

**HHS 2015 Health Policy Standards
Fact Sheet**

The Department of Health and Human Services (HHS) is releasing key standards for health insurers and the Health Insurance Marketplace for 2015, ensuring that consumers have multiple health insurance coverage options, that states continue to have flexibility in their markets, and that issuers and employers have the early guidance and certainty they need to provide affordable health coverage next year.

“These policies implement the health care law in a common-sense way by continuing to smooth the transition for consumers and stakeholders and fixing problems wherever the law provides flexibility,” said HHS Secretary Kathleen Sebelius. “This comprehensive guidance will help ensure that consumers, employers and insurers have the information they need to plan for next year and make it easier for families to make decisions to access quality, affordable coverage.”

As part of ongoing efforts to implement the Affordable Care Act, HHS has heard from families, states, businesses, health professionals, Congress, insurance commissioners, and insurers who want certainty on what’s coming as early as possible so that they can plan ahead. The policies being announced today are another step in our ongoing efforts to bring millions of Americans access to affordable coverage.

These provisions, developed in close consultation with members of Congress, including but not limited to Senators Mark Warner, Mary Landrieu, Jeanne Shaheen, Mark Udall and Representatives Tim Bishop, Elizabeth Esty, Carol Shea-Porter, Gary Peters, Scott Peters, Ann Kuster, Kyrsten Sinema, Ann Kirkpatrick, and Ron Barber, provide flexibility to states and provide consumers with choices so they can decide what is best for themselves and their families.

Today’s announcements include the release of a bulletin on the Extension of the Transition Policy through October 1, 2016, as well as the HHS Notice of Benefit and Payment Parameters for 2015 final rule. Together, the policies being announced extend a number of 2014 policies to 2015, continue to phase in provisions of the health care law, and allow for a smooth transition where needed – so that consumers, employers, health plans and others can plan for the future.

Bulletin on Extension of the Transition Policy

Overview

On November 14, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a letter to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. The letter provided insurers the option, if permitted by their state, to renew their current policies for current enrollees without adopting all of the 2014 market rule changes. CMS also indicated that it would consider extending the transitional policy beyond 2014. Today’s bulletin extends this transitional policy for two years: to policy years beginning on or before October 1, 2016. This gives consumers in the individual and small group markets the choice of staying in their plan or joining a new Marketplace plan as the new system is fully implemented.

Issuers offering such renewals will be required to provide notices to consumers informing them of their options and new consumer protections that are available in other plans. Specifically, issuers must inform consumers about the protections their renewed plan will not include, and how they can learn

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about the new options and financial assistance available to them through the Marketplaces. This policy applies to “early renewals” in states that permit it.

Today’s bulletin can be accessed here: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>

HHS Notice of Benefit and Payment Parameters for 2015 Final Rule

Overview

The HHS Notice of Benefit and Payment Parameters for 2015 final rule provides certainty and stability as stakeholders prepare for 2015. The final rule describes payment parameters applicable to the 2015 benefit year and standards relating to:

- the premium stabilization programs;
- the open enrollment period for 2015;
- the annual limitations on cost sharing;
- consumer protections;
- financial oversight; and
- the Small Business Health Options Program (SHOP).

Qualified individuals and qualified employers are now able to purchase private health insurance coverage through Health Insurance Marketplaces (Marketplaces). Individuals who enroll in a qualified health plan (QHP) through a Marketplace may be eligible to receive premium tax credits to make health insurance more affordable and financial help to reduce cost sharing. The premium stabilization programs are intended to promote price stability, especially in the early years of implementation of the new health law. These programs, together with other reforms of the Affordable Care Act, make high-quality health insurance affordable and accessible to millions of Americans. Key policies in today’s final rule include:

Promoting Stable Individual Market Premiums through the Transitional Reinsurance Program: We are decreasing the reinsurance attachment point (the threshold at which reinsurance is triggered) from \$60,000 to \$45,000 for the 2014 benefit year due to updated estimates. For 2015, we are finalizing the following uniform reinsurance payment parameters: an attachment point of \$70,000, a reinsurance cap of \$250,000, and a coinsurance rate of 50 percent. And, for 2014 and 2015, if reinsurance contributions collected for a benefit year exceed the requests for reinsurance payments for the benefit year, we will increase the coinsurance rate up to 100 percent on our reinsurance payments prior to rolling over any excess funds to the next year, to ensure that the contributions collected for the benefit year are expended for claims for that benefit year to maximize the benefits of the reinsurance program.

We are finalizing a 2015 annual reinsurance contribution rate of \$44 per enrollee to be paid by health insurance issuers and certain self-insured group health plans, which is to fund the reinsurance pool, payment to the U.S. Treasury, and reinsurance administrative expenses for 2015. We are modifying our contributions collection schedule for the reinsurance program. We will collect from all contributing entities the reinsurance contribution amounts for reinsurance payments and administrative expenses earlier in the calendar year following the applicable benefit year, and collect the reinsurance

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contribution amounts for payments to the U.S. Treasury in the last quarter of the calendar year. For example, the \$63 per capita reinsurance contribution for the 2014 benefit year will be collected in two installments: \$52.50 in January 2015 and \$10.50 late in the fourth quarter of 2015. In addition, we made changes to refine the definition of “major medical coverage,” prevent more than one payment for one enrollee, and exclude from the obligation to make reinsurance contributions for 2015 and 2016 certain self-insured, self-administered group health plans.

