OEA **EDUCATION POLICY RESEARCH & MEMBER ADVOCACY** Bulletin

Maximum Out-of-Pocket Limits and the Affordable Care Act (ACA) – September 12, 2013

Considerable misinformation is circulating about how ACA reforms will impact insurance plan design and costs in 2014. Specific to the subject of this bulletin, a growing number of insurers, third party administrators and brokers are claiming that because the ACA requires that all copayments (e.g**.** office visit, emergency room, urgent care, prescription drug) must now be included in out-of-pocket costs, people will reach the annual spending limits faster, leading to higher utilization of benefits, which will in turn drive up the cost of healthcare premiums. This claim is often made in conjunction with attempts to pressure local associations to agree to higher out-of-pocket maximums, or reduced benefits, to avoid significant premium rate hikes. This claim, however, is based on an incorrect interpretation of the ACA.

It is correct that, beginning in 2014, annual maximum out-of-pocket (MOOP) costs for medical expenses that are paid by the insured will be limited to $6,350 for single coverage and $12,700 for family – federal law ties MOOP amounts to the out-of-pocket limits used for high deductible health plans (HDHP). It is also correct that – like an HDHP – deductibles, coinsurance and copayments are all applied to the federal MOOP levels. What is incorrect is that copayments under employer sponsored health plans must also be included in the out-of-pocket maximums.

The correct interpretation of ACA rules is as follows. If an insurance plan has out-of-pocket maximums that are lower than the MOOP allowed under the ACA, then the plan can continue to exclude copayments from the plan's out-of-pocket maximums. Copayments need only be considered for the purposes of filling the gap between the plan specific out-of-pocket maximums and the federal MOOP. For example, if a health plan has a family out-of-pocket maximum for the deductible and co-insurance of $2,000, then plan participants will be responsible for up to an additional $10,700 in copayments. Most families will not accumulate $10,700 in copays in a single year.

The ACA also mandates that dental and vision benefits for pediatrics only must be included in the federal MOOP. At this time, we know that at least Delta Dental is issuing statements claiming that all dental benefits must be applied to the MOOP for self-insured groups, unless participants have the ability to opt out of the dental plan and pay for a portion of the dental coverage. This is also an erroneous interpretation of the law. So long as the dental benefits are not embedded in the major medical benefits, expenses associated with dental benefits beyond pediatrics do not have to be applied toward the MOOP.

OEA staff contacted the federal Centers for Medicare and Medicaid Services (CMS) to confirm our interpretation of the ACA rules. This correct interpretation was verified by a senior CMS official.[i]

Thus, the MOOP rules under the ACA should not be the basis for a spike in insurance premiums or funding rates. If an issue related to the maximum out-of-pocket allowable by the Affordable Care Act surfaces in your local, please bring it to the attention of the appropriate local association official or OEA Labor Relations Consultant.

Resources

U.S. Department of Health & Human Services: http://www.healthcare.gov/

U.S. Department of the Treasury: http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions

[i] Per conversation with Douglas Pennington, Director of Rate Review with the Center for Consumer Information and Insurance Oversight (CCIIO) on September 10, 2013.