



# AMERICAN BENEFITS COUNCIL

June 17, 2015

Phyllis C. Borzi  
Assistant Secretary of Labor  
Employee Benefits Security  
Administration  
U.S. Department of Labor  
200 Constitution Ave, NW  
Washington, DC 20210

Mark Irwy  
Senior Advisor to the Secretary  
Deputy Assistant Secretary for Retirement  
and Health Policy  
U.S. Treasury Department  
1500 Pennsylvania Ave, NW  
Washington, DC 20220

Kevin Counihan  
Director & Marketplace Chief Executive  
Officer  
Center for Consumer Information and  
Insurance Oversight  
U.S. Department of Health and Human  
Services  
200 Independence Ave, SW  
Washington, DC 20201

## **Re: Requirements to “Embed” Maximum Out-of-Pocket Limits**

Dear Assistant Secretary Borzi, Dep. Assistant Secretary Irwy and Director Counihan:

We write to express our serious concerns regarding recent agency Frequently Asked Questions (“FAQ”) guidance requiring “embedded” individual out of pocket maximums for insured large group and self-funded group health plans for 2016 policy and plan years.

As discussed below, we believe the Departments’ recent interpretation regarding the maximum out-of-pocket (“MOOP”) limits under Public Health Service Act (“PHSA”) 2707(b) is inconsistent with the plain language of the statute and Congressional intent.

The Council and its members are particularly concerned that the process used to

impose this new requirement lacked prior and clear notice of the Departments' intent to apply the embedded MOOP interpretation to large group insured and self-funded plans. The timing of this guidance is highly problematic in that most large plan sponsors have finalized their plan designs for plan year 2016 and have insufficient time to comply with this new requirement.

Another significant concern is that this "embedded" MOOP requirement increases plan costs at a time when employers are faced with the challenge of lowering plan costs in order to avoid the 40 percent excise tax on health benefits effective 2018.<sup>1</sup>

In light of these concerns, we request that the FAQ guidance be rescinded and the Departments use notice and comment rulemaking for any future implementation of the PHSa 2707(b) cost-sharing limits. As a first step, we urge the Departments to issue an immediate clarification that the recent FAQ guidance will not apply to 2016 plan or policy years.

## **BACKGROUND**

PHSA Section 2707(b), as added by the Affordable Care Act ("ACA"), 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 ACA. Under Section 1302(c)(1), an enrollee's out-of-pocket costs for essential health benefits are limited.<sup>2</sup>

In the Preamble to the final U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016 ("NBPP") (80 FR 10750) issued February 27, 2015, HHS stated that under Section 1302(c)(1) of the ACA, 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 (for example, family coverage). The HHS interpretation effectively requires an "embedded" individual out-of-pocket maximum such that, even within a family plan, an individual's cost sharing for the essential health benefits ("EHB") may never exceed the self-only annual limitation on cost sharing.

The HHS guidance is specific to how insurers comply with the NBPP with respect to

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<sup>1</sup> Internal Revenue Code 4980I

<sup>2</sup> 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.

qualified health plans sold in the health exchange. The HHS guidance created uncertainty for employers as it did not address the applicability of HHS' embedded MOOP interpretation to large group insured and self-funded plans.

On May 12, 2015, the U.S. Department of Labor ("DOL") posted the previously issued HHS guidance on its website regarding the embedded individual out of pocket maximum, but still did not clarify whether the HHS guidance applied to all non-grandfathered plans, or only the small group and individual insurance market.

The Departments finally clarified that the new embedded MOOP requirement applied to all non-grandfathered plans, including self-funded and large insured group health plans in ACA FAQs Part XXVII issued on May 26, 2015.<sup>3</sup>

#### **"EMBEDDED" MOOPs ARE NOT SUPPORTED BY STATUTE OR CONGRESSIONAL INTENT**

We believe that the Departments' interpretation regarding the MOOP limits is not consistent with the plain language of the statute and is not what Congress intended.

