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Health Reform

Out-Of-Pocket Maximums: Confusion Over Delay

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Recently, the media announced a delay in the Affordable Care Act out-of-pocket maximum requirement scheduled to be effective for plan years beginning in 2014. The confusion centers around a limited safe harbor that may affect employer-sponsored group health plans with certain carve-out arrangements that use multiple service providers to administer benefits (such as a TPA for major medical coverage and a separate pharmacy benefit manager for prescription drug coverage). Despite these media reports, this safe harbor was announced back in February 2013 (we provided you with information on it in prior articles).

Background

For plan years beginning on or after January 1, 2014, non-grandfathered group health plans must comply with annual cost-sharing limitations that cap an individual's (or family's) out-of-pocket spending on any in-network essential benefits at $6,350 for single coverage and $12,700 for family coverage. Included in cost-sharing are deductibles, copays, coinsurance and any other expenditure required by the plan which is a qualified medical expense. This requirement remains in effect and has not changed.

The Safe Harbor

In February 2013, the Departments announced a special safe harbor that provides some relief for certain group health plans that use multiple service providers to administer benefits to coordinate systems to fully comply with the out-of-pocket maximum limitation. It is this provision that has sparked the confusion; however it is likely that only a handful of plans will qualify for the relief.

For the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums, the Departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied:

- The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage); and

- To the extent the plan or any health insurance coverage 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 dollar amounts ($6,350/$12,700 for 2014).

For example, a group health plan complies with the safe harbor for a plan year that begins on or after January 1, 2014 where the plan has more than one service provider to administer benefits subject to the out-of-pocket limitations, the major medical coverage complies with the $6,350/$12,700 out-of-pocket limitation and the other program (e.g., the pharmacy carve-out) includes an out-of-pocket maximum and that maximum does not exceed $6,350/$12,700.

It also appears, at least under some interpretations, that this safe harbor may apply if the carve-out program does not have an out-of-pocket limitation, thus not requiring the program to implement such a limitation for 2014. We anticipate further clarification on this issue.

Once the safe harbor expires (plan years beginning on or after January 1, 2015), then the plan must coordinate the out-of-pocket limitations across the various benefits and service providers to comply with a single limit cost-sharing requirement.

Confusion

Although there was a frenzy in the media around this issue, there is nothing new here and the applicability is quite limited. Employers with certain carve-out arrangements will want to consider the potential for relying on this safe harbor for 2014, but full compliance will be required for the 2015 plan year.