UBA PPACAAdvisor

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**The following is a summary of proposed regulations.
Some or all of the provisions may change when final rules are issued.**

HHS ISSUES PROPOSED RULES ON 'BENEFIT AND PAYMENT PARAMETERS,' MULTI-STATE PLAN PROGRAM

On Dec. 5 and 7, 2012, the Department of Health and Human Services (HHS) issued two more sets of proposed rules that provide added details on how the Patient Protection and Affordable Care Act (PPACA) will probably unfold.

The "Benefit and Payment Parameters" proposed rule addresses a number of topics. Of particular interest to employers are proposed rules regarding:

- The temporary reinsurance and risk adjustment programs
- Small-business health options program (SHOP) exchanges
- A timing change for medical loss ratio (MLR) beginning in 2014
- A user fee for those using federally facilitated exchanges

The public comment period for this proposed rule ends Dec. 31, 2012.

Temporary Reinsurance Program

The Temporary Reinsurance Program (TRP) is intended to provide funding to cover additional costs associated with covering formerly uninsured individuals who may have unmet health needs. The program will run from 2014 through 2016 and would be funded by both fully insured and self-funded plans. The estimated fee for 2014 is $5.25 per covered person per month ($63 per year). This fee will decline by about one-third for 2015 and by yet another one-third for 2016.

The fee would be assessed based upon the average number of covered lives (employees, pre-Medicare retirees and dependents) covered by major medical plans during the year, which means that standalone dental and vision, specified disease, hospital indemnity, employee assistance programs (EAPs), wellness programs, health reimbursement arrangements (HRAs), health savings accounts (HSAs) and health

flexible spending accounts (FSAs) would not be included.

The insurer would be responsible for reporting and paying the fee if the employer only offers one fully insured plan. If the plan is self-funded, or if the employer offers multiple options, the plan sponsor (typically, this is the employer) would be responsible for determining the fee, to allow each person to only be counted once. The calculation would be similar to that used for the Patient Centered Outcomes Research (PCORI) fee, which among other things, allows use of a quarterly or monthly snapshot. (Employers would be allowed to use different methods of counting covered lives for the PCORI and TRP reporting.)

Data would be reported by Nov. 15 based upon covered lives during the first nine months of the calendar year. The amount to be available for this program is set out in the law ($10 billion to 12 billion in 2014, $6 billion to 8 billion in 2015 and $4 billion to 5 billion in 2016), so HHS would divide that amount by the reported covered lives to determine each entity's liability. That amount would be billed mid-December and would be due around Jan.15 of 2015, 2016 and 2017. Amounts would then be disbursed to insurers in the individual market to help pay large claims.

Risk Adjustment Program

The risk adjustment program is permanent, and will involve the annual transfer of funds from insurers who have a concentration of low-risk insureds to those with high-risk insureds. The program will impact all nongrandfathered insured plans in the individual and small group markets, whether the plan is provided through or outside of an exchange.

Each year, an insurer's total risk would be calculated, and insurers below the average risk would transfer funds to insurers with a total risk above the average risk. Insurers would pay a fee to HHS each June to cover the administrative costs of the program; the fee is expected to be about $1 per covered life per year.

FFE Fee

HHS has proposed a fee of three and one-half percent of premium to cover the cost of running a federally facilitated exchange (FFE) for those states that choose not to run their own exchange.

SHOP Exchange

The proposed rule provides that, at least through 2016, eligibility for the small-business health option program (SHOP) exchange would be limited to small employers. An employer would be "small" for exchange purposes if it has 100 or fewer employees, although a state could elect to use 50 employees for the limit in 2014 and 2015. Employees would be counted the same way employees are counted for purposes of the employer shared responsibility/play or pay penalty (employees who average 30 or more hours per week would be considered full-time, and the hours of part-time employees would be totaled to calculate "full-time equivalent" employees). In states that have a federally-facilitated exchange (because the state chose not to set up its own exchange), the maximum number of full-time and full-time equivalent employees an employer could have to be in the SHOP would be 100 employees.

In FFEs (and in states with their own exchanges unless the state opts to do otherwise), the employer would choose a metal level (bronze, silver, gold or platinum), and employees would choose the plan they want that is available at that metal level. The employer would be required to offer coverage to all full-time

employees who had satisfied the waiting period. A 70 percent participation rate (excluding those with coverage through another employer, Medicare, Medicaid and TRICARE) would apply unless a different rate is generally used in the state. The employer would choose the amount it would contribute toward the cost of coverage (carriers would be allowed to impose a minimum contribution requirement).

MLR Adjustments

The proposed rule provides that if an MLR payment is used to reduce premiums, it would need to be applied to the next premium due after the MLR due date. Also, beginning in 2014, the MLR payment due date would be Sept. 30.

The text of the proposed rule is here: Proposed Rule - Benefit and Payment Parameters

Multi-State Plan Program

PPACA directs the federal Office of Personnel Management (OPM) to enter into contracts with private health insurance issuers to offer at least two Multi-State Plans (MSPs) through the exchanges. Health insurance issuers who wished to provide an MSP would apply to OPM. OPM would determine which issuers are qualified to become MSP issuers, enter into contracts with the issuers and approve the plans to be offered on exchanges.

The proposed rules:

- Would require the MSP issuer to be operating in all states by 2018 but allow it to phase in the states in which it offers coverage from 2014 to 2018
- Provide that insurers and nonprofits operating under a single service mark or common ownership could join together to provide the required national coverage
- Provide for assessment of user fees to help OPM cover the cost of running the MSP program
- Allow an MSP to choose between offering the state essential health benefits (EHB) package approved in each state in which it operates, or offering one of three EHB benchmark plans available to federal employees
- Provide that an MSP would have to comply with the same cost-sharing rules that apply to other plans in the exchange, would have to offer at least gold-level coverage and silver-level coverage and would be included in the state's risk pool

The text of the proposed rule is here: Proposed Rule - Multi-State Plan Program

Public comments are due Jan. 4, 2013.

Important: These rules are still in the "proposed" stage, which means that there may be changes when the final rule is issued. Employers should view the proposed rules as an indication of how plans will be regulated beginning in 2014, but need to understand that changes are entirely possible.

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