buckconsultants
xerox
FYI®
For Your Information®

Volume 37 | Issue 71 | June 10, 2014

FAQs offer guidance on out-of-pocket maximums, preventive care, SBCs, and more

The Departments of Labor, Health and Human Services, and Treasury recently issued FAQs that provide clarification on how sponsors of non-grandfathered plans may comply with ACA's limits on out-of-pocket maximums and requirement that they provide first-dollar coverage of tobacco cessation interventions as part of the preventive care mandate. The FAQs also discuss whether health FSA carryovers will affect the FSA's status as an excepted benefit and whether there are any changes to SBC requirements for the upcoming year.

In this article: Background | ACA limits on out-of-pocket maximums | Coverage of tobacco use intervention services | Health FSA carryovers and excepted benefit status | Summary of Benefits and Coverage | In closing

Background

The Departments of Labor, Health and Human Services, and Treasury (departments) recently issued FAQs about Affordable Care Act Implementation (Part XIX) that address questions they've received about various aspects of ACA compliance. In addition to providing guidance about the updated COBRA model notices, which include additional information about the availability of marketplace coverage, (see our June 3, 2014 *For Your Information)* the FAQs address two areas affecting non-grandfathered plans — the ACA's limits on out-of-pocket (OOP) maximums and the coverage of tobacco cessation interventions as part of the preventive care mandate. They also answer questions regarding the impact of health FSA carryovers on an FSA's status as an excepted benefit and on whether there are any changes to the rules regarding summaries of benefits and coverage for the upcoming year.

Essential health benefits include items and services in these categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision

Volume 37 | Issue 71 | June 10, 2014

ACA limits on out-of-pocket maximums

For plan years beginning in 2014, non-grandfathered group health plans may not have annual out-of-pocket maximums on essential health benefits (EHB) greater than $6,350 for self-only coverage and $12,700 for coverage other than self-only coverage. These limits are indexed for subsequent years — in regulations published on March 11, 2014, HHS proposed annual OOP maximums for 2015 of $6,600 for self-only coverage and $13,200 for coverage other than self-only coverage.

Prior guidance confirmed that cost-sharing such as deductibles, coinsurance, copayments, or similar charges for EHB must be applied towards the OOP maximum as well as other qualified medical expenses related to an EHB covered by the plan. It also confirmed that a plan may, but is not required to, take into account premiums, non-covered services, balance billing amounts from non-network providers or out-of-network cost-sharing. (See our March 11, 2014 *For Your Information*.) However, the guidance had not addressed the interplay between medical management techniques and the OOP limits.

The new FAQs address the following issues related to the OOP maximum limits:

Prescription drugs

In order to provide participants with an incentive to use less-costly prescription drugs, many prescription drug programs have different coverage tiers for prescription drugs and require participants to pay higher copayments for non-generic drugs than for generics. Some programs, commonly referred to as “mandatory generic programs,” further provide that a participant who purchases a brand-name drug when a generic drug is available must also pay the difference in cost between the generic and brand-name drug. It was generally assumed that brand name copayments would count towards the OOP maximum, although it was unclear whether any difference in cost between the generic and brand name drug that a participant might have to pay would be counted.

The FAQs appear to limit the extent to which a plan must take any cost-sharing for brand-name drugs into account for purposes of the OOP maximum. Noting that self-insured group health plans and large group market coverage have discretion in defining “essential health benefits,” the FAQ describes how a plan could be designed so that only generic drugs would be considered essential health benefits (if available and if determined medically appropriate) and that brand-name drugs at higher cost-sharing could be elected as a separate option that was not an essential health benefit. If an individual chooses to purchase a brand name prescription drug when a generic was available and medically appropriate, the plan could provide that both the copayment and any cost difference under mandatory generic programs drug would not count towards the OOP maximum. The FAQ notes that if a plan is subject to ERISA, the SPD must explain which covered benefits will not count towards an individual’s out-of-pocket maximum.

When is a generic drug medically appropriate?

In determining whether a generic drug is medically appropriate, a plan may defer to the recommendation of an individual’s personal physician, or it may offer an exceptions process meeting the requirements that qualified health plans in the marketplace must have in place to allow enrollees access to clinically appropriate drugs not covered by the health plan.

Buck comment. Employers with prescription drug programs that require additional cost sharing for brand drugs (such as a mandatory generic program or step therapy) should review those programs immediately to ensure compliance with these new requirements.

Reference-based pricing

Reference-based pricing is a medical management technique in which a plan pays a fixed amount for a particular procedure, such as knee replacement, and contracts with certain providers who agree to accept the fixed amount as payment in full. An individual may choose a provider who does not accept it as payment in full but will incur additional out-of-pocket expenses.

The FAQ discusses whether a plan would have to apply these additional out-of-pocket expenses towards the OOP maximum. Although the departments express concern that reference-based pricing could be a subterfuge for imposing limitations on coverage, the FAQ states that until guidance is issued and effective, a plan will not be deemed to violate the OOP limit because it treats providers that accept the reference amount as the only in-network providers, as long as the plan uses a reasonable method to ensure that it provides adequate access to quality providers.

