December 4, 2012

Guidance Issued on Exchanges, Medical Loss Ratio and Additional Medicare Taxes; Update on 11-20-2012 Guidance

On November 30, 2012, several Federal agencies released Proposed Rules on Patient Protection and Affordable Care Act (PPACA) provisions.

This alert provides highlights of these regulations as well as additional details about the regulations that were issued on November 20.

NOVEMBER 30, 2012 GUIDANCE

Notice of Benefit and Payment Parameters for 2014

Issued by HHS and the Centers for Medicare & Medicaid Services (CMS) on November 30. Comments are due 30 days from date of publication in the Federal Register, which is pending as of this writing.

The proposed rule provides additional details related to these topics. Brief summaries of each are provided below.

1.a. The medical loss ratio (MLR) program

1.b. Implementation of the federally facilitated Small Business Health Options Program (SHOP) Exchange

1.c. Exchange website disclosure/agents and brokers

1.d. User fees for insurers offering policies on the federally facilitated Exchange

1.e. The risk adjustment, reinsurance and risk-corridors programs ("3Rs")

1.f. Cost-sharing reductions for low-income families purchasing coverage on the Exchange

1.g. Administration of advanced payments of the premium tax credit

1.h. Broker compensation in the federally facilitated Exchange

Summaries

1.a. Change to MLR Timing Effective for 2014 Plan Years (applies to rebates paid in 2015)

- Deadline for insurers to file their MLR report will move from June 1 to July 31.
- Deadline for paying MLR rebates will move from August 1 to September 30.

- Adjusted calculation rules to incorporate payments/receipts related to the 3Rs.

1.b. Implementation of the federally facilitated Small Business Health Options Program (SHOP) Exchange

The proposed rule includes details about employer choice, participation rates and contribution rates.

- **"Employer choice" model** is only permitted when the employer makes all QHPs available at the level of coverage selected by the employer.
- **Minimum participation rate** must be 70%.
- **Contribution rate:** employers must use the specific method outlined in the proposed rule to determine contributions toward employee and dependent coverage.

1.c. Exchange Website Disclosure/Agents and Brokers

Agents or brokers who want to assist individuals or employers in enrolling in coverage through the federally facilitated Exchange or the SHOP Exchange for small businesses **must** complete registration and training before being listed on the Exchange website. State Exchanges **may choose** to limit whether they disclose information about licensed agents and brokers based on whether brokers/agents have completed any required Exchange or SHOP registration or training.

1.d. Federal Exchange User Fee

A Federally Facilitated Exchange (FFE) will operate in states that have chosen not to build their own Exchange. To help cover the administrative costs of the federal Exchange, HHS has proposed a user fee of 3.5% of Exchange-based monthly premiums for health insurers who want to offer policies on the federal Exchange.

1.e. Risk Adjustment, Reinsurance and Risk-Corridors Programs ("3Rs")

These regulations describe the programs designed to mitigate adverse selection and help stabilize premiums in the individual and small group markets by providing payments to insurers with higher risk populations and assessments on insurers with lower-risk populations.

The regulations change the reinsurance assessment on insured and self-insured health plans from quarterly to annual and exempt the following types of plans:

- Plans consisting solely of excepted benefits as defined in PHSA section 2791(c) (e.g., standalone dental and vision benefits, hospital indemnity and specified disease plans)
- Private Medicare, Medicaid, CHIP, state and federal high-risk pools and basic health plans
- Health Reimbursement Accounts (HRAs) integrated with a group health plan
- Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs)
- Employee assistance programs, disease management programs and wellness programs
- Stop-loss and indemnity reinsurance policies

- Military health benefits
- Indian Health Service coverage

1.f. Cost-Sharing Reductions for Low-Income Families Purchasing Coverage on the Exchange

Cost-sharing reductions will be available to low and moderate-income individuals enrolled in certain subsidized plans on the individual Exchange. These cost-sharing reductions must be provided at the point-of-service.

1.g. Administration of Advanced Payments of the Premium Tax Credit

The proposed rule would require HHS to make advance payments of the premium tax credit to issuers on behalf of certain individuals. The proposed rule also outlines health insurance issuer responsibilities with respect to these advance payments.

1.h. Broker Compensation in a Federally Facilitated Exchange

A health plan must pay the same broker compensation for individual and small group plans offered through the federally facilitated Exchange as it pays for similar health plans offered in the state outside of the Exchange.

2. Establishment of the Multi-State Plan Program for the Exchange

Issued by the U.S. Office of Personnel Management on November 30. Comments are due 30 days from date of publication in the Federal Register, which is pending as of this writing.

This proposed rule defines the requirements for insurers that want to offer policies through the Exchanges in all states. It outlines the plans and benefits that must be offered as well as network adequacy requirements.

