Final Benefit and Payment Parameters for 2016 Issued by CMS

On February 20, 2016, the Centers for Medicare & Medicaid Services (CMS) released the HHS Notice of Benefit and Payment Parameters for 2016 Final Rule (BPP). The BPP is very lengthy and covers a wide range of topics. Although most of the topics affect insurance carriers, some will have a significant impact on sponsors of self-funded group health plans. Key provisions in the BPP for self-funded employers include:

- Transitional Reinsurance Program Fee

  The Affordable Care Act (ACA) requires fully insured and most self-funded plans providing major medical coverage to pay a fee to the U. S. Department of Health & Human Services (HHS) for the Transitional Reinsurance Program (TRP). ñMajor medical coverageòis defined as health coverage for a broad range of services and treatments provided in various settings that provide minimum value as defined under the ACA.

  The TRP fee must be paid for 2014, 2015 and 2016. It helps fund a reinsurance pool for insurance carriers that incur high claims costs for high risk populations that purchase coverage through the Health Insurance Marketplace.

  The fee, as listed below, is assessed for each covered life (employees and dependents) covered under the plan. Enrollment counts are based on the first nine months of the calendar year. The counts must be submitted and payment(s) scheduled through www.pay.gov no later than November 15, 2014, 2015 or 2016, as applicable.

2014	$63
2015	$44
2016	$27

  The fee may be paid as follows:

  1. In one payment by January 15, 2015, 2016 or 2017, as applicable; or
  2. In two separate payments with the first due by January 15, 2015, 2016 or 2017, as applicable, ($52.50 per covered life for 2014, $33.00 per covered life for 2015 and $21.60 per covered life for 2016) and the second due by November 15, 2015, 2016 or 2017, as applicable, ($10.50 per covered life for 2014, $11.00 per covered life for 2015 and $5.40 per covered life for 2016).

  If the due date is not a business day, the deadline is the next business day.

  Self-funded group health plans that do not use a third party administrator (TPA) do not pay the TRP fee in 2015 and 2016. CMS considers a TPA to be an entity that is not under ñcommon ownershipò with the plan or its sponsor that provides core administrative functions (such as claims processing or plan enrollment). For purposes of the TRP, the BPP stipulates that common ownership should be determined in accordance with section 414(b) and (c) of the Internal Revenue Code.

  For 2015 and 2016, the BBP indicates that self-funded expatriate health coverage is exempt from the TRP fee. For TRP purposes only, CMS defines self-funded expatriate health coverage as any self-funded group health plan for which enrollment is limited to participants, and any covered dependents, who reside outside of their home country for at least six months of the plan year.

  The BPP also clarifies how certain counting methods are to be used when a plan terminates or is established in the middle of a quarter.

- Essential Health Benefits Package

  Non-grandfathered, insured health plans offered in the individual and small group markets must provide a package of health care services known as ñessential health benefitsò (EHBs). The ACA requires the following categories of EHBs to be included:

  1. Ambulatory patient services
  2. Emergency services
  3. Hospitalization
  4. Mental health and substance abuse disorders/behavioral health treatment
  5. Maternity and newborn care
  6. Prescription drugs
  7. Rehabilitative and habilitative services/devices
  8. Laboratory services
  9. Preventive and wellness services, and chronic disease management
  10. Pediatric services, including oral and vision care

  To minimize the variability in benefits and lack of coverage for habilitative services versus rehabilitative services, CMS establishes a uniform definition of habilitative services in the BPP. Habilitative services, including devices, are provided to a person to attain, maintain or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or a disabling condition.

  The BPP also requires pediatric services to continue until at least the end of the month in which the enrollee turns 19 years of age.

  Self-funded group health plans are not required to cover EHBs. However, if a self-funded group health plan elects to cover habilitative or pediatric services, it is likely that the plan will be subject to the habilitative services definition and minimum age limit for pediatric services.

- Cost-Sharing Requirements

  Beginning in 2014, the ACA places an annual limit on cost-sharing for EHBs for non-grandfathered insured and self-funded group health plans. The limits are indexed annually. The 2014, 2015 and 2016 limits are as follows:

2014	$6,350/individual $12,700/family
2015	$6,600/individual $13,200/family
2016	$6,850/individual $13,700/family

  The BPP provides some important clarifications about the cost-sharing requirements:

  1. The out-of-pocket maximum includes deductibles, coinsurance, copayments or similar charges, and any other expenditure required of an individual that is a qualified medical expense for EHB covered under the plan. It does not include premiums, balance billing amounts for non-network providers or spending for non-covered services.
  2. Plans may, but are not required to count the cost-sharing for out-of-network services towards the annual limit.

3. At this time, employers may determine the timeframe for setting the annual limit for cost-sharing (i.e., calendar year or plan year), but cannot reset the annual limit more frequently than once a year.
4. For all plans, including qualified high deductible plans offered in conjunction with a health savings account, the annual cost-sharing limit for individual coverage must be *embedded* (i.e., apply to all individuals, including each individual under family coverage).

- Minimum Value

  Beginning in 2015, certain large employers may be subject to penalties for not offering group health coverage that provides minimum value (MV). In general, a plan provides MV if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of the costs.

  Consistent with a notice previously issued by the Internal Revenue Service, the BPP reiterates that no large employer group health plan will satisfy MV standards without providing *substantial coverage for inpatient hospital and physician services*. The BPP does not define "substantial coverage," but indicates that CMS intends to provide further clarity on the requirements as circumstances warrant. These MV standards apply to group health plans, including those that are in the middle of a plan year, on April 28, 2015.

  There is a phase in for when large employers sponsoring plans without substantial coverage of inpatient hospital and physician services may be penalized for not providing MV:

  1. Pre-November 4 Plans – If the employer entered into a binding, written commitment prior to November 4, 2014 to adopt the plan, or began enrolling employees into the plan prior to November 4, and the plan year begins no later than March 1, 2015, the plan will be considered to provide MV through the end of the plan year, if it otherwise pays at least 60% of the total allowed costs of benefits.
  2. November 4 or After Plans – These plans will cease providing MV on April 28, 2015.

The 476-page BPP may be viewed at http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf. Significa is currently reviewing the BPP more closely and will provide updates as necessary. In the meantime, please feel free to contact us with any questions about the BPP or services we provide to assist with ACA compliance.