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HEALTH LAW ALERT
January 9, 2014

Federal Agencies Publish Affordable Care Act FAQs

Subjects Include Out-of-Pocket Cost Limitation, Tamoxifen Coverage, Mental Health Parity, and Other Issues

Today, the Departments of Health and Human Services, Labor, and the Treasury (the Agencies) published Frequently Asked Questions on several aspects of Affordable Care Act Implementation. Click here for a copy of the FAQs. The FAQs address:

- **Coverage of Tamoxifen** or similar medications to reduce the risk of breast cancer (in limited circumstances). Coverage must be provided as preventive care, without cost-sharing. (*See* further discussion below and FAQ # 1.)

- **Application of a Single Out-of-Pocket Cost Sharing Limit** to all essential health benefits. Previous guidance allowed (in limited circumstances) health plans to apply separate out-of-pocket maximums to (for example) major medical and prescription drug coverage. The FAQs clarify that this policy will no longer be in effect for plan years beginning on or after January 1, 2015 and provides guidance on how the requirement must be implemented. (*See* further discussion below and FAQs # 2 - # 5.)

- **Application of the Mental Health Parity Rules** to individual and small group coverage with respect to grandfathered and non-grandfathered plans. (*See* FAQ # 12.)

- **Wellness Program Requirement Clarifications**, including indicating that an outcome-based wellness plan is allowed (but not required) to offer pro-rated rewards for individuals who enroll in the program mid-year (rather than at the beginning of the year). (*See* FAQs # 8 - # 10.)

- **Expanded Definition of Fixed Indemnity Insurance**, under which coverage that pays on a per-service basis (rather than a per day or other time-period basis) may be considered Fixed Indemnity Insurance that is an

"excepted benefit," exempt from many Affordable Care Act (and HIPAA) requirements. (*See* FAQ # 11.)

- **The Definition of Expatriate Plans** and the scope of temporary transitional relief for such plans. (*See* FAQs # 6 - # 7.)

Preventive Health Care: Tamoxifen Coverage

The Agencies explain that on September 24, 2013 the United States Preventive Services Task Force (USPSTF) issued a new recommendation concerning the use of medications to reduce the risk of breast cancer "[f]or women who are at increased risk for breast cancer and at low risk for adverse medication effects." Under the Affordable Care Act, health plans must cover medical services consistent with such recommendations at no cost to members. Health plans must cover such services for plan (or policy) years that begin one year after the date the recommendation is made. The FAQ therefore indicates that health plans must cover the cost of tamoxifen, raloxifene, or other such risk-reducing medications in plan (or policy) years that begin on or after September 24, 2014. (The requirement does not apply to grandfathered health plans.)

Application of a Single Out-of-Pocket Cost Sharing Limit

The Affordable Care Act requires health plans to limit a member's 2014 annual out-of-pocket costs to $6,350 for self-only coverage and $12,700 for family or other coverage. Under previously-issued guidance, the Agencies indicated that self-funded or insured group plans that utilized multiple service providers (*i.e.*, an insurer or third party administrator for major medical claims and a Pharmacy Benefit Manager for prescription drug claims) was not required to combine cost-sharing limits for the different service providers to comply with the requirement for plan years beginning in 2014. The FAQs reiterate, however, that for plan years beginning on or after January 1, 2015, health plans must ensure that members are subject to a single "overall out-of-pocket" cost limit that applies to all essential health benefits.

The FAQs also clarify that plans with multiple service providers may comply with the overall out-of-pocket limit by using separate maximums that, when combined, are equal to or less than the maximum allowed by law. Thus, for example, a health plan could limit major medical out-of-pocket costs to $5,000 and prescription drug out-of-pocket costs to $1,350 to comply with the $6,350 maximum for 2014.

In addition, the FAQs clarify that a health plan is not required to count costs for out-of-network or non-covered services towards the annual out-of-pocket limitation.

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