ACA Section 1302(c) requires that the "cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage...shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code *for self-only and family coverage, respectively.*" HHS proposed and finalized an interpretation that for purposes of the cost-sharing requirements, the self-only coverage limit for the annual limitation on cost sharing applies to all individuals regardless of whether the individual has other than self-only coverage. Section 1302(c), however, states that the limits apply *respectively*. This would mean that cost-sharing under self-only coverage cannot exceed the 2014 self-only high deductible health plan ("HDHP") limit adjusted for ACA purposes as outlined under section 1302(c)(1)(B). Similarly, cost-sharing under family coverage cannot exceed the adjusted family HDHP limit.

Code Section 223 (the HDHP provision) is clear that the maximum out-of-pocket limits are separate – one limit for self-only coverage and another limit for family coverage (or coverage other than self-only) – and there is nothing in Code Section 223 which would require an embedded limit on self-only cost-sharing under a family plan. Since Code Section 223 does not require a separate, embedded limit on self-only cost-sharing (in fact, the HDHP rules set specific and *separate* self-only and family cost-

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<sup>3</sup> FAQs About Affordable Care Act Implementation (Part XXVII) May 26, 2015

sharing limits) it strongly implies that, in Section 1302(c), Congress intended one limit for self-only coverage and a separate limit for family coverage.

## **IMPACT ON LARGE GROUP HEALTH PLANS**

Applying the embedded MOOP interpretation to the large group insured and self-funded plans will result in unanticipated costs for 2016 policy and plan years. With 2016 fast approaching, most large plan sponsors have finalized or are very near finalizing their plan designs for the 2016 plan year. To require these sponsors to make plan changes at this late date to implement an embedded MOOP requirement would entail significant time and expense (for example, consulting actuaries to determine premium rates for the modified coverage, implementing programming changes, amending enrollment materials and communicating plan benefit changes to employees and beneficiaries).

Applying the embedded MOOP to the large group insured and self-funded plans is especially problematic given the looming threat of the 40 percent tax on employee benefits, which is effective 2018. Employers are currently making changes to their plans to avoid triggering the 40 percent tax. The embedded MOOP interpretation will make avoiding the tax even more difficult for large group and self-funded plans.

Implementation of the 40 percent tax and benefit mandates --including the embedded MOOP interpretation -- are at odds with each other and put employers in an untenable position. On the one hand, the 40 percent tax is forcing employers to decrease benefits and increase employee cost-sharing -- on the other hand, mandates such as the MOOP interpretation require employers to increase benefit levels. This is not a sustainable path for employer-sponsored coverage.

## **FUTURE INTERPRETATIONS OF ACA COST SHARING LIMITS**

To the extent the Departments intend for the embedded MOOP interpretation to apply to large group insured and self-funded plans, sound public policy strongly advocates in favor of the Departments only doing so through a proposed rulemaking with a public comment period. In fact, the Departments had stated an intent to do so in the Preamble to the 2013 EHB final rule in which HHS explained that the Departments interpret the out of pocket maximum in Section 1302(c)(1) to apply to all markets, including self-insured and large group insured plans, and further stated that the Departments *intend to engage in future rulemaking to implement Section 2707(b) of the PHSA* and noted that Section 45 CFR Section 147.150(b), the regulation section that would apply to insured group health plans, would be reserved (i.e., no applicable regulations were issued). This intent to engage in future rulemaking to implement PHSA 2707(b) was reiterated in FAQs issued simultaneously with the 2013 EBH final rule.

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Thank you for your consideration. We look forward to working with you to resolve these important concerns.

Sincerely,

A handwritten signature in black ink that reads "Kathryn Wilber". The script is cursive and fluid, with a prominent dot over the 'i' in "Wilber".

Kathryn Wilber

C: Amy Turner, EBSA, U.S. Department of Labor  
Christin Young, CMS, HHS