FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXVII)

May 26, 2015

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at http://www.dol.gov/ebsa/healthreform/ and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the Affordable Care Act and benefit from it, as intended.

Limitations on Cost Sharing under the Affordable Care Act

Public Health Service (PHS) Act section 2707(b), as added by the Affordable Care Act, provides that a non-grandfathered group health plan shall ensure that any annual cost sharing imposed under the plan does not exceed the limitations provided for under section 1302(c)(1) of the Affordable Care Act. Under section 1302(c)(1), an enrollee's out-of-pocket costs for essential health benefits are limited.[1]

For plan or policy years beginning in 2015, the maximum annual limitation on cost sharing under section 1302(c)(1) is $6,600 for self-only coverage and $13,200 for coverage other than self-only coverage.[2] For plan or policy years thereafter, the maximum annual limitation on cost sharing (also referred to as the maximum annual limitation on out-of-pocket costs) is increased by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4). For plan or policy years beginning in 2016, the maximum annual limitation on cost sharing is $6,850 for self-only coverage and $13,700 for other than self-only coverage.

In the final HHS Notice of Benefit and Payment Parameters for 2016 (2016 Payment Notice) (80 FR 10750), HHS clarified that under section 1302(c)(1) of the Affordable Care Act, the self-only maximum annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or in coverage other than self-only. In response to this clarification, the Departments received questions regarding the application of the clarification to self-funded and large group health plans. The Departments are issuing the following FAQs to address these questions from stakeholders.

Q1. The 2016 Payment Notice clarified that under section 1302(c)(1) of the Affordable Care Act, the self-only maximum annual limitation on cost sharing applies to each

[1] This annual limitation also applies to non-grandfathered individual market coverage through the essential health benefits requirements of PHS Act section 2707(a). On April 1, 2014, Public Law No. 113-93 was enacted. Section 213 of that law repeals the limitation on deductibles under plans offered in the small group market that was previously required under section 2707(b) of the PHS Act and section 1302(c)(2) of the Affordable Care Act.

[2] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 FR 30240 (May 27, 2014).

individual, regardless of whether the individual is enrolled in self-only coverage or in coverage other than self-only. Does PHS Act section 2707(b) apply this requirement to all non-grandfathered group health plans?

Yes. PHS Act section 2707(b) applies this requirement to all non-grandfathered group health plans, including non-grandfathered self-insured and large group health plans**.** The Departments read section 2707(b) as requiring non-grandfathered group health plans to comply with the maximum annual limitation on cost sharing promulgated under section 1302(c)(1) of the Affordable Care Act,[3] including the HHS clarification that the self-only maximum annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or in coverage other than self-only. Accordingly, the self-only maximum annual limitation on cost sharing applies to an individual who is enrolled in family coverage or other coverage that is not self-only coverage under a group health plan.

Example: Assume that a family of four individuals is enrolled in family coverage under a group health plan in 2016 with an aggregate annual limitation on cost sharing for all four enrollees of $13,000 (note that a plan is permitted to set an annual limitation below the maximum established under section 1302(c)(1), which is an aggregate $13,700 limitation for coverage other than self-only for 2016). Assume that individual #1 incurs claims associated with $10,000 in cost sharing, and that individuals #2, #3, and #4 each incur claims associated with $3,000 in cost sharing (in each case, absent the application of any annual limitation on cost sharing). In this case, because, under the clarification discussed above, the self-only maximum annual limitation on cost sharing ($6,850 in 2016) applies to each individual, cost sharing for individual #1 for 2016 is limited to $6,850, and the plan is required to bear the difference between the $10,000 in cost sharing for individual #1 and the maximum annual limitation for that individual, or $3,150. With respect to cost sharing incurred by all four individuals under the policy, the aggregate $15,850 ($6,850 + $3,000 + $3,000 + $3,000) in cost sharing that would otherwise be incurred by the four individuals together is limited to $13,000, the annual aggregate limitation under the plan, under the assumptions in this example, and the plan must bear the difference between the $15,850 and the $13,000 annual limitation, or $2,850.