The departments are soliciting comments on how the OOP maximum should be applied to reference pricing and on the standards that plans using reference-based pricing structures should be required to meet to ensure that individuals have meaningful access to medically appropriate, quality care.

Balance billing

The FAQ states that a plan with a provider network that chooses to apply a portion of an amount billed by a non-network provider to the OOP limit may use any reasonable method for doing so. It notes, for example, that the plan could apply only out-of-network coinsurance amounts paid by a participant towards the OOP limit while excluding any balance billed amounts.

Buck comment. As noted above, a plan is only required to apply in-network cost sharing for essential health benefits towards the OOP limits and does not have to apply costs incurred by a participant who receives services from out-of-network providers.

Coverage of tobacco use intervention services

Non-grandfathered group health plans are required to provide benefits, without cost-sharing, for certain preventive services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved. (See our July 20, 2010 and March 15, 2013 issues of *For Your Information.*) One of the USPSTF recommendations is that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. The recommendation does not specify the frequency, method, treatment, or setting of the tobacco cessation intervention services.

The FAQ attempts to offer some clarification regarding the tobacco cessation intervention services that a plan must provide without cost-sharing to satisfy the preventive care mandate. Noting that a plan may use reasonable medical management techniques to determine when and how a preventive service will be provided when the recommendation does not otherwise specify, the FAQ suggests that plans refer to evidence-based clinical practice

guidelines. It then cites an approach for tobacco use counseling and intervention set out in the Public Health Service-sponsored Clinical Practice Guideline Treating Tobacco Use and Dependents: 2008 Update (guideline). The guideline provides for:

- Screening for tobacco use for all covered individuals
- For those who use tobacco products:
  - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group, and individual counseling) without prior authorization
  - All Food and Drug Administration (FDA)-approved tobacco cessation medications (both prescription and over-the-counter) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization

The FAQ states that the departments will consider a plan to be in compliance with the tobacco use counseling and intervention preventive care requirement if it provides these services with no cost-sharing.

> Buck comment. Plans are not required to cover the services as provided in the guideline, but a plan that does not do so may have to find other evidence-based clinical practice guidelines to support its approach.

Health FSA carryovers and excepted benefit status

Excepted benefits generally are exempt from the Health Insurance Portability and Accountability Act (HIPAA) and ACA market reform requirements. Health FSAs generally will be considered excepted benefits only if both of the following conditions are met:

- The employer also offers health coverage that is not limited to excepted benefits for the year to the class of health FSA participants
- The maximum benefit payable to any employee participant in the class does not exceed two times the employee's salary reduction election for the year, or if greater, $500.

The FAQ clarifies that amounts carried over to a health FSA from the preceding plan year as permitted by the modification to the "use-or-lose" rule should not be taken into account when determining if the health FSA satisfies the maximum benefit payable limit described above. For more information about the health FSA carryover, see our November 1, 2013 and April 24, 2014 issues of *For Your Information.*

> Buck comment. Health FSAs offered to employees not eligible for the employer's medical plan (e.g., part-time employees) will not be considered excepted benefits if they reimburse medical (as opposed to dental or vision) expenses. This means that they will be subject to ACA mandates, including the prohibition on annual dollar limits, and the plan sponsor could be subject to excise taxes for failure to comply. Therefore, employers should confirm that that all employees offered health FSAs are also eligible for their medical coverage.

Volume 37 | Issue 71 | June 10, 2014

Summary of Benefits and Coverage

The FAQs state that until further guidance is issued, the SBC template and other documents made available on the CMS and DOL websites in April 2013 continue to be authorized for use. They also note that the safe harbors and other enforcement relief that were provided by the departments last year will be extended. (See our May 10, 2013 *For Your Information*.) The FAQ also reiterates that the departments' basic approach to ACA implementation is to assist plan sponsors with compliance rather than imposing penalties.

In closing

The FAQs provide plan sponsors with useful guidance, particularly with respect to the OOP maximum limits and preventive care mandates applicable to non-grandfathered plans. Affected sponsors should review their current plan designs in these areas to determine not only whether they are in compliance but also whether they may want to make any changes as permitted by the guidance.

Authors
Leslye Laderman, JD, LLM
Richard Stover, MAAA, FSA

Produced by the Knowledge Resource Center of Buck Consultants at Xerox
The Knowledge Resource Center is responsible for national multi-practice compliance consulting, analysis and publications, government relations, research, surveys, training, and knowledge management. For more information, please contact your account executive or email fyi@xerox.com.

You are welcome to distribute *FYI®* publications in their entireties. To manage your subscriptions, or to sign up to receive our mailings, visit our Subscription Center.

This publication is for information only and does not constitute legal advice; consult with legal, tax and other advisors before applying this information to your specific situation.

©2014 Xerox Corporation and Buck Consultants, LLC. All rights reserved. Xerox® and Xerox and Design® are trademarks of Xerox Corporation in the United States and/or other countries. Buck Consultants® is a registered trademark of Buck Consultants, LLC in the United States and/or other countries.