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Health Care Reform:
Cost Sharing Limits, Preventive Services and Minimum Value

Recently, the Department of Labor, the Department of Health and Human Services ("HHS"), and the Internal Revenue Service (the "Departments") released new guidance on the Health Care Reform Act ("HCRA") in the form of Frequently Asked Questions ("FAQs"). This twelfth round of FAQs focuses on cost-sharing limitations and preventive services.

HHS also released a preliminary calculator to assist in determining whether an employer-sponsored group health plan meets the HCRA minimum value requirements.

Cost-Sharing Limits. The HCRA imposes cost-sharing limits on deductibles and out-of-pocket maximums. The FAQs provide additional information on how these rules apply to self-insured and large group health plans.

- ***Deductible Limitations.*** Until future guidance is issued, the rules regarding limitations on deductibles will *only* apply to small group health plans (generally those maintained by employers with 100 or less employees). Under these rules, deductibles cannot exceed $2,000 for employee coverage or $4,000 for family coverage in 2014. These amounts are indexed and will likely increase in 2015.

- ***Annual Limitations on Out-of-Pocket Maximums.*** All non-grandfathered group health plans, *including* self-insured and large group health plans, are required to comply with the HCRA annual limitation on out-of-pocket maximums. Starting in 2014, these plans may not impose out-of-pocket limits in excess of a certain indexed dollar amount. This dollar amount is generally equal to the limits that would apply to a high-deductible health plan in 2014 (in 2013, the limits are $6,250 for self-only coverage and $12,500 for family coverage). After 2014, this amount will be indexed separately.

  In recognition of the practical difficulties with coordinating an out-of-pocket maximum when a plan has multiple service providers for different benefits (*e.g.*, separate providers for major medical, prescription drug,

and behavioral health), the FAQs create a one-year transition rule for the plan's first plan year beginning on or after January 1, 2014. A group health plan that uses more than one service provider to administer benefits that are subject to out-of-pocket maximums will be considered to have satisfied the HCRA rules if:

- The plan's major medical benefits comply with the annual out-of-pocket maximum rules; and

- The out-of-pocket maximums that apply to each of the other benefits that do not exceed the maximum dollar amount.

Note that the Mental Health Parity and Addiction Equity Act of 2008 provides that group health plans may not impose an annual out-of-pocket maximum on medical/surgical benefits and a *separate* annual out-of-pocket maximum on mental health and substance use disorder benefits. This means that plans may still not maintain a separate out-of-pocket maximum for mental health and substance abuse use disorder benefits.

Preventive Services Coverage. The FAQs also provided guidance on the HRCA preventive services mandate, which generally requires that non-grandfathered group health plans provide certain benefits without any cost-sharing by participants.

- ***Out-of-Network Providers.*** Plans are generally only required to offer preventive services without cost-sharing for in-network services. However, if the plan does not offer any in-network options, no cost-sharing may be imposed on out-of-network preventive services.

- ***Over-the-Counter ("OTC") Drugs.*** Plans are required to cover the cost of OTC drugs without cost-sharing only when they are prescribed by a health care provider.

- ***"Well-Woman" Care.*** Plans are generally required to provide preventive services identified by the Health Resources and Services Administration (the "HRSA"). The HRSA recommends at least one annual well-woman visit for adult women to obtain the recommended preventive services, including preconception and prenatal care. The FAQs provide that due to a woman's health needs, more than one visit may be necessary for a woman to obtain all recommended preventive services. Accordingly, additional well-woman visits must be provided by a plan without cost-sharing.

Minimum Value Calculator. HHS has released a minimum value calculator - a tool that may be used by employers to determine whether the benefits offered under their group health plans provide "minimum value." As explained in the January 16, 2013 issue of *theHRBenefitsAuthority*, *Health Care Reform: Proposed Regulations on Employer Penalties*, whether a plan provides minimum value is extremely important

in evaluating whether an employer may be subject to a “play or pay” penalty under the HCRA.

The HHS minimum value calculator may be accessed here.

Contact Information. For more information from Mazursky Constantine, please contact Amy Heppner (404.888.8825), Kelly Meyers (404.888.8838), Carl Lammers (404.888.8872) or Jared Beckerman (404.888.8857). For more information from VCG Consultants, please contact Leslie Schneider (770.863.3617).

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999 Peachtree Street • Suite 1500 • Atlanta, GA 30309
www.mazconlaw.com • 404.888.8820
www.VCGConsultants.com • 770.863.3600