Guidance on Cost-Sharing Limits, Wellness, and Mental Health Parity in New ACA FAQs

January 10, 2014

On January 9, 2014 the Departments of Labor, Health and Human Services (HHS) and Treasury (collectively, the "Departments") issued an 18th set of frequently asked questions about the Affordable Care Act, including issues raised by that law's intersection with the Mental Health Parity and Addiction Equity Act ("MHPAEA"), as well as a grab-bag of other issues. A summary of some of the points covered in the FAQs follows.

Coverage of Preventive Services re: Breast Cancer

- For plan or policy years beginning on or after September 24, 2014, non-grandfathered group health plans must cover, with no cost sharing, medications that reduce the risk of breast cancer (such as tamoxifen or raloxifene), when recommended for preventive purposes to women at increased risk of breast cancer and at low risk for adverse side effects from the medicines.

Cost-Sharing Limitations

- For plan or policy years beginning in 2014, the annual limitation on out-of-pocket costs for essential health benefits (EHB) provided under a non-grandfathered plan or policy is $6,350 for self-only coverage and $12,700 for coverage other than self-only. Non-EHB items are not subject to the dollar limits.
- In a previous FAQ, the Departments offered transition relief to plans and insurers that use more than one service provider to provide medical benefits. The transition relief applies only to plan or policy years that begin on or after January 1, 2014. For that plan or policy year only, the out-of-pocket maximum will be considered to be met by a plan using multiple service providers only if both of the following criteria are met:
    - Major medical coverage remains subject to the maximum out-of-pocket limits; and
    - Out-of-pocket limits that separately are imposed on coverage provided by other service providers (such as prescription drug coverage) do not exceed the maximum out-of-pocket limits.
    - The new FAQ makes clear that the transition relief is only available for plan or policy years beginning in 2014. For plan or policy years beginning on or after January 1, 2015, all essential health benefits (EHB) are subject to the individual and non-individual out-of-pocket limits, regardless of the number of service providers used.
    - However, plans may allocate the dollar limit across multiple categories of benefits (e.g., pharmacy vs. major medical) in lieu of reconciling claims across multiple service providers, so long as the total amount does not exceed the maximum

limits. The guidance notes however that it would not be permissible, under the MHPAEA, to impose an out-of-pocket maximum on mental health or substance use disorder benefits that accumulates separately from an out-of pocket limitation on medical/surgical benefits.

- Significantly, plans and policies may, but do not have to, count dollars spent on out-of-network items and services towards the maximum out-of-pocket limits.
- Plans and policies also may, but are not required, to count an individual's out-of-pocket spending for non-covered services, such as cosmetic services, towards annual maximum out-of-pocket costs.
- Also keep in mind for this purpose that large-group and self-funded plans are not required to offer EHB, but EHB items or services they do offer are subject to the out-of-pocket maximum limits. The FAQ provides that self-insured and large group health plans can use any definition of EHB that is authorized by the Secretary of HHS, which at this point primarily includes the state base-benchmark plans.

Wellness Programs

- A wellness program need not provide the opportunity to avoid the tobacco surcharge to a participant who initially declines but later joins a tobacco cessation program, if the participant could have avoided the surcharge by joining the cessation program at the time of enrollment or annual re-enrollment. The program may voluntarily provide the reward (i.e., avoidance of the tobacco surcharge) either in full or on a pro-rated basis to a participant that joins tobacco cessation program mid-year.
- The FAQ describes an outcome-based, health-contingent wellness program (i.e., one that conditions the reward on attainment of a physical result or goal) in which a participant's doctor advises the plan that the standard for attaining a reward is medically inappropriate for the participant, and suggests a weight-reduction program as a reasonable alternative.[1] In such an instance, the FAQs state that the employer sponsoring the wellness program does retain a "say" in which weight-reduction program is used, but the wording of the answer suggests that the employer must "discuss different options" with the participant rather than dictate a particular weight loss plan.
- The FAQ provides that employers and insurance providers may modify the sample notice of reasonable alternative standards that is provided in the wellness regulations so long as the modified version contains all of the required content described in the regulations. All health-contingent wellness programs – whether activity only or outcome-based – must provide the notice of reasonable alternative standards in all written descriptions of a wellness program. The sample notice in the regulations is set forth below; the regulations also contain other sample language for outcome-based wellness programs.

"Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

Excepted Benefits

- The FAQ describes conditions under which fixed indemnity insurance in the individual market (such as hospital indemnity coverage) could pay benefits on a per-service basis, rather than the traditional per-period basis (e.g., per each day of hospitalization), and still qualify as "excepted benefits" that need not meet ACA market reform requirements. The described conditions will apply only in states where HHS has direct enforcement authority over the individual market but the FAQ recommends that states with their own exchanges also treat fixed indemnity coverage meeting the conditions as an excepted benefit.

Effect of the ACA on the Mental Health Parity and Addiction Equity Act

- The FAQ summarizes the intersection of these two laws, namely that EHB includes mental health and substance use disorder services, and Section 1563 of the ACA extends mental health parity protections to the entire individual market, including both grandfathered and non-grandfathered coverage. As a consequence:
    - Non-grandfathered individual market coverage: policies must provide mental health and substance use disorder benefits in accordance with interim final MHPAEA regulations for policy years beginning on or after January 1, 2014. For policy years beginning on or after July 1, 2014 (January 1, 2015 for calendar year policies), policies must comply with final MHPAEA regulations.
    - Individual policies that were to be cancelled by insurers but were covered by the HHS transition policy announced on November 14, 2013, are excepted.
    - Grandfathered individual market coverage: these policies are not subject to EHB requirements and need not cover mental health or substance use disorder benefits. However, beginning on or after July 1, 2014 (January 1, 2015 for calendar year policies) coverage must comply with final MHPAEA regulations to the extent that mental health or substance use disorder benefits are provided voluntarily.
    - Non-grandfathered small group market coverage: Non-grandfathered small group coverage that is not subject to the cancellation transition policy must include coverage for mental health and substance use disorder benefits for plan years beginning on or after January 1, 2014, and the coverage must comply with the interim final MHPAEA regulations from February 2010. The coverage must comply with final MHPAEA regulations for plan years beginning on or after July 1, 2014 (January 1, 2015 for calendar year plans.)
    - Grandfathered small group market coverage: These plans are not required to comply with either EHB or mental health parity rules.

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[1] Under final wellness regulations issued on June 3, 2013, employees in outcome-based wellness programs may request to involve a personal physician at any time, and if the physician agrees to participate, he or she may adjust recommendations at any time, consistent with medical appropriateness.

http://www.dol.gov/ebsa/faqs/faq-aca18.html

http://www.dol.gov/ebsa/faqs/faq-aca12.html

http://www.cms.gov/cciio/resources/data-resources/ehb.html

http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf

http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=27169

http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF

http://www.gpo.gov/fdsys/pkg/FR-2013-06-03/pdf/2013-12916.pdf