FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXI)

October 10, 2014

Set out below is an additional Frequently Asked Question (FAQ) regarding implementation of the Affordable Care Act. This FAQ has been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at http://www.dol.gov/ebsa/healthreform/ and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), this FAQ answers questions from stakeholders to help people understand the new law and benefit from it, as intended.

Limitations on Cost-Sharing Under the Affordable Care Act

Public Health Service (PHS) Act section 2707(b), as added by the Affordable Care Act, provides that a non-grandfathered group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under section 1302(c)(1) of the Affordable Care Act. Section 1302(c)(1) limits an enrollee's out-of-pocket costs.[1]

For plan or policy years beginning in 2015, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under Affordable Care Act section 1302(c)(1) is $6,600 for self-only coverage and $13,200 for coverage other than self-only coverage.[2] Beginning with the 2015 plan or policy year and for plan or policy years thereafter, the annual limitation on out-of-pocket costs is increased by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4).

Previous FAQs provided guidance on the MOOP requirements under PHS Act section 2707(b).[3] The FAQs clarified that if a plan includes a network of providers, the plan may, but is not required to, count an individual's out-of-pocket spending for out-of-network items and services toward the annual limitation on cost sharing. The FAQs also addressed reference-based pricing in non-grandfathered large group insurance market and self-insured group health plans,[4] under

[1] This annual limitation is also applied to non-grandfathered individual market coverage through the essential health benefits package requirements of PHS Act section 2707(a). On April 1, 2014, Public Law No. 113-93 was enacted. Section 213 of that law repeals the limitation on deductibles in the small group market that was previously required in this market under section 2707(b) of the PHS Act and section 1302(c)(2) of the Affordable Care Act.

[2] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 FR 30240 (May 27, 2014).

[3] See Affordable Care Act Implementation FAQs, Part XII, Q2, available at http://www.dol.gov/ebsa/faqs/faq-aca12.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html; Affordable Care Act Implementation FAQs, Part XVIII, Q2-Q5, available at http://www.dol.gov/ebsa/faqs/faq-aca18.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html; Affordable Care Act Implementation FAQs, Part XIX, Q2-Q4, available at http://www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

[4] The FAQ stated that, for non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act,

which the plan pays a fixed amount for a particular procedure (for example, a knee replacement), which certain providers will accept as payment in full.[5] In the FAQ, the Departments explained that reference-based pricing is designed to encourage plans to negotiate treatments with high-quality providers at reduced costs. At the same time, the Departments expressed concerns that such a pricing structure could be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers.

The FAQ further stated that, until guidance was issued and effective, with respect to a large group market plan or self-insured group health plan that utilizes a reference-based pricing design, the Departments would not consider a plan or issuer as failing to comply with the MOOP requirements of PHS Act section 2707(b) because the plan or issuer treats providers that accept the reference amount as the only in-network providers, as long as the plan or issuer uses a reasonable method to ensure that it offers adequate access to quality providers. The FAQ also solicited comments on the application of the MOOP requirements to such benefit designs, indicating a particular interest in standards that plans or issuers using reference-based pricing should be required to meet to ensure that individuals have meaningful access to medically appropriate, quality care.

The Departments received a range of comments and questions on the application of the MOOP requirements to various provider network benefit designs. Many comments suggested that plans and issuers should be permitted to limit counting an individual's out-of-pocket costs exceeding the reference price towards the MOOP only with respect to certain types of services (such as non-emergency services or routine procedures). Other comments suggested network adequacy and quality standards or procedures that a plan or issuer should be required to meet if the plan or issuer wants to utilize a network design under which less-than-full credit is given against the MOOP for non-preferred providers. Many of these comments also suggested that plans establish an exceptions process in certain circumstances to allow an enrollee's full cost sharing for non-reference based providers to count toward the MOOP. Additional comments addressed disclosure issues, to ensure that individuals had timely and adequate information to make informed treatment decisions.

Based on comments received, set forth below is an additional FAQ regarding the MOOP requirements. This FAQ addresses only group health plans' and group health insurance issuers' obligations under section 2707(b) of the PHS Act. For non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act, additional requirements apply.

Compliance with section 2707(b) of the PHS Act is not determinative of compliance with any other provision of law, including PHS Act section 2713, relating to coverage of preventive services, and PHS Act section 2719A, relating to choice of a health care professional and

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additional requirements apply. Grandfathered health plans are exempt from both section 1302(a) of the Affordable Care Act and section 2707(b) of the PHS Act.

[5] Affordable Care Act Implementation FAQs, Part XIX, Q4, available at http://www.dol.gov/ebsa/faqs/faq-aca19.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

benefits for emergency services (incorporated by reference into the Employee Retirement Income Security Act (ERISA) section 715 and Internal Revenue Code (Code) section 9815) and implementing regulations.

Q: Under PHS Act section 2707(b), what specific factors will the Departments consider when evaluating whether a non-grandfathered plan that utilizes reference-based pricing (or similar network design) is using a reasonable method to ensure that it provides adequate access to quality providers at the reference-based price?

Pending issuance of future guidance, for purposes of enforcing the requirements in PHS Act section 2707(b), the Departments will consider all the facts and circumstances when evaluating whether a plan's reference-based pricing design (or similar network design) that treats providers that accept the reference-based price as the only in-network providers and excludes or limits cost-sharing for services rendered by other providers is using a reasonable method to ensure adequate access to quality providers at the reference price, including:

1) Type of service. Plans should have standards to ensure that the network is designed to enable the plan to offer benefits for services from high-quality providers at reduced costs, and does not function as a subterfuge for otherwise prohibited limitations on coverage. For this purpose:
    a. In general, reference-based pricing that treats providers that accept the reference amount as the only in-network providers should apply only to those services for which the period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider.
    b. Limiting or excluding cost-sharing from counting toward the MOOP with respect to providers who do not accept the reference-based price would not be considered reasonable with respect to emergency services.[6] Furthermore, any provision in a non-grandfathered plan that involves a more restrictive network cannot be applied to emergency services pursuant to PHS Act section 2719A (incorporated by reference into ERISA section 715 and Code section 9815) and its implementing regulations.[7]

2) Reasonable access. Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries. For this purpose, plans are encouraged to consider network adequacy approaches developed by States, as well as reasonable geographic distance measures, and whether patient wait times are reasonable. (Insured coverage is also subject to any applicable requirements under State law.)

[6] For this purpose, "emergency services" has the same meaning as the term in the Departments' interim final regulations related to coverage of emergency services, which is defined generally in accordance with the meaning of the term under the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act.

[7] See 29 CFR 2590.715-2719A(b) and 45 CFR 147.138(b).

3) Quality standards. Plans should have procedures to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

4) Exceptions process. Plans should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the reference price to be treated as if the services were provided by a provider that accepts the reference price if:
    a. Access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable wait time or travel distance).
    b. The quality of services with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or patient safety issues).

5) Disclosure. Plans should provide the following disclosures regarding reference-based pricing (or similar network design) to plan participants free of charge.
    a. Automatically. Plans should provide information regarding the pricing structure, including a list of services to which the pricing structure applies and the exceptions process. (This should be provided automatically, without the need for the participant to request such information, for example through the plan's Summary Plan Description or similar document.)
    b. Upon Request. Plans should provide:
        i. A list of providers that will accept the reference price for each service;
        ii. A list of providers that will accept a negotiated price above the reference price for each service; and
        iii. Information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

The Departments will continue to monitor the use of reference-based pricing and may provide additional guidance in the future, including guidance relating to requirements other than those under section 2707(b) that is applicable to non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act.