Refining the Temporary Risk Corridors Program: In the November 14, 2013 transitional policy announcement, CMS indicated that, in order to protect against the potential impacts on premiums, it would explore ways to modify the temporary risk corridors program formula. Because issuers’ premium estimates did not take the transitional policy into account, the transitional policy could potentially lead to unanticipated higher average claims costs for issuers of plans that comply with the 2014 market rules.

Today’s final rule implements a state-level adjustment in the risk corridors formula to account for the transitional policy’s effect on the expected 2014 risk pool in a way such that the program is projected to be budget neutral, with payments in equaling payments out, while helping to ensure that prices remain affordable in 2015 and beyond. Because we believe that the effect of the transitional policy on the risk pool will be greater in states with higher enrollment in transitional plans, we will vary the state-specific percentage adjustment to the risk corridors formula based on the percentage enrollment in transitional plans within a state. Issuers will exclude any additional risk corridors adjustment amount from their medical loss ratio (MLR) calculations so that MLR calculations will not be affected. We also indicate in today’s final rule that we continue to review the policy and budgetary implications of a recommendation raised in comments to raise the ceiling on allowable administrative costs for QHP issuers in all states.

The final payment notice also includes refinements to the risk adjustment program.

Open Enrollment Period for 2015: We finalized the annual open enrollment period for the 2015 benefit year such that it would begin on November 15, 2014 and extend through February 15, 2015. This schedule gives issuers additional time before they need to set their 2015 rates and submit their QHP applications, gives states and HHS more time to prepare for open enrollment, and gives consumers until February 15, 2015 to shop for coverage. The rule does not change the schedule for the open enrollment period currently underway.

State Flexibility: We provide states more time to transition into a state-based Marketplace after 2014 by finalizing the proposal to move the date on which a state must have an approved or conditionally approved Blueprint in place for the following year from January 1 to June 15. We finalize provisions to allow additional Marketplace flexibility regarding the use of applicant eligibility and enrollment information to promote the efficient operations of a Marketplace.

Limiting Individuals and Families from Out-of-Pocket Expenses: The Affordable Care Act sets limits on cost sharing to protect individuals from excessive out-of-pocket expenses. The statute requires that these limits be updated annually based on the percent increase in average premiums per person for health insurance coverage. For 2015, we updated these limits based on projections of average per enrollee employer sponsored insurance (ESI) health insurance premiums from the National Health Expenditure Accounts (NHEA), a change from the proposed notice due to public comments. We believe

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that this methodology best represents the average private health insurance spending figure per person. Therefore, the premium adjustment percentage for 2015 is 4.21 percent, which results in a maximum annual limitation on cost sharing for 2015 for self-only coverage of \$6,600 (\$13,200 for families), and a maximum annual limitation on deductibles for 2015 for plans in the small group market for self-only coverage of \$2,050 (\$4,100 for families) (these amounts are lower than the amounts originally proposed). We are also finalizing the 2015 Actuarial Value (AV) Calculator to be the 2014 AV Calculator with an updated annual limit on cost sharing. Both the AV Calculator and Methodology are accessible through CCIO's website.

Additionally, we establish that a stand-alone dental plan covering the pediatric dental essential health benefit (EHB) under 45 CFR 155.1065 in any Marketplace, cost sharing may not exceed \$350 for one covered child and \$700 for two or more covered children, lower than the current limits but slightly higher than the proposed limits to keep premiums for such coverage affordable.

Protecting Enrollees in QHPs: We are implementing patient safety standards over time to provide consumers with access to health care that meet adequate safety and quality standards. For the initial two years, we are aligning QHP issuer standards with the Medicare Hospital Condition of Participation requirements for a quality assessment and performance improvement program and discharge planning. Additionally, as a means of ensuring that all QHPs offered through the Federally-facilitated Marketplace (FFM) are in the interests of qualified individuals and qualified employers, the final rule states that a plan generally must be considered "meaningfully different" from all other plans offered by the same issuer in order to be certified as a QHP in the FFM.

Protecting Federal Funds: We finalized several oversight provisions applicable to the premium stabilization programs, including authority for HHS to conduct audits of issuers and entities in the HHS-operated risk adjustment and reinsurance programs, as well as audits of state-operated reinsurance programs and standards regarding risk adjustment data validation. We also clarified that HHS has the authority to net payments to issuers against amounts owed to HHS by the issuer or their affiliates. We finalized a dispute resolution and appeals process to address any disputes regarding such payments or charges.

Implementing and Improving SHOP: We finalized several standards that accompany the employee choice and premium aggregation provisions in Federally-facilitated SHOPS (FF-SHOPS). The final rule also allows employers in the FF-SHOPS to offer employees either a single stand-alone dental plan or a choice of all stand-alone dental plans available at a stand-alone dental AV level. After 2015, an FF-SHOP may permit employers to contribute differently to the premiums of full-time and non-full-time employees. In FF-SHOPS, when an employer elects to offer employees a choice of plans, premiums would be set using per-member rating. We also clarified that a small employer in the SHOP that becomes a large employer would continue to be rated as a small employer. The final rule permits states to allow enrollment in a QHP through the SHOP by using the website of an agent or broker in those states that allow that activity under state law, subject to certain consumer protections. We are also considering proposing that states could recommend modifications to the provision that allows employees to choose any plan within a coverage level if doing so would preserve and promote affordable insurance for employees and small businesses.

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In addition to finalizing these provisions, we are also finalizing amendments to §155.705(b)(6) which were proposed in the Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards Proposed Rule (78 FR 37032) regarding the timing of quarterly rate changes, making explicit that this market-wide policy also applies to SHOP.

The 2015 AV Calculator and Methodology can be accessed at:

<http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html>

EMBARGOED