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REFORM Update

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The Department of Labor (DOL), Department of Health and Human Services (DHHS) and the Department of Treasury recently issued a list of Frequently Asked Questions (FAQs) on health care reform. These FAQs cover the 2014 cost-sharing limitations and preventive care services.

Cost-Sharing Limitations

Two cost-sharing limitations may apply to group health plans in 2014. First, small group health plans will have a deductible limit. States define the size of small group plans. Some states will define them as those with fewer than 50 employees. Other states will define small group as fewer than 100 employees. However, by 2016, small group will be universally defined as an employer with fewer than 100 employees. Second, all group health plans will have maximum out-of-pocket limits. Both of these limits will apply to plans as of the first day of the first plan year beginning on or after January 1, 2014.

The FAQs clarify the deductible limit. The 2014 limit is $2,000 for single coverage and $4,000 for family coverage. The Departments intend to issue more guidance on this requirement. These limits will not apply to self-funded plans or large group insured plans.

The out-of-pocket maximum limits will apply to all group health plans. While not clear in regulations, DHHS has verbally confirmed this provision is grandfathered. The maximums tie to the maximum out-of-pocket limits connected to qualifying high deductible health plans. Qualified high deductible health plans are associated with health savings accounts. For 2013, those limits are $6,250 for single coverage and $12,500 for family coverage. If your plan has a physician network, the maximum limits apply only to the in-network level of benefits.

Complying with these maximums will be a challenge. All member cost-sharing must accumulate toward that out-of-pocket maximum. The deductible, coinsurance and all copays (office visit, emergency room and prescription drug) must count toward the out-of-pocket maximum. Currently, most plans accumulate only coinsurance or the coinsurance and deductible toward the out-of-pocket maximum.

This requirement will be especially difficult for employer plans that carve out administration of their prescription drug programs. The pharmacy benefit manager (PBM) will have to notify the medical carrier of member copays in order for those copays to be applied to each member's out-of-pocket maximum. However, the FAQs allow a one-year delay on meeting the requirement for prescription drug copays, so long as the plan meets both of the following:

- The plan's major medical coverage complies with the out-of-pocket limit requirements.
- The plan's out-of-pocket maximum on coverage other than major medical (for example, prescription drug coverage) does not exceed the maximum amount permitted.

This one-year delay is not available for carve-out mental health and substance abuse arrangements because the Mental Health Parity and Addiction Equity Act already requires out-of-pocket cost for these services to accumulate toward the plan's out-of-pocket limits.

The requirement to count all member cost-sharing in the plan's out-of-pocket maximum will increase costs for many plans. Employers may choose to increase out-of-pocket maximums to take into account that more services will be accumulating toward that maximum.

Preventive Care Services

The FAQs clarify a number of preventive care services requirements. Keep in mind that one of the first requirements of health care reform was to provide 100 percent coverage for specific preventive care services. The original effective date for this expanded coverage was the first day of the first plan year beginning on or after September 23, 2010. The effective date could be delayed for grandfathered plans.

A number of governmental agencies specified the preventive care services that plans must cover with no cost-sharing. For example, plans need to cover any preventive service that received an "A" or "B" rating from the United States Preventive Service Task Force (USPSTF) without cost-sharing. Other government agency recommendations are also included. For example, routine immunizations for children and adults are covered with no cost-sharing. However, plans need to cover only the immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC).

The government recently expanded this list of preventive care services to include specific well-woman services, including FDA-approved contraceptives.

These FAQs clarify the following issues:

- If a plan does not differentiate between in- and out-of-network benefits, the plan must cover the required items with no cost-sharing regardless of the provider.
- The USPSTF recommends certain people take aspirin to reduce the risk of heart attacks. If a doctor prescribes the aspirin, the plan must cover it without member cost-sharing.
- Assume a patient has a USPSTF recommended colonoscopy and the physician removes polyps during the procedure. Can a plan impose cost-sharing for the polyp removal? No, a plan cannot impose cost-sharing for the polyp removal if the colonoscopy is being done as a USPSTF-recommended screening. The actual polyp removal is considered part of that preventive screening. However, a plan can impose cost-sharing if the procedure is not a recommended preventive service (for example, if the colonoscopy and polyp removal is done to investigate a medical complaint or condition).
- Does the recommendation for genetic counseling and evaluation for the breast cancer susceptibility gene (BRCA) include the BRCA test itself? Yes, it does include the BRCA test. Plans must cover that test with no member cost-sharing when USPSTF guidelines recommend it. The USPSTF recommends with a "B" rating that women who have a family

history showing an increased risk for harmful mutations in the BRCA1 or BRCA2 gene be referred for genetic counseling and BRCA testing.

- Some of the USPSTF recommendations apply specifically to high-risk groups. The patient's attending physician will determine whether the patient is in a high-risk group. If so, then the plan must cover the preventive recommendations in the high-risk category with no cost-sharing.
- What is included in a "well-woman" visit? The Health Resources and Services Administration (HRSA) recommends at least one well-woman visit a year for age and developmentally-appropriate recommended preventive services, including pre-conception and prenatal care. A woman may need more than one visit. This seems to imply that prenatal care must be included as part of the preventive services requirement, with no cost-sharing.
- May a plan cover oral contraceptives only and still meet the requirements of the expanded well-woman services? No, because the purpose of the HRSA guidelines is to ensure that women have access to a full-range of contraceptive methods. These could include barrier methods, hormonal methods, implanted devices or sterilization. Plans must cover all FDA-approved contraceptive methods, but they can use medical management techniques to help control costs. For example, a plan can cover generic oral contraceptives with no cost-sharing while requiring a copay for brand-name medications. However, if the brand-name contraceptive is medically necessary, the plan must waive the brand copay.
- Is a plan required to cover contraceptive services that are generally available over-the-counter, such as contraceptive sponges and spermicides? Plans need only cover FDA-approved over-the-counter contraceptives when the woman's health care provider prescribes them. The HRSA guidelines do not require that plans cover contraceptives for men.
- Must a plan cover services related to the follow-up, management, side effects, and device removal for contraceptives? Yes, the HRSA guidelines include these services and plans must cover them with no cost-sharing.
- How long after childbirth must a plan cover lactation counseling and breastfeeding equipment and supplies? Plans must cover these services during the time a woman breastfeeds her child. Plans and insurers may use reasonable medical management techniques to handle costs. However, plans cannot set time limits on how long these services will be covered for a breastfeeding mother.

For the most part, your health plan will determine how it will cover preventive services. These FAQs clarify how plans should cover specific preventive services. For example, they seem to imply that prenatal and postnatal care must be covered as part of the preventive services mandate.

Concluding Thoughts

Both employers and health plans will welcome these FAQs.

Employers that currently carve out prescription drug coverage will have another year to set up the data exchanges they will need to calculate the total out-of-pocket maximums.

Plans are also struggling with covering preventive services. The required services seem to be a moving target. In some cases, the wording in these recommendations is vague. In other situations, the wording has been updated, affecting covered services. Employers should rely on their vendors to help determine what preventive services should be covered without cost-sharing.

The government will continue to issue FAQs throughout 2013. Employers are starting to work on implementing the required changes for 2014, but how to handle these issues is not always clear. Employers should make a good faith effort and watch for additional clarification from the government.