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### New Health Care Reform FAQs, Part II

The DOL, HHS, and IRS (the “Departments”) recently released new Health Care Reform Frequently Asked Questions (“FAQs”). The FAQs provide guidance on cost-sharing limitations and coverage of preventive services.

**Cost-Sharing Limits.** With respect to non-grandfathered group health plans, Health Care Reform imposes cost-sharing limitations and out-of-pocket maximums, both of which limit participants’ overall out-of-pocket costs for essential health benefits (“EHBs”). Generally “cost-sharing” refers to amounts participants are required to pay, such as deductibles, coinsurance, copayments or similar charges. The annual out-of-pocket maximum for 2014 is \$6,350 for single coverage and \$12,700 for family coverage.

- **Out-of-Network Items and Services.** A prior FAQ provided that a plan that includes a network of providers may, but is not required to, count amounts paid for out-of-network items and services towards the plan’s annual out-of-pocket maximum. These FAQs clarify that a plan that counts such spending towards the out-of-pocket maximum may use any reasonable method for doing so.
- **Brand Name Prescription Drugs.** Large group market plans and self-insured group health plans have the discretion to define EHBs. This means that they may, for example, include only generic drugs (if medically appropriate and available) as EHBs, and provide a separate non-EHB option that allows participants to elect a brand name drug at a higher cost sharing amount. Under this type of plan design, if an individual selects a brand name drug when a generic was available and medically appropriate, the plan may provide that all or some of the amount paid by the individual (e.g., the difference between the cost of the brand name drug and the generic drug) is not required to be counted towards the annual out-of-pocket maximum. The SPD, for an ERISA plan, must explain which covered benefits do not count towards an individual’s out of pocket maximum.
- **Reference-Based Pricing Structure.** Until further guidance is issued, a large group market plan or self-insured group health plan using a reference-based pricing structure (*i.e.*, where the plan pays a fixed amount for a particular procedure) will not fail to comply with the out-of-pocket maximum requirements because it limits in-network providers to those that accept the reference amount. However, such plans must use a reasonable method to ensure that they provide adequate access to quality providers.

**Coverage of Preventive Services for Tobacco Cessation.** Health Care Reform requires that non-grandfathered group health plans provide certain preventive care benefits, including tobacco cessation benefits without any cost sharing by participants. The FAQs clarify that non-grandfathered group health plans may comply with the tobacco cessation coverage requirement by (i) screening for tobacco use, and (ii) offering tobacco users at least two tobacco cessation attempts per year, each of which include four tobacco cessation counseling sessions of at least 10 minutes and FDA-approved tobacco cessation medications for a 90-day treatment regimen.

**Contact Information.** For more information from Mazursky Constantine, please contact [Amy Heppner](#) (404.888.8825), [Kelly Meyers](#) (404.888.8838), or [Alden Corrigan](#) (404.888.8839). For more information from VCG Consultants, please contact [Leslie Schneider](#) (770.863.3617).

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