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BENEFITS BRIEF

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Applicability of the Embedded MOOP to Large Group and Self-Funded Plans

Informal guidance from the Department of Labor ("DOL") and the Department of Health and Human Services ("HHS") (the Departments) has called into question a common practice of high deductible health plans regarding how out of pocket maximums are applied.

Generally, where a high deductible health plan offers self and family coverage, the out of pocket maximum for self-only coverage is not applied for individuals who are enrolled in family coverage. For example, if the self-only coverage out of pocket maximum is $6,000, and the family maximum is $12,000, the plan would not pay at 100% until the family maximum is met, even if that means all of the costs are attributable to one individual. This plan design is expressly permitted by the Internal Revenue Service in its guidance for health savings accounts (HSAs) and high deductible health plans.

DOL and HHS are now saying informally that typical plan design is no longer permitted by the Affordable Care Act ("ACA") --i.e., the maximum self-only limit for HSAs and high deductible health plans must be applied to individuals enrolled in family plans. This is known as the so-called "embedded" maximum out of pocket ("MOOP") rule. The Departments are also indicating that the change is effective for plan years beginning on or after January 1, 2016. There is some possibility that the agencies will issue more clarifying guidance, but in the absence of such guidance plan sponsors should carefully evaluate the risks of retaining their current plan design.

This Benefits Brief provides background regarding the cost-sharing provisions under the ACA and summarizes the recent guidance on cost-sharing issued by the Departments. Finally, it clarifies the applicability of the embedded MOOP to large group and self-funded group health plans.

Background

On February 27, 2015, HHS issued its 2016 Notice of Benefit and Payment Parameters ("NBPP"), a rulemaking that primarily applied to individual and small group market plans offered through an Exchange, but also included rules of more general applicability to insured plans.

As part of the Preamble guidance to the 2016 NBPP, HHS clarified that it interprets the annual limitation on cost sharing provision to require that the limit for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only. In other words, there is an "embedded" individual out of pocket maximum even within a family plan, so that an individual's cost sharing for the essential health benefits may never exceed the self-only annual limitation on

cost sharing.

For example, if a family plan has an annual limitation on cost sharing of $12,000 and one individual in the family plan incurs $20,000 in expenses from a hospital stay, that particular individual would only be responsible for paying the cost sharing related to the costs of the hospital stay covered as essential health benefits up to the annual limit on cost sharing for self only coverage (proposed to be $6,850 for 2016).

As of May 20, 2015, the Departments have not issued rules implementing section 2707(b) or any guidance that states that HHS's embedded MOOP requirement applies to either large insured group health plans or self-funded group health plans of any size.

Embedded MOOP Limits for Large Group and Self-funded Plans

The lack of clear guidance regarding the applicability of the embedded MOOP to the large group and self-funded plans has created uncertainty in these markets. Despite the lack of clarity on this issue, it appears that the Departments do intend to require large group and self-funded plans to comply with the "embedded MOOP" requirements implemented in the 2016 NBPP. The Departments are primarily relying on the cross-reference in section 2707(b) of the Public Health Service Act to extend the embedded MOOP requirement to large group and self-funded plans.

We are concerned that the Departments have not provided clearer guidance of their intent to apply this interpretation to large group and self-funded group health plans. As a result, employers and plan sponsors have not had the opportunity to comment on the costly new requirement or, at the very least, had time to redesign their benefit plans and reprogram their systems. We are also concerned that there could be widespread inadvertent noncompliance by self-insured plans that would not normally even look to HHS guidance for fully-insured individual market and small group plans. We note that DOL's recent posting of the HHS embedded MOOP-related guidance on its website is an effort to alert the employer community of this requirement, but those two FAQs are specifically limited to how "issuers" can be in compliance with the new guidance (including how issuers must file the templates required when offering coverage through an Exchange) and there is no explanation regarding why DOL posted the HHS FAQs. Therefore this posting does little to clear up the confusion.

We will continue to monitor this situation closely. Please contact any of the attorneys in the Health and Welfare Practice Group at Groom Law Group or your regular Groom Law Group attorney for further information.