3. Additional Medicare Payroll Tax

Issued by the IRS on November 30. Comments are due 90 days from date of publication in the Federal Register, which is pending as of this writing.

Effective January 1, 2013, individuals with annual earnings of more than $200,000 and couples filing jointly with earnings of more than $250,000 will pay an additional Medicare payroll tax of .9% on earnings above these amounts.

Employers will need to begin withholding the additional Medicare tax once an employee's 2013 earnings reach $200,000. If an employer deducts less than the required amount, the employer is liable until the employee pays the tax. Even after an employee pays the tax, the employer remains responsible for any penalties or additional taxes resulting from the failure to withhold as required.

The additional Medicare tax also applies to income from self-employment. Individuals are responsible for reporting and paying this tax even if their employer fails to withhold it (for example if a couple earns a total of more than $250,000 but neither of them earns $200,000 individually).

There is no additional Medicare payroll tax for employers.

NOVEMBER 20, 2012 GUIDANCE UPDATE

On November 20, just before Thanksgiving, we issued a News Alert summarizing the guidance issued that day. We let you know that we were assessing the guidance and would get back to you with additional information as we completed our analyses.

The following provides additional information of particular interest to clients and brokers:

4. Health Insurance Market Rules and Rate Review

We have further clarified the impacts and timing:

- **Guaranteed Availability of Coverage and Guaranteed Renewability of Coverage** apply to non-grandfathered individual and non-grandfathered group health plans the first plan/policy year beginning on or after 1/1/14.
- **Fair Health Insurance Premiums, Single Risk Pool and Rate Increase Disclosure and Review** apply to non-grandfathered individual and small group plans the first plan/policy year beginning on or after 1/1/14.
- **Fair Health Insurance Premiums** are effective 1/1/17 for the large group market, if coverage is available through an Exchange.
- **Enrollment in Catastrophic Plans** applies to the individual market, effective 1/1/14.

Additional information about Guaranteed Availability of Coverage:

- Issuers offering **non-grandfathered plans** are required to accept every individual or employer who applies for coverage.
- Issuers must offer **all products that are approved for sale**. This includes non-grandfathered closed blocks of business.
- **Guarantee Issue Limitations** – There are exceptions to the guarantee issue requirement that allow enrollment to be limited to: (a) open and special enrollment periods; (b) individuals or employees who live or work in the service area; (c) certain situations involving network and financial capacity; (d) small employers who satisfy the same contribution and participation requirements at issuance that the issuer is permitted to consider at renewal.
- **Open Enrollment**
    - **Group market:** year round
    - **Individual:** periods consistent with those required by Exchanges for individual Qualified Health Plans (QHPs)
- **New Special Enrollment Period** – There is a new 30 calendar day special enrollment period in both the individual and group markets in connection with the events that would trigger eligibility for COBRA coverage.

This is in addition to existing special enrollment events for loss of eligibility for other coverage or dependent special enrollment.

- **New Marketing Standard** – Prohibits marketing practices and plan benefit designs that discourage enrollment of individuals with significant health needs.

5. Essential Health Benefits, Actuarial Value and Accreditation

Further information about impacts:

Coverage offered by insurers and group health plans must meet a minimum value (MV) of 60%. **Note:** As of this writing, the MV calculator has not yet been released by the government.

The Actuarial Value (AV) calculator to be used for Qualified Health Plans (QHP) and individual and small group markets is now available to the public on the CCIIO website.

In addition, the proposed rule offered the following changes:

- States can select or change their previously selected benchmark plan until the end of the Essential Health Benefits proposed rule comment period on 12/26/12.
- "Pediatric services" is defined as services for individuals under the age of 19, but states can extend that definition beyond age 19.
- If the benchmark plan does not provide coverage for pediatric oral and vision services, the benchmark will cover services from either the FEDVIP dental or vision plan with the largest enrollment, or the state CHIP plan.
- PPACA rules limiting out-of-pocket amounts apply to QHPs and to the individual and small group market only. Limits on deductibles apply to the small group market only.
- For Habilitative Services, if the benchmark plan does not include coverage of habilitative services, the state may determine which services are included in that category.
- For Prescription Drugs, plans subject to the EHB requirements must cover the greater of (1) one drug in every United States Pharmacopeia (USP) category and class, or (2) the same number of prescription drugs in each category and class as the benchmark plan.
- NCQA and URAC were recognized as accrediting entities for QHP certification.

6. Wellness Programs in Group Health Plans

Additional information about the Wellness Programs proposed rule:

- Wellness programs are allowed for individual plans, but insurers in the individual market will not have specific guidance on the parameters for an acceptable wellness program.
- Pilot state programs for the individual market are proposed in the law and the rules.

- If a wellness program's incentives affect eligibility, coverage or premium contribution levels, it will need further analysis to determine compliance with this proposed rule.

We encourage you to bookmark our health care reform website, InformedOnReform.com.