



**EXPERT  
UPDATE**

## Health Care Reform - Cost-Sharing Limits for Health Plans

On February 23, 2013, HHS issued a final rule on Essential Health Benefits that addressed the Affordable Care Act's cost-sharing limits for health plans. The limits apply to group health coverage as well as individual coverage sold in the private market and in the Exchange marketplace.

### Health Plans Impacted by the New Regulations

Non-grandfathered health plans must comply with the limits that go into effect in 2014. While there was significant uncertainty prior to the release of these final rules what provisions apply to small group coverage, large group plans and self-insured coverage, we do know now exactly what is required for each type of health plan.

The cost-sharing provisions are divided into two categories, Annual Deductible Limit and Out-of-Pocket Maximum.

- **Annual Deductible Limit:** In the final rule, HHS confirms that the Act's annual deductible limit applies only in the insured small group market which is defined under state law. The annual deductible limit **does not apply** to self-insured plans or large group market plans.

The annual deductible limit for a health plan in the small group market **may not exceed \$2,000 for single-only coverage and \$4,000 for family coverage**. Health plan deductibles that apply to out-of-network benefits do not count toward the annual deductible limit.

HHS has indicated that the deductible levels do not increase to take into account employer flexible spending account (FSA) contributions although HHS has communicated that they will revisit this determination in the future.

The final rule provides that a health plan's annual deductible may exceed the limit if a plan can not reasonably reach the actuarial value of a given level of coverage (i.e., bronze, silver, gold or platinum) without exceeding the limit.

- **Out-of-pocket Maximum:** Unlike the annual deductible limit, which references health plans in the small group market, the out-of-pocket maximum broadly refers to "health plans." The final rule provides that the Act's out-of-pocket maximum applies to **all non-grandfathered health plans**, which means that this limit applies to self-insured health plans and insured health plans **of any size**. The annual limit applies to an enrollee's cost-sharing for essential health benefits. Cost-sharing includes any expense required by or on behalf of an enrollee with respect to essential health benefits, such as deductibles, co-pays, coinsurance, and other similar charges. The limit does not apply to

premiums or services that are considered “non-covered,” and for plans that include cost-sharing for out-of-network benefits, the limit does not apply to this out-of-pocket expense as well.

The Act ties the out-of-pocket cost-sharing limit to the out-of-pocket maximum for HSA compatible high deductible health plans. For 2014, the out-of-pocket maximum cannot exceed \$6,350 for self-only coverage and \$12,700 for family coverage.

Resource: <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>

Refer to DOL FAQ (Q2) for 2014 transition relief when two or more service providers are involved in the administration of a health plan: <http://www.dol.gov/ebsa/faqs/faq-aca12.html>

Join the Conversation:



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