* * * IMPORTANT BULLETIN * * *

TO: All Group Health Clients
FROM: Greenberg & Associates Insurance, LLC
DATE: April 27, 2015
RE: **FINAL 2016 NOTICE OF BENEFIT AND PAYMENT PARAMETERS**

The Department of Health and Human Services (HHS) recently issued final regulations on the 2016 Notice of Benefit and Payment Parameters. The regulations address a variety of Patient Protection and Affordable Care Act (PPACA) benefit provisions for 2016 affecting both the group and individual markets. While HHS clarified a few items from the proposed rule – namely the open enrollment period, minimum value, and medical loss ratio – many of the provision requirements remain the same. Here is an overview.

2016 Cost Sharing Limits

The 2016 maximum annual out-of-pocket limits are confirmed at $6,850 for individual coverage and $13,700 for family coverage. Additionally, 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.

Minimum Value Standards

The final rule establishes new standards by which employer-sponsored plans meet the minimum value requirement. HHS now requires employer plans to provide "substantial" coverage of inpatient and physician services. This will apply to employer-sponsored plans on the effective date of the final notice, and these plans will not meet minimum value unless they provide this specific coverage. Separate further guidance is expected to provide more clarification around the definition of "substantial."

Rate Reviews

Premium rate increases in the individual and small group markets of 10 percent or more (or above a threshold specified by a state) triggered at the "plan-level" will be reviewed by state regulators or HHS to determine whether they are reasonable. This is a change from the previous requirement that was triggered at a "product level."

Issuers seeking the increase are required to publicly disclose the proposed increases and the justification for them. Beginning with rates filed in 2016 for coverage effective on or after January 1, 2017, rate increases will be subject to review by HHS.

Reinsurance Fee

The final rule confirms that the 2016 Reinsurance Fee is $27 per person. In addition, self-funded group health plans that do not use a third-party administrator will be exempt from making reinsurance contributions in the 2015 and 2016 benefit years.

The final rule also confirms that self-insured expatriate plans are also not required to make reinsurance contributions for the 2015 and 2016 benefit years.

Medical Loss Ratio (MLR) Program

The final rule clarifies that Federal and State employment taxes should be included in premium for the MLR and rebate calculations. In addition, subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates, or a rebate distribution, within three months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do. This provision is effective January 1, 2016 for the 2016 MLR reporting year, which must be submitted in 2017.

Resources

There are many other details confirmed in this final rule. A fact sheet on the final rule is available here.

Sincerely,

Sharon Greenberg & Adrienne Hutchins