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Cost-sharing Limitations and Preventive Care Coverage Clarified

The Affordable Care Act (ACA) includes many changes related to health care coverage and raises a number of questions for employers. The Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (Departments) jointly provide guidance in the form of Frequently Asked Questions (FAQs) to assist in implementing ACA's changes.

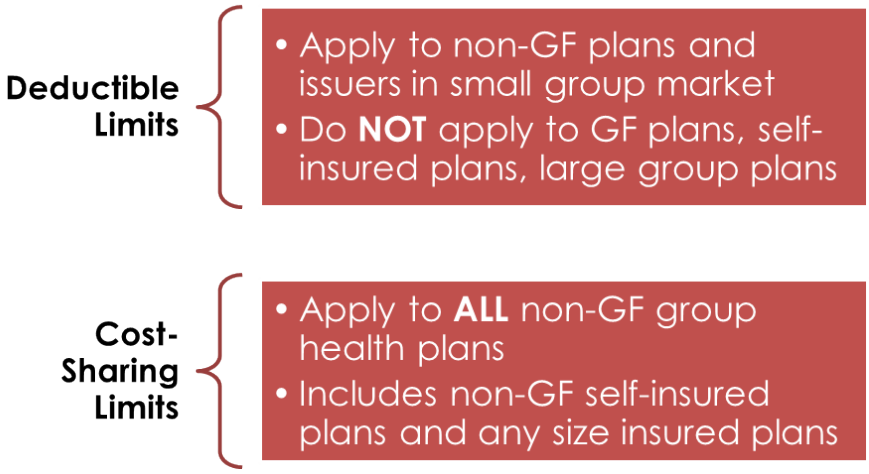
On Feb. 20, 2013, the Departments issued FAQs on the ACA's limitations on cost-sharing and coverage of preventive care services.

LIMITATIONS ON COST-SHARING UNDER THE ACA

The ACA added Public Health Service (PHS) Act section 2707(b). This section requires a group health plan to ensure that any annual cost-sharing imposed under the plan does not exceed the ACA's limitations on out-of-pocket maximums and deductibles for employer-sponsored plans.

These limits are found in Section 1302(c)(1) and (2). Section 1302(c)(1) limits out-of-pocket maximums and section 1302(c)(2) limits deductibles for employer-sponsored plans. The out-of-pocket maximums are tied to the limits under high-deductible health plans and the deductible limits are slated to start at $2,000 for single coverage and $4,000 for other than single coverage.

Due to unclear language in the statute, there has been confusion over which plans are subject to these limits, although grandfathered plans are clearly not subject to these requirements. The FAQs, along with the final rule on essential health benefits issued by HHS, provide clarification on this issue. This information is illustrated below, with additional detail provided in the following sections.



Deductible Limits

The Departments stated that they continue to believe that only non-grandfathered **plans and issuers in the small group market** (that is, small insured plans) are required to comply with the deductible limit described in section 1302(c)(2).

Under this guidance, the annual deductible limit does not apply to self-insured plans or large group market plans. The Departments intend to issue additional rules related to self-insured and large group health plans. Until final guidance is issued and becomes effective, self-insured or large group health plans can rely on the Departments' stated intention to apply the deductible limits only to plans and issuers in the small group market.

Small insured plans are provided some relief in the final rule. A health plan's annual deductible may exceed the ACA limit if a plan could not reasonably reach the actuarial value of a given level of coverage (that is, a metal tier—bronze, silver, gold or platinum) without exceeding the limit.

Out-of-Pocket Maximum Limits

The text of ACA's out-of-pocket maximum limit broadly refers to "health plans." HHS' final rule provides that ***all* non-grandfathered group health plans** will be required to comply with the limitation on out-of-pocket maximums. This would include, for example, self-insured health plans and insured health plans of any size.

The Departments recognize that plans may use more than one service provider to help administer benefits (for example, a third-party administrator for major medical coverage, a separate pharmacy benefit manager and a separate managed behavioral health organization). Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. These processes will need to be coordinated to comply with the annual out-of-pocket maximum limit, which may require new regular communications between service providers.

The Departments have determined that, only for the first plan year beginning on or after Jan. 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual out-of-pocket maximum limit, the annual limit will be satisfied if both of the following conditions are met:

- The plan complies with the out-of-pocket maximum limit with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
- To the extent there is an out-of-pocket maximum on coverage that does not consist solely of major medical coverage, this out-of-pocket maximum does not exceed the maximum dollar amount under ACA.

The Departments note, however, that existing regulations implementing Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibit a group health plan (or health insurance coverage offered in connection with a group health plan) from applying a cumulative financial requirement or treatment limitation, such as an out-of-pocket maximum, to mental health or substance use disorder benefits that accumulates separately from any cumulative financial requirement or treatment limitation established for medical/surgical benefits. Accordingly, under MHPAEA, plans and issuers are prohibited from imposing an annual out-of-pocket maximum on all medical/surgical benefits and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits.

COVERAGE OF PREVENTIVE SERVICES

ACA requires *non-grandfathered* health plans to cover certain preventive health services without imposing cost-sharing requirements for the services. This requirement generally became effective for **plan years beginning on or after Sept. 23, 2010**. It does not apply to grandfathered health plans.

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The FAQs address which specific services non-grandfathered health plans must cover in order to comply with this requirement. Most notably, non-grandfathered health plans must cover:

- ***Contraceptives –*** The FAQs confirm that the preventive care coverage requirements ensure women's access to **the full range of FDA-approved contraceptive methods** including, but not limited to, barrier methods, hormonal methods and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. Thus, a plan or issuer is not permitted to cover *only* oral contraceptives. However, plans and issuers may use reasonable medical management techniques to control costs and promote efficient delivery of care. For example, plans may cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs (although certain limitations apply).
- ***Lactation Counseling and Breastfeeding Equipment and Supplies –*** Coverage of comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding. Nonetheless, plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive item or service, to the extent not specified in the recommendation or guideline.

Additionally, the FAQs address issues relating to out-of-network services, if a plan does not have any in-network providers to provide a particular preventive service required under the ACA. While nothing in the interim final regulations generally requires a plan or issuer that has a network of providers to provide benefits for preventive services provided out-of-network, this provision is premised on enrollees being able to access the required preventive services from in-network providers. Thus, if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.

Source: U.S. Department of Labor