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BENEFITS UPDATE

AGENCIES ISSUE AFFORDABLE CARE ACT FAQs RELATING TO 2014 COST-SHARING RESTRICTIONS FOR NON-GRANDFATHERED PLANS

In our last Benefits Update, we reported on a set (Part XI) of Frequently Asked Questions jointly issued by the U.S. Departments of Labor and Health and Human Services and the Internal Revenue Service relating to the Patient Protection and Affordable Care Act. Since then, the agencies have issued a new set (Part XII) of FAQs. This new set of 20 FAQs deals primarily with two issues:

- Overall limitations on cost-sharing (deductibles and other patient out-of-pocket costs); and
- Coverage of certain preventive services without cost-sharing.

Overall Limitations on Cost-Sharing

Starting with plan years that begin in 2014, the ACA limits two aspects of cost-sharing by *non-grandfathered* health plans: annual deductibles and overall out-of-pocket costs. The FAQs address all three pieces of this new rule, as follows:

- Neither limit applies to grandfathered health plans (which are plans that were in existence on March 23, 2010 and have not been significantly modified since, based on very technical agency rules).

- The limit on deductibles in 2014 will be $2,000 for self-only coverage and $4,000 for more-than-self-only coverage and will be indexed for later years. This will apply only to small-group insurance (generally, employers with 100 or fewer employees, though states may reduce this cap to 50 employees for years before 2016). It is unclear whether a small employer's health flexible spending account might permit a higher deductible.

- The limit on overall patient out-of-pocket costs will be the limit that would apply for the year to "high-deductible health plans" that are compatible with health savings accounts. For 2013 (the 2014 numbers won't be available until late 2013), these limits are $6,250 for self-only coverage and $12,500 for more-than-self-only coverage. This limit will apply to large-group and self-insured health plans as well as to small-group insurance.

The agencies recognized that some plans may have different out-of-pocket maximums for different services and that coordination among the different service providers may be difficult. So, there is a transition rule that may permit retention of these separate maximums just for the first plan year beginning in 2014. The agencies warned, however, that that the Mental Health Parity and Addiction Equity Act prohibits out-of-pocket maximums for mental-health or substance-abuse benefits that is separate from the maximum for medical/surgical benefits.

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Coverage of Preventive Services without Cost-Sharing

The ACA requires non-grandfathered health plans to provide certain in-network preventive services without cost-sharing (meaning no deductibles, co-payments, co-insurance, or other cost-sharing). Most of the FAQs flesh out this requirement. The general rules regarding the preventive services subject to this requirement are these:

- Evidence-based items or services with an "A" or "B" rating from the U.S. Preventive Services Task Force for an individual are included.
- Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for an individual are included.
- For patients up to adolescent age and for women, evidence-informed preventive care and screenings provided in the comprehensive guidelines of the Health Resources and Services Administration are included.
- If a recommendation described above does not specify the frequency, method, treatment or setting for a service, the health plan may impose reasonable medical-management rules.

The agencies interpreted these general rules in specific contexts in the FAQs, as follows:

- If a health plan has no in-network provider for a preventive service, it may not impose cost-sharing if a covered person goes to an out-of-network provider.
- Over-the-counter products, which might include aspirin or certain women's contraceptives, must be covered without cost-sharing if prescribed by the patient's health care provider.
- Treatment that is "an integral part" of a screening procedure (such as polyp removal during a colonoscopy) must be covered without cost-sharing, but treatment that is just recommended after but not integral to a screening procedure may be subject to cost-sharing.
- Genetic counseling, evaluation for the breast cancer susceptibility gene and testing for that gene are preventive services, if recommended by a woman's health care provider.
- Where a preventive service is recommended for a "high-risk" population, a person's attending provider determines whether that person is part of the high-risk population.
- If the CDC makes a new immunization recommendation, it must be covered without cost-sharing starting with the plan year that begins at least one year after the date the recommendation is issued.
- "Well-woman" visits, as well as any recommended preventive services, must be covered without cost-sharing as recommended in the general guidelines above (currently once per year). The plan may require that multiple services be

provided in a single visit, if consistent with the general guidelines, but the attending provider may require additional visits.

- The general guidelines cover the full range of women's contraceptives, so a limitation to oral contraceptives would not be permissible.
- Plans may apply cost-sharing to branded drugs, if a generic drug is provided without cost-sharing, unless the patient's health care provider determines that the generic drug would be "medically inappropriate."

Coping with the ACA Generally

At the same time that it issued the FAQs discussed above, the agencies also issued final regulations regarding the "essential health benefits," including cost-sharing limitations, that health insurers in the small group and individual markets must offer in 2014, both inside and outside the state health insurance exchanges. The final regulations also define the "minimum value" that large employers' health plans may have to provide for the employer to escape the "play or pay" penalty for failing to provide "affordable" coverage to full-time employees.

As noted in our last Benefits Update, the agencies are issuing new guidance on the ACA's requirements frequently as we approach 2014. We encourage employers to watch for new developments, using the DOL website, among other sources, and speak with their advisors about the possible effects of these new rules:

- The "play-or-pay" penalties;
- The rules that prohibit discrimination in favor of "highly compensated individuals" with respect to features such as entry dates, employee contributions, benefit levels or subsidized COBRA coverage; and
- Plan mandates, such as those prohibiting limits on annual benefits and preexisting conditions and capping eligibility-waiting periods.

We regularly speak with clients, individually and in group presentations, about the ACA and would be happy to help employers address these issues. Please feel free to contact us any time with any questions about these matters or any other labor, employment, or benefits issues.

~THOMAS I. KRAMER

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