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Health Reform

Annual Limits on Cost-Sharing

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Effective the first plan year that begins on or after January 1, 2014, all non-grandfathered group health plans (both insured and self-insured) , regardless of size, must comply with annual cost-sharing limitations on out-of-pocket maximums that are the same as the limits that apply to HSA-qualified high deductible health plans. These limits are adjusted annually. For 2014, the limits are $6,350 for single coverage and $12,700 for family coverage.

The Departments of Labor, Health and Human Services and the Treasury have indicated they will issue further guidance on this, but existing guidance provides what constitutes cost-sharing, whether the limits apply for out-of-network services, and how to treat carve-out arrangements, as discussed below.

Cost-Sharing

Cost-sharing includes deductibles, coinsurance, copays, or similar charges and any other expenditure required by the health plan which is a qualified medical expense with respect to any essential benefits offered under the plan. Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

Out-of-Network Services

The limits on out-of-pocket maximums do not apply for out-of-network services; they only apply in-network. Where a plan uses a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network shall not count towards the annual limitation on cost-sharing. However, special rules apply with respect to emergency services.

Carve-Out Arrangements

Currently, plans that utilize multiple service providers to help administer benefits (such as a third-party administrator for major medical coverage and a separate pharmacy benefit manager) may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. These processes will need to be coordinated with the various vendors to ensure compliance with these new annual cost-sharing limits.

The Departments created a safe harbor that applies only to the first plan year that begins on or after January 1, 2014. The safe harbor allows a group health plan that utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums to satisfy this requirement in this first year if two conditions are met: (1) the plan complies with all the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage); and (2) to the extent the plan includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the prescribed threshold. Therefore, for 2014, where the out-of-pocket maximum is $6,350, both the major medical and separate prescription drug plan may each satisfy this threshold independently. After 2014, the entire plan cannot impose a total annual limitation that exceeds the mandated threshold, so coordination between the benefits will be required.

Action to Take

Employers subject to this requirement should review existing coverage to determine whether adjustments will be needed to ensure that the appropriate categories (e.g., deductibles, copays) are applied to the out-of-pocket maximum. If employers currently use multiple service providers to administer benefits, they will need to confirm compliance with the relief available for 2014 and make sure there will be coordination between vendors to appropriately administer benefits in the future.