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HHS Creates A New Out-of-Pocket Limit For Health Plans: Health and Human Services

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In case you missed this development—which was buried in the preamble of a 129-page *Federal Register* notice dealing mainly with rules for the individual and small group markets—***Health and Human Services, or HHS***, has created a new ***out-of-pocket limit*** for group ***health plans*** that provide family coverage. HHS says that the limit for self-only coverage applies to each individual who has family coverage. This new individual limit is in addition to the existing limit for family coverage, which applies to the aggregate costs of the covered individuals.

ACA Out-of-Pocket Limits

Many employers were surprised to learn back in 2013 that the Affordable Care Act limits out-of-pocket spending for essential health benefits under non-grandfathered group health plans, including self-insured plans. The limits are indexed for inflation: in 2016, the ACA limits will be $6,850 for self-only coverage and $13,700 for family coverage. “Family” coverage is any coverage that applies to more than one person: for example, employee-plus-one coverage is family coverage for purposes of the out-of-pocket limits.

The ACA limits are based on the out-of-pocket limits for high-deductible health plans (although the method of indexing the limits for inflation is different, with the result that the dollar amounts don’t match). The out-of-pocket limit for family coverage under an HDHP is an “umbrella” limit: the limit applies to the aggregate out-of-pocket costs of all covered family members, regardless of which family member incurs the expense. The HDHP out-of-pocket limit for self-only coverage is not applicable to family coverage. Employers assumed that the ACA out-of-pocket limits would apply in the same way.

HHS “Clarifies” The ACA Out-of-Pocket Limits

In the preamble of the Notice of Benefit and Payment Parameters for 2016, published in late February, HHS announced that any coverage other than self-only coverage will be subject to both the family out-of-pocket limit *and* the individual out-of-pocket limit. As a result, if one member of a family incurs costs for essential health benefits that exceed the out-of-pocket limit for self-only coverage, the plan will have to pay 100% of that family member’s remaining expenses, even if the aggregate costs

of all family members have not yet reached the out-of-pocket limit for family coverage.

It is not clear that HHS's interpretation is supported by the statute. The preamble acknowledges that some commenters have questioned "whether this clarification was within the Congressional intent of the statute," but the agency does not offer a substantive response to this objection. It is also unclear how the "clarification" in the preamble coordinates with the language of the regulation, which nowhere suggests that the limit for self-only coverage also applies to individuals with family coverage.

Which Plans Are Subject To The New Rule?

HHS has jurisdiction to interpret the provisions of ACA that apply to individual insurance and insurance in the small group market, and the provisions of the Public Health Service Act that apply to group health plans maintained by governmental employers. Many ACA provisions—including the out-of-pocket limits—are incorporated in ERISA and the Internal Revenue Code, which are administered by the Department of Labor and the IRS. The agencies normally issue joint interpretations of the provisions that affect all three statutes.

It is odd that HHS would adopt an interpretation of one of these shared provisions without involving the other agencies, particularly when its interpretation differs so fundamentally from the IRS's interpretation of the HDHP out-of-pocket limits on which the ACA limits are based. Nevertheless, all three statutes incorporate the same out-of-pocket limits; and although the agencies have jointly issued "sub-regulatory" guidance, HHS alone is responsible for the regulation that implements the ACA cost-sharing limits.

There is no basis for concluding that the ACA out-of-pocket limits applicable to individual and small group insurance would apply differently to self-insured plans. Because HHS has characterized its new interpretation as a "clarification" that does not require any amendment to its existing regulation, the new rule apparently is self-executing: it applies to all plans that are subject to the ACA limits, including self-insured employer group health plans.

Problems For HDHPs

Although the new ACA rule apparently applies to all non-grandfathered group health plans, including (but not limited to) HDHPs, the new rule is likely to create special headaches for HDHPs with deductibles that exceed the minimum statutory deductible. For example, suppose an HDHP offers family coverage in 2016 that is subject to an $8,000 deductible and a $12,500 out-of-pocket limit. If one family member incurs $6,850 in out-of-pocket expenses (the ACA self-only limit for 2016), the HDHP must cover the individual's remaining expenses for essential health benefits, even though the family has not reached (and might never reach) the $8,000 family deductible.

As long as the ACA self-only limit remains above the minimum family deductible under the HDHP rules (which is $2,600 in 2015—the 2016 minimum has not yet been announced), the plan in our example will not violate the HDHP rules. By forcing the plan to pay expenses of an individual when the plan's deductible has not been reached, however, the ACA limit compromises a fundamental aspect of the plan's design.

When Is The New Rule Effective?

The fact that HHS has characterized the new rule as a "clarification" of the existing ACA out-of-

pocket limits suggests that rule has been part of the out-of-pocket limits since 2014, when the ACA limits first became effective. Alternatively, since the new rule appears in the preamble of a regulation that generally becomes effective on April 28, 2015, one might conclude that the rule has a 2015 effective date.

It appears, however, that HHS intends that the new rule will not become effective until 2016. The preamble states, “We note that 2016 plans must comply with this policy.” The agency has created a “Cost Sharing FAQ” that also indicates that the rule is effective starting in the 2016 plan year. We have not posted the FAQ here, because it is labeled as an internal agency document (although it is available on some non-HHS Internet sites). We have requested that HHS publish the FAQ on its public website so that the information will be available to all affected group health plan sponsors.

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