same. Here are the highlights of the Final Rule:

Eligibility, Enrollment, and Benefits

Revised Essential Health Benefits Benchmark Selection

The Final Rule clarifies that States may select new benchmark plans for 2017, based on plans available in 2014. Small group plans must cover all benefits included in its state benchmark. Large group fully-insured and self-funded plans can, to a certain extent, control the definition of "essential health benefits" through choosing among any available benchmark plan. This does not mean that the plan must cover all benchmark benefits, but the benchmark is used to determine what constitutes an "essential health benefit". So, to the extent a plan does cover one of the benefits included in the benchmark option, it may not impose annual or lifetime dollar limits on that benefit. For more on benchmark plans, see *Issue 36* in our series.

Strengthening the MLR Program
Consistent with the practice of the majority of issuers, the Final Rule clarifies that Federal and State employment taxes should not be excluded from premium in the medical loss ratio (MLR) and rebate calculations. The Final Rule 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, in the same manner as subscribers of group health plans subject to ERISA.

Payment Parameters

2016 Cost Sharing Limits
The 2016 maximum annual out-of-pocket limits are confirmed at $6,850 for self-only coverage and $13,700 for other than self-only coverage (*e.g.*, family coverage, self plus one, etc.). The Final Rule also clarifies that the out-of-pocket limit for individual coverage applies to all enrollees, even if they are enrolled in family coverage. For example, if the plan has an individual out-of-pocket maximum of $5,000 and a family out-of-pocket maximum of $10,000, then if any family member's out-of-pocket maximum reaches $5,000, services for that particular family member will be covered at 100% coinsurance. Notably, it would appear that this clarification will likely extend to self-funded and large-group fully-insured plans as well, so all plan sponsors should revisit their plan design to ensure the out-of-pocket maximums are in compliance (subject to future clarification prior to the effective date of this provision).

Minimum Value Standards
The Final Rule establishes new standards by which employer-sponsored plans meet the minimum value requirement. Under the Final Rule, in order to provide "minimum value", an employer-sponsored plan not only must meet the quantitative standard of the actuarial value of benefits (*i.e.*, provide 60% actuarial value), but also must provide a benefit package that meets a *minimum standard of benefits*. The Final Rule provides that an employer-sponsored plan must provide "substantial" coverage of both inpatient hospital services and physician services in order to meet the new "minimum standard of benefits" rule. Separate further guidance is expected to provide more clarification around the definition of "substantial."

These changes to the minimum value rules under the Final Rule will generally apply to employer-sponsored plans, including plans that are in the middle of a plan year, immediately on the effective date of the final regulations, February 27, 2015. However, there is relief for an employer that adopted a nonconforming plan before November 4, 2014. For employers that entered into a binding written commitment to adopt, or began enrolling employees into a nonconforming plan prior to November 4, 2014, the new rules will not apply until the end of the plan year (as in effect under the terms of the plan on November 3, 2014), so long as that plan year begins no later than March 1, 2015.

The Final Rule notes that the Department of the Treasury and the IRS are expected to publish proposed regulations making clear that the delayed applicability date applies solely for purposes section 4980H of the Code (*i.e.*, the employer mandate). The Final Rule further notes that at no time will any employee be required to treat a plan that fails to provide substantial coverage of inpatient hospital services or physician services as providing minimum value for purposes of eligibility for the premium tax credit under section 36B of the Code.

Reinsurance Contributions

Defining Common Ownership or Control: Prior rules clarified that there is no Transitional Reinsurance Program contribution for self-insured plans that do not use a "third-party administrator (TPA). But, it was still unclear whether an employer that was affiliated with a health plan administrator that used the services of its affiliate for administrative services could take advantage of this exception (*i.e.*, it was unclear whether the affiliate would be considered a "TPA"). Under the Final Rule, a TPA is considered to be an entity that is not under common ownership with the self-insured group health plan

or its sponsor that provides administrative services to the plan. The Final Rule clarifies that common ownership should be determined according to the controlled group rules under Section 414(b) and (c) of the Internal Revenue Code.

Self-insured Expatriate Plans: Insured expatriate plans do not make reinsurance contributions. The Final Rule provides that self-insured expatriate plans are also not required to make reinsurance contributions for the 2015 and 2016 benefit years. The Final Rule notes that HHS, in conjunction with the Departments of Labor and Treasury, will undertake future rulemaking consistent with new federal legislation on expatriate plans. HHS indicates that it does not anticipate that the future rulemaking will affect the availability of the exemption for the expatriate plans in the Final Rule.

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