update
Compliance News for Staff Plans
June 10, 2015

New Rules for Cost-Sharing Limits Applicable to Non-Grandfathered Plans

Health Compliance Topic:

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On May 26, 2015, the Departments of Labor, Treasury and Health and Human Services (HHS) (the "Departments"), which are responsible for implementing group health plan standards under the Affordable Care Act,[1] released new answers to frequently asked questions (FAQs) clarifying how non-grandfathered health plans must apply the law's limitations on cost sharing (also known as the limitations on out-of-pocket maximums).[2] Effective with the plan year beginning in 2016, non-grandfathered plans will be required to limit cost sharing to the individual limit ($6,850 in 2016) for each member of a family.

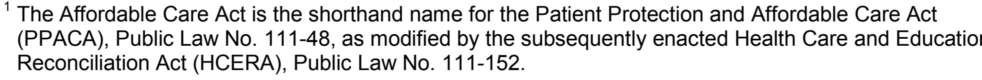
This *Update* provides background on the cost-sharing limits and summarizes the new guidance.

Background

The Affordable Care Act requires non-grandfathered group health plans to limit the amount that participants (and their families) have to pay out of pocket for in-network essential health benefits.[3] For 2015, those limits are $6,600 (individual)/$13,200 (family). For 2016, those limits will increase to $6,850 (individual)/$13,700 (family).

Application of the Cost-Sharing Limitation to Group Health Plans

Effective with the plan year beginning in 2016, non-grandfathered plans will be required to apply the self-only limit ($6,850 in 2016) to each individual member of a family. This means that an individual will never have to pay more than $6,850 (in 2016) in cost sharing for in-network benefits, even if the plan has a family out-of-pocket maximum that has not yet been met. Essentially, plans with a family out-of-pocket maximum higher than $6,850 must "embed" an individual out-of-pocket maximum within the family out-of-pocket maximum. The plan must pay 100 percent for covered in-network benefits as soon as an individual's out-of-pocket costs exceed $6,850, even if the plan has a higher family out-of-pocket maximum.



[1] The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

[2] The new FAQ is available at Frequently Asked Questions - The Affordable Care Act Implementation Part XXVII.

[3] The scope of essential health benefits varies state by state, but a wide range of medical, prescription drug, and behavioral health benefits would be considered essential health benefits. For information on earlier FAQs on the cost-sharing limits, see Segal's December 17, 2014 *Capital Checkup*, "Reference-Based Pricing and the Affordable Care Act's Rules on Out-of-Pocket Limits" and June 11, 2014 *Capital Checkup*, "Latest Guidance on the Affordable Care Act's Rules for Out-of-Pocket Limits and Preventive Services Requirements."

Those plans that have family out-of-pocket maximums under the self-only limit ($6,850 in 2016) will not face this problem. In addition, many plans already administer out-of-pocket maximums on an individual basis, and will also not have a problem with the new rule. Only those non-grandfathered plans that require that the family meet its out-of-pocket maximum before the plan pays for covered expenses at 100 percent will be affected.

Plan sponsors that offer a Health Savings Account (HSA)-compliant non-grandfathered high-deductible health plan (HDHP) must also review their plans to assure that the out-of-pocket maximum is administered consistently with the new rule.[4]

Cost-Sharing Limit Illustration

One answer to an FAQ provides an example of how this will work. That example is shown in the table below.

How the Affordable Care Act's Cost-Sharing Limits Apply in 2016 to a Plan with a $13,000 Out-of-Pocket Maximum for Family Coverage: An Example for a Family of Four

	Out-of-Pocket (OOP) Costs for Covered Expenses	OOP Costs After Application of Affordable Care Act's Cost-Sharing Limit	Plan's Responsibility
Person #1	$10,000	$6,850	$3,150 ($10,000 – $6,850)
Person #2	$3,000	$3,000	N/A
Person #3	$3,000	$3,000	N/A
Person #4	$3,000	$3,000	N/A
Family	**$19,000**	**$15,850**	**$2,850 ($15,850 – $13,000)***

* The plan is responsible once the family accrues claims of $13,000.

Implications for Plan Sponsors

Plan sponsors of non-grandfathered plans should review with their claims administrator whether the out-of-pocket maximum is applied on an individual or family basis. Plan sponsors should assure that both plan descriptions and operations apply the Affordable Care Act cost-sharing limitations on an individual, not a family basis. Plans that do not currently apply the individual limit to each member of a family should review the financial implications of modifying these practices, and plan to change plan administration and revise plan documents for the plan year beginning in 2016.

Changes should be discussed in the plan's open enrollment materials (if any) and reflected in the plan's Summary of Benefits and Coverage (SBC).

[4] HHS issued a related FAQ for HSA-compliant HDHPs (FAQ # 10452), which was posted on May 8, 2015 and is available on the following website (registration required): REGTAP | Registration for Technical Assistance Portal

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