Benefits BUZZ

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DID YOU KNOW?

The Affordable Care Act's (ACA) prohibition on pre-existing condition exclusions (PCEs) for plan years beginning on or after Jan. 1, 2014, makes HIPAA certificates of Creditable Coverage unnecessary. Beginning Dec. 31, 2014, group health plans and issuers are not required to provide HIPAA Certificates for 2015 and following years.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans and issuers had to provide HIPAA Certificates to individuals when they lost coverage under the plan or upon request for 24 months after coverage was terminated. The HIPAA Certificate allowed individuals to establish prior creditable coverage in order to reduce or eliminate PCEs.

HHS Issues Proposed Benefit and Payment Parameters for 2016

On Nov. 21, 2014, the Department of Health and Human Services (HHS) issued the 2016 Notice of Benefit and Payment Parameters Proposed Rule, which contains several proposed changes for 2016. Among these changes are adjustments to the reinsurance program's annual contribution rate, the Health Insurance Marketplace open enrollment period for 2016 and following years, and annual limitations on cost-sharing.

The transitional reinsurance program, created by the Affordable Care Act (ACA) to help stabilize coverage premiums in the individual market for the first three years of the Exchange, imposes fees on health insurance issuers and self-insured group health plans. The fees are lowered each year that they are assessed. The 2015 annual fee is $44 per enrollee, and the proposed contribution rate for 2016, the final year of the reinsurance program, is $27 per enrollee.

The Nov. 21 Notice also addresses the Marketplace open enrollment period for 2016. The 2015 period of Nov. 15, 2014, to Feb. 15, 2015, remains the same, but the proposed rule changes the open enrollment period for 2016 and following years to run from Oct. 1 to Dec. 15 of the year prior to the benefit year.

Annual cost-sharing limitations are also addressed in the proposed rule. The ACA generally requires non-grandfathered plans to have an out-of-pocket maximum for essential health benefits, which is updated annually based on the percent increase in average premiums per person for health insurance coverage. The 2015 out-of-pocket maximum for self-only coverage is $6,600 and the proposed 2016 maximum is $6,850. For family coverage, the 2015 maximum is $13,200 and the proposed maximum for 2016 is $13,700.

The Notice also addresses proposed changes to the minimum value of employer-sponsored plans, the affordability exemption for the individual mandate, medical loss ratio rebate requirements and provisions for the Small Business Health Options Program (SHOP).

The changes addressed in the Notice are proposed rules, so the HHS may still change them before finalizing benefit and payment parameters for 2016.

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ACA Affordability Percentages Increase for 2016

On Nov. 21, 2014, the IRS released affordability contribution percentages for 2016. Affordability contribution percentages measure a plan's affordability and apply to three provisions under the ACA: the employer-shared responsibility penalty, the individual mandate and the premium tax credit.

These updated affordability percentages are effective for taxable years and plan years beginning **after Dec. 31, 2015**:

- The new affordability percentage for the individual mandate is 8.13 percent for 2016.
- The affordability percentage for the employer mandate and the premium tax credit eligibility rules is 9.66 percent for 2016.
- Employers that use an affordability safe harbor under the pay or play rules will continue using a contribution percentage of 9.5 percent.

For **2015** plan years, the individual mandate affordability percentage is 8.05 percent, and it is generally 9.56 percent for the employer mandate and premium tax credit eligibility.