



Health Care Reform LEGISLATIVE BRIEF

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Cost-sharing Limits for Health Plans

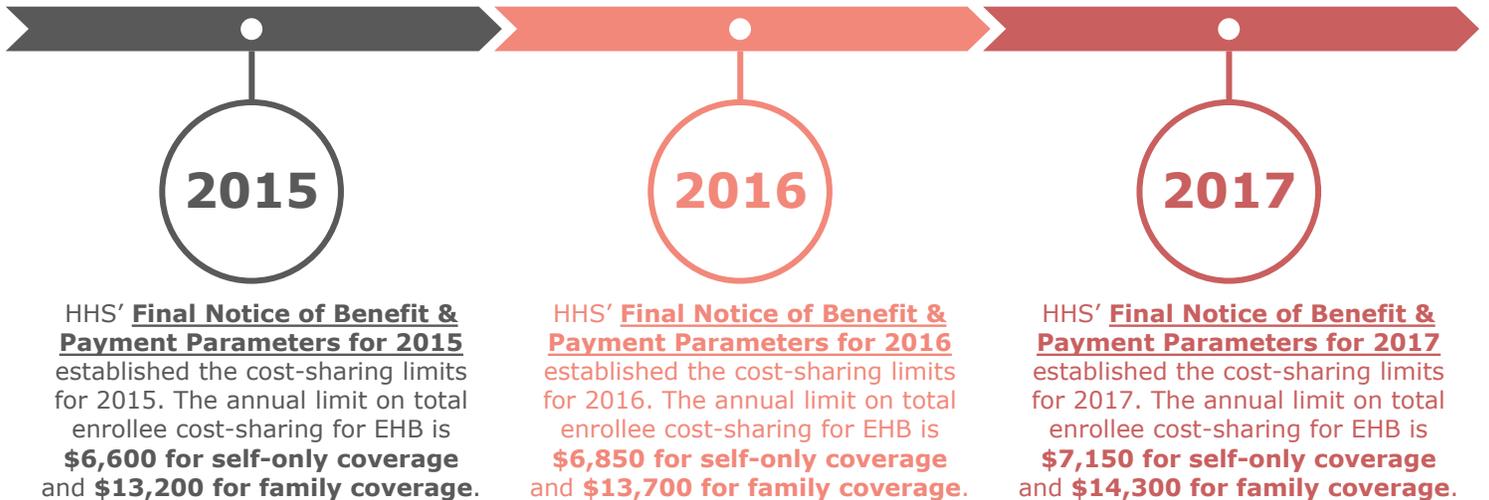
Beginning in 2014, the Affordable Care Act (ACA) requires certain health plans to comply with cost-sharing limits with respect to their coverage of essential health benefits. Under the ACA, “essential health benefits” (EHB) must be equal in scope to benefits covered by a typical employer plan and must include items and services in ten general categories, including hospitalization, prescription drugs and maternity and newborn care.

The cost-sharing limits include an overall annual limit (or an out-of-pocket maximum) and an annual deductible limit. On Feb. 25, 2013, the Department of Health and Human Services (HHS) issued a [final rule](#) on EHB that addresses the ACA’s cost-sharing limits for health plans. The limits are effective for **plan years beginning in 2014**.

On April 1, 2014, President Obama signed into law the [Protecting Access to Medicare Act of 2014](#) (H.R. 4302), which **repealed the annual deductible limit** under the ACA. This repeal was effective as of the date that the ACA was enacted, back on March 23, 2010.

UPDATES TO LIMITS

The ACA requires the cost-sharing limits to be updated annually based on the percent increase in average premiums per person for health insurance coverage. The increased annual out-of-pocket maximums are announced each year in HHS’ Notice of Benefit and Payment Parameters for that year.



AFFECTED PLANS

Grandfathered plans are not subject to the ACA’s cost-sharing limits. There was some uncertainty regarding which types of non-grandfathered plans must comply with the cost-sharing limits. The ACA’s out-of-pocket maximum broadly refers to “health plans,” and does not specifically reference health plans in the small group market. Thus, the

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final rule provides that the out-of-pocket maximum applies to *all* non-grandfathered health plans. This includes, for example, self-insured health plans and insured health plans of any size.

COST-SHARING LIMITS

The ACA's cost-sharing limits included an overall annual limit (or an out-of-pocket maximum) and an annual deductible limit. These limits became effective for plan years beginning on or after Jan. 1, 2014. However, the Protecting Access to Medicare Act of 2014 (signed into law on April 1, 2014) repealed the annual deductible limit, effective as of the date that the ACA was enacted, back on March 23, 2010.

