



May 10, 2013

Guidance on Out-of-Pocket Maximums in 2014 for Non-Grandfathered Health Plans

Starting with the first plan year beginning on or after January 1, 2014, the Affordable Care Act¹ will require all non-grandfathered plans, including self-insured plans and insured plans in the large group market, to comply with a new annual limit on cost-sharing, also known as an out-of-pocket maximum. The three federal agencies responsible for implementing the Affordable Care Act — the Departments of Labor, Health and Human Services and Treasury (collectively, the “Departments”) — have issued guidance in the form of answers to frequently asked questions (FAQs)² that begins to explain how these cost-sharing limits will work in 2014.

This *Capital Checkup* provides background information on the annual limitation on out-of-pocket maximums, notes where additional guidance is needed and describes the new guidance.

Background on the Annual Limitation on Out-of-Pocket Maximums in 2014 and Beyond

For the plan year beginning in 2014, the annual limitation on out-of-pocket maximums will be the same as those that apply in 2014 to high-deductible health plans (HDHPs) combined with Health Savings Accounts (HSAs). These maximums are \$6,350 for an individual and \$12,700 for a family.

For 2015 and beyond, the out-of-pocket maximum will be adjusted based on increases in the average per capita premium for health insurance coverage, and will no longer be linked to the out-of-pocket maximums for HDHP/HSAs.

Based on language in the Affordable Care Act and a final rule applicable to Exchange plans,³ it is likely that future rules will define the cost-sharing limit to include deductibles, coinsurance and copayments. Premiums, balance-billing amounts for non-network providers and spending for non-covered services would be excluded. It also appears that the out-of-pocket maximum may apply only to in-network coverage.⁴ Consequently, plans could have an unlimited out-of-pocket maximum for out-of-network coverage. However, this has not been clearly stated by the Departments. It is also unclear whether the cost-sharing limits will apply only to benefits that qualify as essential health benefits under the Affordable Care Act or will apply more broadly.

Transition Rule for Plans Using Multiple Service Providers

The Departments recognize that many plans use multiple service providers to help administer benefits. For example, a plan might use a third-party administrator (TPA) to administer major medical coverage, a pharmacy benefit manager (PBM) for prescription drug coverage and a managed behavioral health organization. In order for a non-grandfathered plan to be able to comply with the annual limit on out-of-pocket maximums, the processes

used by different administrators may have to be coordinated.

The Departments announced a special transition rule for the first plan year beginning on or after January 1, 2014. The Departments will consider the annual limit on out-of-pocket maximums deemed to be met if the following two conditions are met:

- ε The plan complies with the requirement for its major medical coverage (e.g., excluding prescription drug coverage), and
- ε If the plan has an annual out-of-pocket maximum on other coverage (e.g., a separate out-of-pocket maximum applies to drug coverage), that separate out-of-pocket maximum does not exceed the allowed dollar amount.

The Departments further note that the plan must also comply with the Mental Health Parity and Addiction Equity Act (MHPAEA),⁵ which prohibits a separate out-of-pocket maximum for mental health or substance use disorder benefits.

Implications for Non-Grandfathered Plans

Sponsors of non-grandfathered group health plans should begin to plan for the new annual limitation on out-of-pocket maximums for the 2014 plan year. This would include:

- ε Identifying current out-of-pocket maximums, and whether they apply on an in-network only or on both an in-network and out-of-network basis,
- ε Determining whether there are charges that are not counted toward the out-of-pocket maximum, but will now need to be considered, including benefits provided by service provider (e.g. PBM), and
- ε Discussing the new annual limit on out-of-pocket maximums with service providers to determine how they are addressing these new rules.

Plan sponsors should also monitor federal regulations for guidance to address implementation issues.

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As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their legal counsel for authoritative advice on the interpretation and application of the Affordable Care Act and related guidance, including the new guidance summarized in this Capital Checkup. The Segal Company can be retained to work with employers and their attorneys on compliance issues.

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- 1 The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152. The latest answers to FAQs are on the Centers for Medicare & Medicaid Services website and the DOL website. (Return to the *Capital Checkup*.)
 - 2 These answers to FAQs are on the DOL's website. (Return to the *Capital Checkup*.)
 - 3 See 45 CFR 156.20 and 45 CFR 155.20 (definition of "cost sharing") 77 Fed. Reg. 18445, 18469 (March 27, 2012). (Return to the *Capital Checkup*.)
 - 4 See 45 CFR 156.130(c) 78 Fed. Reg. 12867. (Return to the *Capital Checkup*.)
 - 5 For information about MHPAEA, see The Segal Company's November 2008 *Bulletin*, "New Law Requires Parity in Coverage for Mental Health" and March 2010 *Bulletin*, "MHPAEA Regulations Released." (Return to the *Capital Checkup*.)
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[Back](#)



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