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Maxing Out

Guidance on out-of-pocket maximums

Starting this year, the Patient Protection and Affordable Care Act (ACA) prohibits group health plans from imposing an out-of-pocket maximum (OOP max) that exceeds statutory limits.

Once an individual has met the plan's OOP max, the plan must pay 100% of covered benefits. This requirement applies to plan years that started on or after this January 1, except with respect to grandfathered plans.

The Department of Health and Human Services (HHS) has issued regulations in the context of exchange-qualified health plans, but these regulations do not apply directly to other group health plans, such as Employee Retirement Income Security Act (ERISA) plans—although it can be viewed as analogous guidance. The agencies have not provided regulations applicable to group health plans, but have issued several Q-and-A's. The most recent were released in January and May of this year and can be found at www.dol.gov/ebsa/faqs (see Parts XVIII and XIX).

In this issue, we answer several questions group health plans may have that have been addressed in the agency Q-and-A's.

Q: What is the OOP max amount?

For the 2014 plan year, the allowed OOP max amount is $6,350 for self/$12,700 for family. For the 2015 plan year, the allowed OOP max amount is $6,600 for self/$13,200 for family.

For the 2015 plan year, the Q-and-A's provide that the plan must combine the out-of-pocket costs for all service providers to count toward one OOP max.

Q: What expenses count toward the OOP max?

The ACA provides that cost-sharing amounts that must be counted toward the OOP maximum include deductibles, co-insurance and co-payments. The statute provides that such cost sharing may exclude premiums, balance billing amounts for non-network providers or spending for non-covered services.

The Q-and-A's further clarify that:

- Plans are not required to count cost sharing with respect to non-network providers toward the OOP max;
- Plans are not required to count cost sharing for non-covered services toward the OOP max;
- Plans are not required to count amounts charged above the usual, customary and reasonable (UCR) amount toward the OOP max;
- Plans are required to count only cost sharing for essential health benefits toward the OOP max—the same group of benefits to which the annual and lifetime limit rules apply; and
- Plans may limit the costs of prescription drugs that are counted toward the OOP max to generic only and are not required to count the cost of brand prescription drugs if a generic is available and medically appropriate. Note that the determination as to whether a generic drug is "medically appropriate" is to be made by the individual's personal physician.

Q: Does the OOP max apply to each plan option separately, or must OOP max amounts be combined?

Prior to the ACA, group health plans often had separate OOP maximums applied to different types of benefits, particularly where these benefits were administered by different service providers. For example, a plan may have one OOP max for medical benefits and a separate OOP max

for pharmacy benefits.

The Q-and-A's clarified that out-of-pocket costs paid with respect to all of these benefits must be added together and counted toward the OOP max. However, recognizing that these different service providers may need more time to coordinate, the agencies allowed a one-year transition for the current plan year.

For the 2014 plan year, a plan that had separate OOP max amounts for benefits with different service providers could maintain the separate OOP maximums, but each still would need to be no greater than the allowed OOP max amount.

For example, this year, where the allowed OOP max for individuals is $6,350, the plan could have a $6,350 OOP max for medical and a $6,350 OOP max for pharmacy.

For the 2015 plan year, the Q-and-A's provide that the plan must combine the out-of-pocket costs for all service providers to count toward one OOP max. The Q-and-A's did note that the plan could retain separate OOP maximums for different benefits, as long as they did not exceed the allowed OOP max when added together.

Thus, in 2015, when the allowed OOP max for individuals is $6,600, the plan could have only one $6,600 individual OOP max for both medical and pharmacy. However, the plan could split the allowed $6,600 OOP max and have a $2,300 OOP max for pharmacy and $4,300 for medical, as long as the total OOP max does not exceed the allowed amount.

Plans should ensure that they count all required costs toward the required OOP max, particularly where they have had separate OOP maximums in the past. In addition, plans should review the Q-and-A guidance because they are not necessarily required to count every out-of-pocket cost toward the OOP max. The sooner an individual meets the OOP max, the sooner the plan must start paying benefits at 100%, so plans will want to understand where they can draw the line and limit what is counted toward the OOP max, as well.

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These Q-and-A's first appeared on plansponsor.com in August. As health care law is evolving rapidly, there may have been further developments since the initial publication.