



## Health care reform update – March 2014

# Cost-sharing requirements

### Summary

Effective for new and renewing plans on and after January 1, 2014, all health plans, regardless of group size or funding type must apply all member cost share for in-network services and out-of-network emergency services to the in-network out-of-pocket (OOP) maximum, which cannot exceed the following limits allowed by the Affordable Care Act (ACA):

- Yearly limit on cost-sharing beginning in 2014
  - 2014: \$6,350 self-only / \$12,700 other than self-only
  - 2015: \$6,600 individual / \$13,200 family
  - 2016 forward: increased for cost of medical inflation
- Yearly limit on deductibles (applies only to non-grandfathered fully-insured small group plans) beginning in 2014
  - 2014: \$2,000 self-only / \$4,000 other than self-only
  - 2015: \$2,050 self-only / \$4,100 other than self-only
  - 2016 forward: increased for cost of medical inflation

### One year safe harbor for group health plans using different vendors

The Departments have said that, **only for the first plan year** beginning on or after January 1, 2014, where a group health plan or group health insurance issuer uses more than one vendor to administer benefits that must apply the yearly limit on out-of-pocket maximums, separate out-of-pocket limits can be used. We believe this means the following:

- No plan can have a medical OOP maximum more than the OOP maximum allowed. The 2014 OOPs maximum is \$6,350 (self-only) / \$12,700 (other than self-only).
- "More than one vendor" means any vendor or administrator responsible for the administration of a set of essential health benefits, including a pharmacy benefit manager.
- The safe harbor applies to our preferred vendors, including ESI.
  - Prescription (Rx) plans that do not have an OOP maximum in place to not have to add one until 2015.
  - Our 2014 individual and small group prescription plans will have an OOP maximum.
- The one year safe harbor applies to both small and large group markets, which has been confirmed by HHS.
- Large group plans are not required to cover pediatric vision or pediatric dental services because they are not required to cover all essential health benefits. If a large group does offer coverage for vision or dental services to their employees and their dependents through separate vision or dental plans, these benefits are considered "excepted" and not subject to the ACA cost share rules related to out of pocket.



## Questions and Answers

**Q. Do plans have to apply all covered services toward the out-of-pocket maximum?**

A. No, but any covered service that is an EHB must be applied to the out-of-pocket maximum. In the individual and small group markets, non-EHBs *may not be applied* to the OOP max. In the large group market, non-EHB services *may be applied* to the out-of-pocket maximum.

**Q. Do all EHB cost share types have to be applied to the out-of-pocket maximum?**

A. Yes. All plan cost shares for in-network EHB services, including plan deductibles, fixed copayments, and coinsurance percentages must be applied to the out-of-pocket maximum.

**Q. Do the cost-sharing requirements combine in- and out-of-network services?**

A. No, only cost-sharing for in-network services count toward the OOP limit and annual deductible limit. Services from a provider outside of a plan's network do not count toward the annual limit on cost-sharing or to the annual limits on deductibles, except for emergency services.

**Q. Do the annual limits on deductibles in the small group market also apply to large group and self-funded plans?**

A. No. The limitation (or cap) on deductibles only applies to non-grandfathered, fully-insured small group plans.

**Q. To what plans do the out-of-pocket annual limits apply?**

A. The out-of-pocket annual cost-sharing limits apply to for all non-grandfathered health plans [individual, small group, large group and self-funded (ASO)].

**Q. Is there any transitional relief for group health plans on applying an out-of-pocket annual limit accumulator?**

A. Yes. It is referred to as the out-of-pocket maximum "enforcement safe harbor." Group health plans have until their plan year beginning on or after January 1, 2015 to aggregate all out-of-pocket costs into one accumulator. In 2014, while benefit plans can have separate out-of-pocket maximums (e.g., medical can have an OOP max of \$6,350 for self-only coverage, and dental and/or vision can have a separate OOP max of \$6,350 for self-only coverage) no plan can have an OOP max that exceeds the HDHP limit on cost-sharing.

**Q. Does the out-of-pocket maximum enforcement safe harbor mean that group health plans do not have to apply cost-sharing requirements like copayments and coinsurance, to the OOP maximum in 2014?**

A. No. All group health plans are required to apply cost shared including copayments and coinsurance toward the out-of-pocket maximum. The enforcement safe harbor means that groups with separate vendors do not have to combine all cost-sharing requirements for all benefits toward one out-of-pocket maximum accumulator until 2015.

**Q. If the enforcement safe harbor does not allow group health plans to postpone applying cost-sharing requirements to the OOP maximum in 2014, what does it do?**

A. The enforcement safe harbor provides relief for group health plans from having to combine all out-of-pocket cost shares from separate vendors into one accumulator until 2015. Beginning in 2015, a member's total out-of-pocket costs cannot exceed \$6,350 for self-only coverage or \$12,700 for other than self-only coverage for all benefits combined.

**Q. Can separate vendors have a deductible higher than the yearly limit on cost sharing?**

A. No. Service vendors that currently have an out-of-pocket maximum can continue to have a separate OOP maximum for 2014, but no OOP maximum can exceed the yearly limit on cost sharing (\$6,350 for self-only coverage or \$12,700 for other than self-only coverage in 2014). For example, major medical can have an OOP maximum of \$6,350 and dental can have an OOP maximum of \$6,350 if the plans previously had an OOP maximum.



- Q. If a group has all their benefits with one carrier, does that mean they need to combine all OOP cost-sharing requirements toward a single OOP maximum in 2014?**
- A. No. Our understanding is that if a group has all their benefits with us, the pharmacy, vision, and dental benefits are administered by "separate vendors" from the major medical plan. So those plans would also be eligible for the one-year enforcement safe harbor and would not have to accumulate all benefit cost shares toward one OOP maximum until 2015. Additional information will be provided when it is released by the Departments.
- Q. When do Rx plans have to have the OOP max limits added?**
- A. In 2015. Current guidance says that out-of-pocket expenses, whether separate or combined, for essential health benefits, cannot be more than \$6,350 for self-only coverage and \$12,700 for other than self-only coverage.
- Q. Is there any provision for the yearly deductible amount for fully-insured small group plans to be more than the \$2,000 / \$4,000 maximum?**
- A. Yes, health insurance coverage may be more than the yearly deductible limit if the plan cannot reasonably reach a given level of coverage (actuarial value or metal tier) without exceeding the deductible limit.

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