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HHS Clarifies PPACA's Cost-Sharing Limits

For plan years beginning in 2014 or later, PPACA requires that non-grandfathered group health plans impose annual out-of-pocket maximums with respect to "self-only" coverage and family coverage, and the maximums cannot exceed certain dollar amounts.[1] For plan years beginning in 2016, the limits are $6,850 for self-only coverage, and $13,700 for family coverage.[2]

HHS recently "clarified" that the self-only out-of-pocket maximum must apply to all individuals covered by the plan, even those with family coverage.[3] For example, if an individual were enrolled in family coverage in a group health plan with annual out-of-pocket maximums of $6,850 for self-only coverage and $13,700 for family coverage, and the individual incurred $8,000 worth of health expenses, the plan could only require the individual pay $6,850 (the "self-only" out-of-pocket maximum)—even if the family out-of-pocket maximum had not yet been reached.[4] (Once the family out-of-pocket maximum is reached, the self-only maximums are deemed to be satisfied for all covered family members.)

HHS's interpretation is effective for plan years beginning on or after January 1, 2016,[5] so plan sponsors should review their plan documents and confirm that their plans' annual out-of-pocket maximums are being administered consistent with this new guidance.[6]

Finally, the preamble to these same regulations states that HHS will not finalize a November 2014 proposed rule which would have required non-calendar year plans to adhere to the annual limitations specific to the calendar year in which the plan year begins (which would serve as the annual limit for the entire plan year).[7]

Not intended as legal advice.

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[1] Generally, all deductibles, copays and coinsurance for essential health benefits incurred in-network will count toward the out-of-pocket maximums. However, for the 2014 plan year, HHS provided a special exception for plans that have to coordinate multiple service providers. See our February 2013 Bulletin, available at http://www.songmondress.com/Articles/February-2013-FAQ-on-Health-Plan-Annual-Out-of-Pocket-Maximums.shtml.

[2] For plan years beginning in 2014, the PPACA limits on out-of-pocket maximums for non-grandfathered group health plans were the same as the Code § 223 limits on out-of-pocket maximums for high-deductible health plans (HDHPs). However, as HHS (which implements PPACA's limits) and the IRS (which implements the Code's limits on HDHPs) use different measures to adjust these limits, the dollar amounts will be different in later years. The IRS has informally stated that HDHPs subject to both PPACA's limits on out-of-pocket maximums and the Code § 223 limits must comply with whichever limits are lower for a given year. *See* ABA JCEB 2013 Q&A with the IRS, Q&A-1, available at http://www.americanbar.org/content/dam/aba/events/employee_benefits/2013_irs_qa.authcheckdam.pdf.

[3] Preamble to Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10749, 10824 (Feb. 27, 2015). IRS and DOL subsequently confirmed that this clarification applies to all non-grandfathered plans, including self-funded group health plans. *See* FAQs about Affordable Care Act Implementation (Part XXVII), Q&A-1, at http://www.dol.gov/ebsa/pdf/faq-aca27.pdf.

[4] HHS's interpretation may raise problems for some HDHPs, with respect to family coverage. Under IRS guidance, an HDHP cannot pay any benefits (other than preventive care) for any covered family member until the deductible for family coverage is met for that plan year. *See* IRS Notice 2004-2. (For 2015, the minimum family coverage deductible for HDHPs is $2,600.) By contrast, under the new HHS guidance, an HDHP must pay benefits for a family member who has met the plan's self-only out-of-pocket maximum, even if the family coverage deductible has not been satisfied. This will only be an issue for an HDHP that sets its self-only out-of-pocket maximum lower than its family coverage deductible.

[5] The preamble notes that "2016 plans must comply with this [clarification]," and subsequently-issued FAQs confirm that the clarification is only effective for plan and policy years that begin in or after 2016. *See* FAQs about Affordable Care Act Implementation (Part XXVII), Q&A-2, at http://www.dol.gov/ebsa/pdf/faq-aca27.pdf.

[6] In the preamble, HHS acknowledged that some commentators had expressed concerns that HHS's clarification is inconsistent with the plain language of PPACA, but made no effort to address this point. Instead, HHS merely stated that applying the "self-only" out-of-pocket maximum to all covered individuals is an important consumer protection. Unless and until HHS's interpretation is overturned by subsequent guidance or the federal courts, plan sponsors should be prepared to begin complying next year.

[7] Preamble to Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10749, 10823-24 (Feb. 27, 2015).