DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: May 8, 2015

Subject: Embedded Self-Only Annual Limitation on Cost Sharing FAQs

Q1. In the final 2016 Notice of Benefit and Payment Parameters (2016 Payment Notice) (80 FR 10750), HHS clarified that the self-only annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in a self-only or other than self-only plan. How should issuers enter information in the Plans and Benefits template to accurately represent cost sharing under this standard?

A1. To accurately record this information, the family fields for the "In Network," "In Network (Tier 2)," and "Out of Network" annual limitation on cost sharing now have additional options. When an issuer selects these fields, a pop-up window will appear, allowing an issuer to enter a per-group amount and a per-person amount. The per-group amount is the total annual limitation when accruing cost sharing for all enrollees on a policy (e.g., the covered members in a family). The per-person amount is the annual limitation that applies separately to each person on a policy (e.g., a dependent covered by the policy).

If a plan is available as other than self-only coverage, an issuer must enter a per-person amount in addition to the per-group amount. The per-person amount for other than self-only coverage must be less than or equal to the annual limitation for self-only coverage ($6,850 in 2016) and for the specific cost-sharing reduction plan variations.

Please refer to section 4.15 of the "Chapter 10: Instructions for the Plans and Benefits Application Section" for guidance on how to enter annual limitations on cost sharing (located here: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html).

Q2. How can an issuer be in compliance with the requirement that the self-only annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in a self-only or in an other than self-only plan, and offer a family high deductible health plan (HDHP) with a $10,000 family deductible?

A2. For 2016, the maximum annual limitation on cost sharing for self-only coverage is $6,850. Consequently, for 2016, an issuer can offer a family HDHP with a $10,000 family deductible, as long as it applies a maximum annual limitation on cost-sharing of $6,850 to each individual in the plan, even if the family $10,000 deductible has not yet been satisfied. This standard does not conflict with IRS rules on HDHPs.

Under the requirements for an HDHP, except for preventive care, an HDHP plan may not provide benefits for any year until the minimum statutory annual deductible for that year has been met. The minimum annual deductible for a family HDHP is $2,600 for 2016. Because the $6,850 self-only maximum annual limitation on cost sharing will exceed the 2016 minimum annual deductible amount for family HDHP coverage, it will not cause the plan to fail to satisfy the requirements for a family HDHP.