HEALTH CARE REFORM: LIMITATIONS ON OUT-OF-POCKET MAXIMUMS

The Affordable Care Act (ACA) sets annual limits on a plan participant's out-of-pocket costs for in-network services for essential health benefits. These out-of-pocket costs include deductibles, co-insurance, and co-payments, but do not include premiums, balance billing amounts for out-of-network services, or costs for services not covered under the plan. All non-grandfathered group health plans must comply with the out-of-pocket limits for plan years beginning on or after January 1, 2014. For 2014, the limits are $6,350 for self-only coverage and $12,700 for family coverage. The limits for 2015 are $6,600 for self-only coverage and $13,200 for family coverage.

TRANSITIONAL RELIEF FOR 2014

The combined out-of-pocket costs for in-network services for essential health benefits provided through a single carrier or vendor must not exceed the annual maximum. Plans with carve-outs, such as those with a separate pharmacy benefit manager or separate managed behavioral health organization, must also combine the total out-of-pocket costs to ensure the total does not exceed the annual maximum.

Plans with carve-out vendors face administrative challenges aggregating these costs. The Departments of Labor, Health and Human Services and the Treasury (collectively, the Departments) recognized that separate carve-out vendors may not only impose different out-of-pocket limits, but may use different methods for crediting expenses against any maximum. Since it will take time to coordinate these activities across vendors and to make any necessary system changes to cross-accumulate the cost-sharing amounts, the Departments issued guidance providing for transitional relief for the 2014 plan year. The relief provides that, only for the plan year beginning on or after January 1, 2014, plans with a carve-out vendor will satisfy the out-of-pocket maximum limitation if **both** of the following conditions are satisfied:

1. The plan complies with the out-of-pocket maximum for its major medical coverage.

2. If the carve-out vendor has an out-of-pocket maximum in place, it also complies with the limit.

Note, under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), plans are prohibited from imposing an annual out-of-pocket maximum on medical benefits and a separate annual out-of-pocket maximum on mental health and substance use disorder benefits. Accordingly, the 2014 transition relief is not available for managed behavioral health carve-outs, and out-of-pocket costs for these benefits must aggregate with the out-of-pocket maximum for major medical coverage.

PLANNING FOR 2015

For plan years beginning on or after January 1, 2015, all non-grandfathered plans with carve-out vendors must ensure the combined out-of-pocket maximum does not exceed the limits for 2015. Again recognizing the administrative challenges involved, the Departments recently issued additional guidance stating that plans may use separate out-of-pocket limits for each carve-out vendor provided that the combined amount of any separate out-of-pocket limits under the plan does not exceed the total annual limitation on out-of-pocket maximums.

For 2015, non-grandfathered plans with carve-out vendors have two options: (1) coordinate across the vendors so that all out-of-pocket costs aggregate into a single maximum, or (2) divide the total out-of-pocket amount for the plan year across vendors. For example, a plan with major medical and a prescription carve-out may choose to allocate $1,000 of the out-of-pocket limit to prescriptions with the remaining available for major medical.

Note, for plans with a behavioral health carve-out, the out-of-pocket costs for these benefits must aggregate with the out-of-pocket maximum for major medical coverage under either option in order to be in compliance with the MHPAEA.

Please contact your Keenan representative for questions regarding this *Briefing* or if you require any additional information regarding the Affordable Care Act.