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In the Spotlight: ACA and Out-of-Pocket Maximums

The Affordable Care Act (ACA) requires that all health insurance issuers and group health plans use a uniform maximum for out-of-pocket expense. The maximum amount for Health Savings Account (HSA) and qualified high deductible plans, is set annually by the Internal Revenue Service. For 2014, the HSA maximum is set at $6,350 for an individual and $12,700 for a family of any size.

What's Included?

In short, almost everything. All expenses incurred by the member in-network on essential health benefits will count toward the maximum. For BCBSNC plans, that means all member medically covered expenses since we will only sell plans that cover the essential health benefits. (Keep in mind that some large self-funded groups may choose to use another state's essential health benefit package. Their out-of-pocket maximum would apply to the set of benefits in that state's package.) The new definition of "out-of-pocket" expenses includes deductibles, coinsurance, and copayments including drugs, office visits, and all other expenses covered under the policy but not paid primarily by the insurer. Because of this more comprehensive definition, sometimes the ACA out-of-pocket maximum is called a "true" out-of-pocket maximum. There are, however, a few things that are not included in the out-of-pocket maximum. For example, premiums, balance billing amounts for out-of-network providers, and expenses for non-covered services will all still be excluded.

Who's Included?

All new, non-grandfathered plans will need to abide by the new, true out-of-pocket maximums. This means groups small and large as well as self-funded and fully-insured. Because essential health benefits requirements are different for large, small, and self-funded groups, some may not cover as many of the essential health benefit categories. In accordance with ACA, the out-of-pocket limit accumulator must apply to essential health benefits / services provided in-network. Since BCBSNC large group standard plans cover all essential health benefits, with the exception of pediatric vision and pediatric dental, we will not be making a distinction for how out-of-pocket limits are administered. All in-network services (including those not defined as essential) will apply to the out-of-pocket limit accumulator. All non-grandfathered small group plans will include all essential benefits.

What's Delayed?

After significant plan pushback on how to administer a single maximum out-of-pocket if pharmacy benefit managers and other vendors are used, the Department of Labor (DOL) issued an "Frequently Asked Questions" document in February of this year with some relief for 2014. In large groups, the carve-out arrangements can be particularly commonplace and there is no standard for sharing information between a vendor and a health plan. The delay applies when a group plan uses more than one service provider to administer benefits. A plan qualifies for the one year delay if the plan both (i) complies with the requirement for major medical and (ii) includes a separate out-of-pocket maximum on coverage that does not consist solely of major medical coverage. In the case of a separate out-of-pocket maximum that applies to other coverage (like prescription drug coverage or mental health), those such out-of-pocket max does not exceed the required amounts.

These plans are expected to comply with the limits for plan years that begin on or after January 1, 2015. BCBSNC will institute this “safe harbor” for Rx integration until 2015 under certain conditions.

BCBSNC Views

Blue Cross and Blue Shield of North Carolina supports a level playing field. All of our insured plans comply with the maximum out-of-pocket limits as initially described.