Legislative Update

Health Care Reform: 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 ACA, "essential health benefits" must be equal in scope to benefits covered by a typical employer plan and must include items and services in ten general categories, such as hospitalization, prescription drugs and maternity and newborn care.

The cost-sharing limits include both 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 essential health benefits that addresses ACA's cost-sharing limits for health plans.

AFFECTED PLANS

Grandfathered plans are not subject to ACA's limits on cost sharing. There has been some uncertainty regarding which types of non-grandfathered plans must comply with ACA's cost-sharing limits that become effective in 2014. However, the final rule provides the following guidance on the types of health plans that must comply with each of these cost-sharing limits:

- ***Annual Deductible Limit:*** ACA states that the annual deductible limit applies to health plans offered in the small group market. In the final rule, HHS confirms that ACA's annual deductible limit applies only in the insured small group market. The small group market is defined under state law. Thus, the annual deductible limit does not apply to self-insured plans or large group market plans.
- ***Out-of-pocket Maximum:*** Unlike ACA's annual deductible limit, which references health plans in the small group market, ACA's out-of-pocket maximum broadly refers to "health plans." The final rule provides that ACA's out-of-pocket maximum applies to *all* non-grandfathered health plans. This would include, for example, self-insured health plans and insured health plans of any size.

COST-SHARING LIMITS

Annual Deductible

Effective for plan years beginning in 2014, the annual deductible for a health plan in the small group market may not exceed **$2,000 for self-only coverage** and **$4,000 for family coverage**.

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 annual deductible limit.

For plan years beginning after 2014, HHS will increase the annual deductible limits by the "premium adjustment percentage," which is set by HHS and will be

announced by HHS annually. The premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds the average per capita premium for health insurance for 2013.

According to HHS, ACA permits, but does not require, contributions to health flexible spending arrangements (FSAs) to be taken into account when determining the annual deductible. In the final rule, HHS standardizes the maximum deductible for all group health plans in the small group market and **does not increase the deductible levels for amounts available under health FSAs**. According to HHS, the final rule does not increase the deductible levels to take into account health FSA contributions due to operational complications with this type of determination. However, HHS notes that it will revisit this policy in later years.

Also, it is possible that states may interpret this ACA provision differently and allow issuers in their small group markets to increase the deductible limit for amounts available under health FSAs. For example, the Wisconsin Office of the Commissioner of Insurance released a bulletin on July 2, 2013, that allows small group health insurance plans offered outside of the Exchange to increase the maximum deductible by employer health FSA contributions. HHS has not provided any formal guidance on how it will respond to varying state interpretations of ACA's annual deductible limit.

Also, the final rule provides that a health plan's annual deductible may exceed the ACA limit if a plan could not reasonably reach the actuarial value of a given level of coverage (that is, a metal tier - bronze, silver, gold or platinum) without exceeding the limit.

Out-of-pocket Maximum

Effective for plan years beginning on or after Jan. 1, 2014, ACA places annual limits on total enrollee cost-sharing for essential health benefits. Once the limitation on cost-sharing is reached for the year, the enrollee is not responsible for additional cost-sharing for essential health benefits for the remainder of the year. According to HHS, the annual limit on cost-sharing, or 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.

Cost-sharing includes any expenditure required by or on behalf of an enrollee with respect to essential health benefits, 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 limit.

ACA's cost-sharing limit is tied to the enrollee out-of-pocket maximum for HSA-compatible high deductible health plans (HDHPs). There are separate limits for self-

only coverage and coverage other than self-only coverage (that is, family coverage). On May 2, 2013, the IRS released Revenue Procedure 2013-25 to provide the inflation-adjusted HSA amounts for 2014. For 2014, the out-of-pocket maximum cannot exceed **$6,350 for self-only coverage** and **$12,700 for family coverage**.

For plan years beginning after 2014, HHS will increase the cost-sharing limits by the premium adjustment percentage, similar to increases in the annual deductible limit.

Transition Relief – Plans with Multiple Service Providers

A set of frequently asked questions (FAQs) issued in conjunction with the final rule address how ACA's out-of-pocket maximum applies to plans that utilize more than one service provider to help administer benefits (for example, a third-party administrator for major medical coverage, a separate pharmacy benefit manager and a separate managed behavioral health organization). Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. According to the FAQs, these processes will need to be coordinated to comply with the annual 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, where a group health plan or group health insurance issuer utilizes 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 both of the following conditions are met:

- 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 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 ACA.