Cost-sharing includes any expenditure required by or on behalf of an enrollee with respect to EHB, such as deductibles, co-payments, co-insurance and similar charges. It excludes premiums and spending for non-covered services. Also, for plans using provider networks, the final rule provides that an enrollee's cost-sharing for out-of-network benefits does not count toward the cost-sharing limits.

Out-of-pocket Maximum

Effective for plan years beginning in 2014, the ACA places annual limits on total enrollee cost-sharing for EHB, known as an out-of-pocket maximum. The out-of-pocket maximum limits are as follows:

	2014	2015	2016	2017
Self-only Coverage	\$6,350	\$6,600	\$6,850	\$7,150
Family Coverage	\$12,700	\$13,200	\$13,700	\$14,300

The out-of-pocket maximum applies for the plan year and not the calendar year for non-calendar year plans. Also, plans and issuers are permitted, but not required, to count out-of-network cost-sharing against the annual out-of-pocket maximum.

Once the out-of-pocket maximum is reached for the year, the enrollee is not responsible for additional cost-sharing for EHB for the remainder of the year. According to HHS, the out-of-pocket maximum ensures that health plans pay for significant health expenses and limits the risk of medical debt or bankruptcy for insured individuals.

Clarification for Family Coverage—Embedded Out-of-pocket Maximum

The 2016 Notice of Benefit and Payment Parameters Final Rule clarifies that the self-only annual limit on cost-sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage. This guidance embeds an individual out-of-pocket maximum in family coverage so that an individual's cost-sharing for essential health benefits cannot exceed the ACA's out-of-pocket maximum for self-only coverage.

Note that the ACA's cost-sharing limit is higher than the out-of-pocket maximum for HDHPs. In order for a health plan to qualify as an HDHP, the plan must comply with the lower out-of-pocket maximum limit for HDHPs. In an [FAQ](#), HHS provides guidance on how this ACA rule affects HDHPs with family deductibles that are higher than the ACA's cost-sharing limit for self-only coverage.

According to HHS, an HDHP plan that has a \$10,000 family deductible must apply the annual limitation on cost-sharing for self-only coverage (\$6,850 in 2016) to each individual in the plan, even if this amount is below the \$10,000 family deductible limit. Because the \$6,850 self-only maximum limitation on cost-sharing exceeds the 2016 minimum annual deductible amount for HDHPs (\$2,600), it will not cause a plan to fail to satisfy the requirements for a family HDHP.

The FAQ indicates that this policy takes effect with the **2016 plan year**, when the self-only limit on cost-sharing increases to \$6,850.

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Transition Relief—Plans with Multiple Service Providers

A set of [FAQs](#) issued in conjunction with the final rule address how the ACA's out-of-pocket maximum applies to plans that use more than one service provider to administer benefits (such as a third-party administrator for major medical coverage, a separate pharmacy benefit manager and a separate managed behavioral health organization). Separate service providers may impose different out-of-pocket limits and use different methods for crediting participants' expenses against out-of-pocket maximums. The FAQs note that these processes must be coordinated to comply with the ACA's out-of-pocket maximum, which may require new regular communications between service providers.

The FAQs provide that, only for the first plan year beginning on or after Jan. 1, 2014 (the first year of applicability), where a group health plan or group health insurance issuer uses more than one service provider to administer benefits that are subject to the annual out-of-pocket maximum, the annual limit will be satisfied if:

- The plan complies with the out-of-pocket maximum with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
- To the extent that there is an out-of-pocket maximum on coverage that does not consist solely of major medical coverage, this out-of-pocket maximum does not exceed the maximum dollar amount under the ACA.

Additional Clarifications

On Jan. 9, 2014, the Departments of Labor (DOL), HHS and the Treasury (the Departments) issued [FAQs](#) clarifying the out-of-pocket maximum requirement following the first year of applicability. These FAQs state that, for plan years beginning on or after Jan. 1, 2015, non-grandfathered group health plans and group health insurance coverage must have an out-of-pocket maximum which limits overall out-of-pocket costs on all EHB. Because the cost-sharing limits apply only to EHB, plans are not required to apply the annual out-of-pocket maximum to benefits that are not EHB.

The list of the authorized plans for purposes of determining EHB for the large group market and self-funded plans is at 45 CFR 156.100. See also [FAQs on Essential Health Benefits Bulletin](#), Question 10. The Departments intend to work with large group market and self-insured plans that make a good faith effort to apply an authorized definition of EHB.

