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Embedded Out-of-pocket Maximum for Family Coverage

The Affordable Care Act (ACA) requires non-grandfathered health plans to include an annual limit on total enrollee cost sharing for essential health benefits (EHB). This annual limit is often referred to as an "out-of-pocket maximum" or "maximum out-of-pocket" (MOOP).

Recent guidance from the Department of Health and Human Services (HHS) and the Department of Labor (DOL) provides that, effective for plan years beginning on or after **January 1, 2016**, non-grandfathered health plans must apply the ACA's self-only MOOP to all individuals, regardless of whether they have self-only or family coverage.

This guidance requires group health plans to embed an individual out-of-pocket maximum in the plan's family coverage when the family out-of-pocket maximum exceeds the ACA's out-of-pocket maximum for self-only coverage. This guidance applies to **all non-grandfathered group health plans**, including self-funded plans and insured plans of all sizes. However, it will likely have the biggest impact on high deductible health plans (HDHPs) because these plans have higher cost-sharing limits.

ACA COST-SHARING LIMIT

The ACA's limit on total enrollee cost sharing became effective for plan years beginning on or after Jan. 1, 2014. It applies to all non-grandfathered plans. This includes, for example, non-grandfathered self-insured health plans and insured health plans of any size. The ACA's out-of-pocket maximum for EHB does not apply to plans with grandfathered status.

Cost sharing includes any expenditure required by or on behalf of an enrollee with respect to EHB, such as deductibles, copayments, coinsurance and similar charges. It excludes premiums and spending for noncovered services.

The ACA's out-of-pocket maximum limits for EHB are as follows:

	2014	2015	2016
Self-only Coverage	$6,350	$6,600	$6,850
Family Coverage	$12,700	$13,200	$13,700

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.

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HDHP/HSA RULES

Federal tax law also imposes a minimum deductible and an out-of-pocket maximum on HDHPs that are compatible with health savings accounts (HSAs). The HDHP out-of-pocket maximum is less than the ACA's out-of-pocket maximum. In order for a health plan to qualify as an HDHP, the plan must comply with the lower out-of-pocket maximum for HDHPs.

With the exception of preventive care benefits, no benefits can be paid by an HDHP until the minimum annual deductible has been satisfied.

The cost-sharing limits for HDHPs are as follows:

Type of Limit		2014	2015	2016
HDHP Minimum Deductible	Self-only	$1,250	$1,300	$1,300
	Family	$2,500	$2,600	$2,600
HDHP Out-of-pocket Maximum	Self-only	$6,350	$6,450	$6,550
	Family	$12,700	$12,900	$13,100

The minimum deductible and out-of-pocket expense limits for HDHP coverage are adjusted for increases in the cost-of-living. By June 1 of each calendar year, the IRS publishes the cost-of-living adjustments that will become effective as of the next Jan. 1. For HDHPs with non-calendar plan years, the adjusted limits for the calendar year in which the HDHP's plan year begins can be applied for that entire plan year.

EMBEDDED OUT-OF-POCKET MAXIMUM

Currently, most group health plans that offer self-only and family coverage have separate out-of-pocket maximums for these levels of coverage, and do not apply the self-only MOOP to individuals who have family coverage. For example, if a plan has a $6,000 MOOP for self-only coverage and a $12,000 MOOP for family coverage, individuals who have family coverage would have their expenses paid at 100 percent for a year, only after the family satisfies the $12,000 MOOP, even if one individual incurred all of the out-of-pocket expenses. According to HHS and the DOL, this type of plan design is no longer permitted for non-grandfathered plans, effective for plan years beginning in or after 2016.

On Feb. 27, 2015, HHS issued its 2016 Notice of Benefit and Payment Parameters under the ACA. In the preamble to this final rule, HHS stated that the ACA's annual out-of-pocket maximum for self-only coverage applies to **all individuals**, regardless of whether an individual is covered by self-only coverage or coverage other than self-only (that is, family coverage).

> ***Example:*** If an HDHP's family coverage has a $10,000 out-of-pocket maximum and one individual in the family coverage incurs $20,000 in expenses from a hospital stay, then that individual would only be responsible for paying the cost sharing related to the costs of the hospital stay covered as an EHB up to the annual limit on cost sharing for self-only coverage ($6,850 for 2016).

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In addition, on May 8, 2015, HHS issued an FAQ explaining how this new guidance affects HDHPs with family deductibles that are higher than the ACA's cost-sharing limit for self-only coverage.

According to HHS' FAQ, for 2016:

- An issuer can offer a family HDHP with a $10,000 family deductible, as long as it applies a maximum annual limitation on cost sharing of $6,850 to each individual in the plan, even if the family $10,000 deductible has not yet been satisfied. This standard does not conflict with IRS rules on HDHPs.
- Except for preventive care, an HDHP cannot provide benefits for any year until the minimum annual deductible for that year has been met ($2,600 for family coverage for 2016). Because the $6,850 self-only maximum annual limitation on cost sharing exceeds the 2016 minimum annual deductible amount for family HDHP coverage ($2,600), it will not cause the plan to fail to satisfy the requirements for a family HDHP.

On May 26, 2015, the DOL issued an FAQ to clarify the application of the new guidance to self-funded and large group health plans and the effective date for the new guidance. In the FAQ, the DOL confirmed that:

- Like the ACA's out-of-pocket maximum for EHB, the requirement that the self-only MOOP be applied to all individuals (regardless of whether they are enrolled in self-only or family coverage) applies to **all non-grandfathered group health plans**. There are no exceptions for self-funded plans and large group health plans.
- This new requirement does not apply to 2015 plan years. It applies to plan years that begin in or after 2016.

The DOL also provided the following example of how the embedded individual MOOP should be applied when a group health plan has a family MOOP that exceeds the ACA's out-of-pocket maximum for self-only coverage.

Example: Assume that a family of four individuals is enrolled in family coverage under a group health plan in 2016 with an aggregate annual limitation on cost sharing of $13,000 for all four enrollees. Assume that individual #1 incurs claims associated with $10,000 in cost sharing, and that individuals #2, #3 and #4 each incur claims associated with $3,000 in cost sharing (in each case, absent the application of any annual limitation on cost sharing). In this case, under the new guidance discussed above, because the self-only maximum annual limitation on cost sharing ($6,850 in 2016) applies to each individual, cost sharing for individual #1 for 2016 is limited to $6,850, and the plan is required to bear the difference between the $10,000 in cost sharing for individual #1 and the maximum annual limitation for that individual, or $3,150. With respect to cost sharing incurred by all four individuals under the policy, the aggregate $15,850 ($6,850 + $3,000 + $3,000 + $3,000) in cost sharing that would otherwise be incurred by the four individuals together is limited to $13,000, the annual aggregate limitation under the plan, under the assumptions in this example, and the plan must bear the difference between the $15,850 and the $13,000 annual limitation, or $2,850.

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