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Deductible Limits and Out-of-Pocket Maximums Begin in 2014

The Patient Protection and Affordable Care Act (PPACA) imposes cost-sharing limits on non-grandfathered group health plans beginning with the first plan year in 2014. These cost-sharing limits apply to medical expenses related to essential health benefits and include costs such as deductibles, co-insurance, co-payments and other qualified medical expenses, but do not apply to premiums, balance bills from non-network providers, or monies paid for services not covered by the health plan. All cost-sharing limits apply to in-network benefits and services only.

Deductible Limits Apply to Small Group Market Plans
Beginning with the first plan year in 2014, insurers and group health plans in the small group market (plans covering up to 50 employees) may not have individual or family (any coverage other than single) deductibles that exceed $2,000 and $4,000 respectively. The agencies (DOL, HHS, and IRS) have interpreted that self-insured and fully-insured plans in the large group market (health plans covering 51 or more employees) are not subject to the deductible limits.

Out-of-Pocket Maximums Apply to All Non-Grandfathered Group Health Plans
PPACA applies an overall cost-sharing limit to all non-grandfathered group health plans, regardless of the plan's size or funding (fully-insured or self-insured) arrangement. This overall cost-sharing limit, commonly referred to as the out-of pocket (OOP) maximum, is $6,350 for self only coverage and $12,700 for family coverage for 2014, which matches the maximum OOP limits for HSAs (health savings accounts) for that year. The OOP maximums will be indexed annually based on the premium adjustment percent.

Generally, the OOP maximum applies to plan years beginning on or after January 1, 2014, but a one-year delay (called a safe harbor) has been granted for plans that use multiple service providers to administer benefits. Under the safe harbor, addressed in question 2 of a DOL FAQ, plans that use separate service providers may impose their own OOP maximum and utilize their own method for credited expenses toward the OOP maximum. Many large employers use different vendors and thus will have the extra year.

This safe harbor does not apply to all plans (only those with multiple service providers in 2014) and plans with a single service provider (i.e., a single service provider for both medical and prescription drug) must have a single OOP maximum and the benefits must coordinate as to not exceed the OOP maximum specified in the law. Thus, the delay applies as follows:

- The overall OOP cost-sharing limit is still required effective in 2014 for all non-

grandfathered group health plans, regardless of the plan's size or funding (fully-insured or self-insured), if the plan is using a single vendor for the administration of both medical and pharmacy.

- The overall OOP cost-sharing limit is delayed until 2015 for a non-grandfathered plan that uses independent managers to handle pharmacy (or other) benefits. The plan is not required to coordinate the OOP maximums for the medical and pharmacy benefits in 2014, and the plan may impose a separate OOP maximum, not to exceed the statutory limits, for each benefit. Consequently, an individual may have to pay $6,350 for doctors' services and hospital care and another $6,350 for prescription drugs under a plan administered by a pharmacy benefit manager.

This delay, which applies to the 2014 plan year only, is intended to provide employers and their plans who split their services another year to consolidate and allow systems to catch up to what is required of them in terms of processing and accounting to coordinate participants' OOP expenses. A number of carriers and administrators have subcontracted a relationship with a pharmacy vendor. These plans may take different interpretations on whether the full mandate for 2014 applies to them, or if they get the deferral. Therefore, for these plans, sponsors must rely on the providers to tell them how they interpret their own programs and confirm the providers have made any needed program changes.

Importantly, under the same FAQ, the DOL notes that a plan is prohibited from having one OOP maximum for mental health benefits and a different OOP maximum for other major medical benefits as prohibited under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Non-grandfathered health plans may need to make plan adjustments and subsequent changes to the plan communication materials to comply with the cost-sharing limit requirements. Contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220 should you have any questions. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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