New HHS Regulations "Clarify" that Health Plans Covering Families Must Have "Embedded" Individual Cost-Sharing Limits

On February 27, 2015, the Department of Health and Human Services (HHS) released its final HHS Notice of Benefit and Payment Parameters for 2016. The lengthy regulation covers a wide range of topics affecting group health plans, including minimum value, determination of the transitional reinsurance fee, and qualified health plan rates and other market reforms applicable to the group and individual insurance markets.

Within the portion of the regulation's Preamble explaining insurance issuer standards under the Affordable Care Act ("ACA"), HHS formally adopted a "clarification" to the application of annual cost sharing limitations. By way of background, the ACA requires that all non-grandfathered group health plans adopt an annual cost sharing limit for covered, in-network essential health benefits for self-only coverage ($6,600 in 2015 and $6,850 in 2016) and other than self-only coverage ($13,200 in 2015 and $13,700 in 2016). Until HHS's clarification, many group health plan administrators applied a single limitation depending on whether the employee enrolled in self-only or other than self-only coverage (e.g., "family" coverage). That is, if an employee enrolled in family coverage, the higher limit applied to the family as a whole, regardless of the amount applied to any single covered individual.

HHS, however, now requires group health plans to embed an individual cost sharing limit within the family limit. For example, suppose an employee and his or her spouse enroll in family coverage with an annual cost sharing limit of $13,000, and during the 2016 plan year, $10,000 of cost sharing payments are attributable to the spouse and $3,000 of cost sharing payments are attributable to the employee. Prior to the HHS's clarification, the full $13,000 would be payable by the covered individuals because the $13,000 plan limit had not been reached on an aggregate basis. However, with the new embedded self-only limitation, the cost sharing payments attributable to the spouse must be capped at the self-only limit of $6,850, with the remaining $3,150 being covered 100% by the group health plan. The employee would still be subject to cost sharing, however, until the $13,000 plan limit is reached.

The HHS clarification is not effective until plan years beginning on or after January 1, 2016. It is important to note that, at the moment, it is unclear whether the HHS clarification is intended to apply to self-insured plans. The 2016 Benefit and Payment Parameters are rules related to the group and individual insured market, including the Marketplace, and the Preamble section under which the clarification is found is titled "Health Insurance Issuer Standards under the Affordable Care Act, Including

Standards Related to Exchanges." Additionally, all previous cost sharing guidance applicable to self-insured plans have been issued jointly by the HHS, Department of Treasury and Department of Labor. As of the date of this blog entry, the Departments of Treasury and Labor have not issued a similar clarification. Nevertheless, although the HHS clarification is potentially unenforceable with respect to self-insured plans, employers and plans sponsors with self-insured plans should be prepared to adopt an embedded cost sharing limit should the other two agencies follow suit.

Peter Marathas, Esq.

Compliance Director