

Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions

Frequently Asked Questions (FAQs) # 11

Release Date: May 22, 2013

Cost Sharing

Q1: Do issuers need to update their maximum out-of-pocket and deductible values for certain plans now that the IRS has published the 2014 out-of-pocket limits for high deductible health plans (HDHP)?

A1: The annual limitation on cost sharing (commonly referred to as a maximum out-of-pocket limit) for 2014 is \$6,350 for self-only coverage and \$12,700 for other than self-only coverage. This affects the allowable maximum out-of-pocket value for Essential Health Benefits for all plans submitted in a QHP application. It also affects the allowable deductible value for catastrophic plans.

These limits are slightly lower than the CMS estimates published on April 5, 2013 in the “Letter to Issuers on Federally-facilitated and State Partnership Exchange.” Issuers that have submitted qualified health plan (QHP) applications to State Regulators or CMS with maximum out-of-pocket values above \$6,350 for self-only coverage or \$12,700 for other than self-only coverage will need to revise their applications. If an issuer used the CMS 2014 estimated limit of \$6,400 and \$12,800, the maximum out of pocket values will only need to change by \$50 or \$100, respectively, which will have a very minor impact on actuarial value. It is unlikely that plans in this situation will need to make changes to other cost sharing data elements in order to meet an actuarial value for a given level of coverage under 45 CFR § 156.140.

Q2: When should an issuer participating in a Federally-facilitated Marketplace (FFM) revise their application?

A2: Issuers have already submitted their QHP applications to CMS through the Health Insurance Oversight System (HIOS) and some plans may be out of compliance with the limits for maximum out-of-pocket or deductible values. Issuers in States enforcing the Affordable Care Act market reforms, including the annual limitation on cost sharing, should contact their State Regulator regarding the process and timing for correcting and resubmitting their applications. In States in which CMS is directly enforcing the Affordable Care Act market reforms, CMS will be contacting those issuers and requesting revisions to their applications.



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Selected Responses

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Q3: When should an issuer participating in a State Partnership or State Based Marketplace revise their application?

A3: The issuer should contact their State Regulator regarding the process and timing for correcting and resubmitting their applications if an issuer has already submitted a QHP application to a State Partnership or State Based Marketplace that does not comply with the limits for maximum out-of-pocket or deductible values.