The Departments recognize that some plans, such as those with multiple service providers, may find it easier to divide the annual out-of-pocket limit across multiple categories of benefits, rather than reconcile claims across multiple service providers. Thus, the Departments are permitting plans and issuers to structure a benefit design using separate out-of-pocket limits, provided that the combined amount of any separate out-of-pocket limits applicable to all EHB under the plan does not exceed the annual out-of-pocket maximum limit for that year.

In addition, a plan may, but is not required to, count out-of-pocket spending for out-of-network items and services towards the plan's annual out-of-pocket maximum limit. Under HHS regulations, cost-sharing requirements for benefits that are EHB from a provider outside of a plan's network of providers are not required to be counted toward the annual out-of-pocket limit.

An [FAQ](#) issued on May, 2, 2014, clarifies that a plan that counts out-of-network spending towards the out-of-pocket maximum may use any reasonable method for doing so. For example, if the plan covers 75 percent of the usual, customary and reasonable amount (UCR) charged for services provided out-of-network and the participant pays the remaining 25 percent plus any amount charged by the out-of-network provider in excess of UCR, the 25 percent of UCR paid by the participant may reasonably be counted, in full or in part, toward the out-of-pocket maximum without including any amount charged above UCR paid by the participant.

With respect to health insurance issuers offering qualified health plans (QHPs) through an Exchange only, HHS strongly encourages QHP issuers to:

- Allow enrollees to receive in-network benefits with respect to any provider listed in the version of the provider directory as of the date of that enrollee's enrollment for the beginning months of coverage, in cases where issuers are unable to maintain provider directories in a current status; and

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- Temporarily cover non-formulary drugs, as well as drugs that are on a QHP issuer's formulary but typically require prior authorization or step therapy prior to being covered, during the first 30 days of coverage, starting on Jan. 1, 2014.

Accordingly, under these limited circumstances, HHS strongly encourages QHP issuers to count enrollees' out-of-pocket expenses on these services and items toward the QHPs' annual maximum out-of-pocket limits.

Treatment of Out-of-pocket Costs for Brand Name Prescription Drugs

A set of [FAQs](#) issued on May, 2, 2014, clarify how large group market coverage and self-insured group health plans should treat an individual's out-of-pocket costs for a brand name prescription drug, in circumstances in which a generic was available and medically appropriate.

Large group market coverage and self-insured group health plans have discretion to define EHB. For example, a plan may include only generic drugs, if medically appropriate (as determined by the individual's personal physician) and available, while providing a separate option (not as part of EHB) of electing a brand name drug at a higher cost sharing amount. If, under this type of plan design, a participant or beneficiary selects a brand name prescription drug in circumstances in which a generic was available and medically appropriate (as determined by the individual's personal physician), the plan may provide that all or some of the amount paid by the participant or beneficiary (for example, the difference between the cost of the brand name drug and the cost of the generic drug) is not required to be counted towards the annual out-of-pocket maximum. For ERISA plans, the SPD must explain which covered benefits will not count towards an individual's out-of-pocket maximum.

In determining whether a generic is medically appropriate, a plan may use a reasonable exception process. For example, the plan may defer to the recommendation of an individual's personal physician or it may offer an exceptions process meeting the requirements of 45 CFR 156.122(c).

Additional requirements apply for non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package.

Plans Using Reference-based Pricing Structures

The [FAQs](#) issued on May, 2, 2014, also clarify how the out-of-pocket limit applies if:

- Large group market coverage or a self-insured group health plan has a reference-based pricing structure, under which the plan pays a fixed amount for a particular procedure (for example, a knee replacement), which certain providers will accept as payment in full; but
- An individual uses a provider that does not accept that amount as payment in full.

Reference pricing aims to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs. However, the DOL is concerned that this pricing structure may be a subterfuge for imposing otherwise prohibited limits on coverage, without ensuring access to quality care and an adequate network of providers.

Accordingly, the DOL is inviting comments on how the out-of-pocket limit should apply to the use of reference-based pricing. The DOL is particularly interested in standards that plans using reference-based pricing structures should be required to meet to ensure that individuals have meaningful access to medically appropriate, quality care.

Until guidance is issued, with respect to a large group market plan or self-insured group health plan that uses a reference-based pricing program, the DOL will not consider a plan or issuer as failing to comply with the out-of-pocket maximum limit because it treats providers that accept the reference amount as the only in-network providers, as long as the plan uses a reasonable method to ensure that it provides adequate access to quality providers.

Additional requirements apply for non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package.

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