Q2. Does the clarification of section 1302(c)(1) of the Affordable Care Act apply for plan or policy years that begin in 2015?

No. The Departments will apply this clarification only for plan or policy years that begin in or after 2016.

[3] See preamble to the HHS final regulation on standards related to essential health benefits at 78 FR 12834 (Feb 25 2013). See also section 1251 of the Affordable Care Act, which limits the application of PHS Act section 2707 to non-grandfathered group health plans and health insurance coverage and Affordable Care Act Implementation FAQs Part XXII, available at http://www.dol.gov/ebsa/faqs/faq-aca12.html. See also CMS guidance released on November 14, 2013 and extended on March 5, 2014, which provides transitional relief for certain individual market and small group market plans with respect to specified market reforms, including PHS Act section 2707, available at http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF and http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf.

Q3. Does the clarification of section 1302(c)(1) of the Affordable Care Act apply to self-only coverage or other coverage that is not self-only coverage under a high-deductible health plan (HDHP) as defined at section 223(c)(2) of the Internal Revenue Code?

Yes. The clarification of section 1302(c)(1) also applies to non-grandfathered HDHPs.

Provider Non-Discrimination

PHS Act section 2706(a), as added by the Affordable Care Act, states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law." PHS Act section 2706(a) "shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer," and nothing in PHS Act section 2706(a) prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." Similar language is included in section 1852(b)(2) of the Social Security Act[4] and HHS implementing regulations.[5]

On April 29, 2013, the Departments issued FAQs,[6] which addressed, among other issues, provider nondiscrimination requirements under PHS Act section 2706(a). Subsequently, the Senate Committee on Appropriations issued a report dated July 11, 2013 (to accompany S. 1284) raising questions about the Departments' FAQs addressing provider nondiscrimination.[7] The Departments published a request for information (RFI) on March 12, 2014, seeking comment on

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[4] Section 1852(b)(2) of the Social Security Act provides that "A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan."

[5] 42 CFR 422.205 provides, in part, that a "[Medicare Advantage (MA)] organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected [*sic*] provider(s) of the reason for the decision." Section 422.205 further provides that it "does not preclude any of the following [actions] by the MA organization: (1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis); (2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty; [and] (3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities."

[6] See FAQs about Affordable Care Act Implementation Part XV, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.

[7] S. Rep. No. 113-71, at 126 (2013). Additionally, in Title I of the report, regarding the Department of Labor Employee Benefits Security Administration, the Committee "directs the Department to work with HHS and the Department of the Treasury to revise their joint FAQ regarding section 2706 of the ACA, as explained in the HHS title of this report." Id. at 27.

all aspects of interpretation of PHS Act section 2706(a).[8] The RFI specifically solicited comments on access, costs, other federal and state laws, and feasibility. The Departments received over 1,500 comments in response to the RFI. The House Committee on Appropriations subsequently issued an explanatory statement dated December 11, 2014 (to accompany 113 H.R. 83),[9] directing the Centers for Medicare & Medicaid Services to provide a corrected FAQ or provide an explanation.

The Departments are issuing the following FAQs in response to the December 11, 2014 explanatory statement.

Q4. What is the Departments' approach to PHS Act section 2706(a)?

In light of the breadth of issues identified in the comments to the RFI, the Departments are re-stating their current enforcement approach to PHS Act section 2706(a). Until further guidance is issued, the Departments will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision, which states:

> A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

Q5. Does Q2 in FAQs about Affordable Care Act Implementation Part XV continue to apply?

No. Q2 in FAQs about Affordable Care Act Implementation Part XV, which previously provided guidance from the Departments on PHS Act section 2706(a), is superseded by this FAQ and notation will be made on the Departments' websites to reflect this modification.

The Departments will continue to work together with employers, plans, issuers, states, providers, and other stakeholders to help them comply with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

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[8] 79 FR 14051 (March 12, 2014).

[9] 160 Cong. Rec. H9837 (daily ed. Dec. 11, 2014).