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SPECIAL BULLETIN

New FAQ Clarifies 2016 Plan Year MOOP Limit for Non-Grandfathered Plans

FAQ on "Provider Non-Discrimination" Removed

The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) just released *ACA* FAQ Set XXVII which clarifies the application of recent guidance in the HHS Notice of Benefit and Payment Parameters for 2016 ("HHS Notice"), as well as addressing the "non-discrimination in providers" rule.

2016 Plan Year MOOP Limit for Non-Grandfathered Plans

The HHS Notice clarified that under Section 1302(c)(1) of the *Affordable Care Act* (*ACA*), the "self-only" annual maximum out-of-pocket (MOOP) 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."

However, because guidance that is generally applicable to self-funded and large group health plans is usually released as a tri-agency release by the Departments, there was some confusion as to whether the HHS Notice guidance MOOP and the follow-up HHS FAQ (that was later posted to the DOL website) applied to self-funded and large group health plans.

The new FAQs answer that question in the affirmative.

Beginning with the 2016 Plan Year, non-grandfathered self-funded and large group plans, including non-grandfathered self-funded multiemployer group health plans, must follow the FAQs "clarification" on how the annual MOOP limit applies. The MOOP limit is referred to in the *ACA* as a "cost-sharing" limit where cost sharing is defined as "*deductibles, coinsurance, copayments, or similar charges."* The annual MOOP cost sharing limit does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

The 2016 Plan Year annual MOOP limit for non-grandfathered large group, self-insured plans and high-deductible health plans (HDHPs) can be no more than

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$6,850 for "*self-only*" coverage and no more than $13,700 for "*other than self-only*" coverage. Plans can set their own MOOP limits at a lower amount. FAQ 1 concludes that the "*self-only*" MOOP limit applies to an individual who is enrolled in "*family coverage*" or other coverage that is "*not self-only coverage*" under a group health plan.

Fortunately, an example has been provided. The example assumes a family of four individuals that is enrolled in family coverage under a group health plan in 2016 with a annual MOOP limit on cost sharing for all four enrollees of $13,000. Individual #1 incurs claims associated with $10,000 in cost sharing, and individuals #2, #3 and #4 each incur claims associated with $3,000 in cost sharing. In this case, under the clarification discussed above, the *self-only* MOOP of $6,850 applies to each individual; therefore, cost sharing for individual #1 for 2016 is limited to $6,850 (NOT $13,000), and the plan is required to bear the $3,150 difference between the $10,000 in cost sharing for individual #1 and the $6,850 annual MOOP limit for that individual.

With respect to the cost sharing incurred by all four individuals under the plan, the total of $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 MOOP limit under the plan. Under the assumptions in this example, the plan must bear the $2,850 difference between the $15,850 incurred cost-sharing and the plan's $13,000 annual MOOP limit.

Provider Non-Discrimination

The *ACA* 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." For background on the "non-discrimination" rule see *Benefit News Briefs 2013-68*.

The Departments had released a set of FAQs on this non-discrimination rule (FAQ 2) which drew the attention of some members of Congress such that the Departments are withdrawing that FAQ as these new FAQs supersede the prior ACA Set XV FAQ on the subject. Details of that history are detailed in the FAQs.

The Departments also published a request for information (RFI) seeking comment on all aspects of interpretation of this section of the law. In light of the over 1,500 comments in response to the RFI, the Departments re-stated their current enforcement approach as follows:

> Until further guidance is issued, the Departments will not take any enforcement action against a group health plan with respect to implementing these requirements as long as the plan is using a good faith, reasonable interpretation of the statutory provision.

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