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BLOG

Latest Set of Obamacare FAQs Clarify Out-of-Pocket Limit Rules for Essential Health Benefits

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New FAQs

On January 9, 2014, the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the "Departments") issued another set of FAQs under the Patient Protection and Affordable Care Act (PPACA). These FAQs provide additional information regarding cost sharing limits, which is summarized below. In addition, the FAQs touch on a range of issues including mental health parity, wellness programs, excepted benefits, coverage of preventative services, expatriate health plans, and fixed indemnity insurance.

Cost-Sharing Limit Relief for 2014

For non-grandfathered plans, PPACA capped the annual out-of-pocket maximum on essential health benefits at $6,350 for individual coverage and $12,700 (indexed for later years) for non-individual coverage beginning in 2014. (It's important to note that plan sponsors of self-funded group health plans or large group health plans have flexibility in defining essential health benefits: these plans can use any definition of essential health benefits that is authorized by the Secretary of the HHS.) This requirement seemed straight-forward enough. However, the sponsors of plans that utilize more than one medical service provider (in particular, it is common to have a separate provider for prescription drug coverage) found themselves faced with the daunting prospect of coordinating the out-of-pocket maximum among multiple service providers. To give these plan sponsors more time to figure out how to comply with the new limits, the Departments previously provided transition relief. The transition relief provided that, for 2014, major medical coverage must adhere to the maximum out-of-pocket limits, but a separate maximum out-of-pocket limit could be imposed for plan coverage provided by other service providers. Essentially, this could double a plan's collective maximum out-of-pocket limit for 2014.

Cost-Sharing Considerations for 2015

The new FAQs reiterate that, for plan or policy years beginning on or after January 1, 2015, a plan must impose a single maximum out-of-pocket limit, even if it uses multiple service providers. The guidance allows plan sponsors to split the maximum among various categories of benefits rather than reconcile claims across multiple service

providers; provided however, that the combined out-of-pocket limit does not exceed the applicable maximum. Note that a plan *cannot* use this “splitting” method with respect to mental health or substance use disorders. In other words, mental health and substance use disorder benefits must be integrated with the plan’s medical/surgical benefits with respect to the maximum out-of-pocket limits. Importantly, plans have the option of whether to include amounts spent on out-of-network items and services, and non-covered services, towards maximum out-of-pocket limits.

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