ANNUAL OUT-OF-POCKET MAXIMUM LIMITS

Group health plans must comply with an out-of-pocket maximum limit on cost-sharing, which is updated annually.

The Affordable Care Act (ACA) requires health plans of all sizes to comply with an overall annual out-of-pocket (OOP) maximum limit on cost-sharing, effective for plan years beginning on or after January 1, 2014. Previously, the ACA also included an annual deductible limit, but that ACA provision was repealed on April 1, 2014, by Public Law No. 113-93.

The OOP maximum limit applies only to "essential health benefits" that are provided on an in-network basis. Essential health benefits are defined broadly to include items and services in 10 general categories:

- Ambulatory and emergency services
- Hospitalization
- Prescription drugs
- Maternity and newborn care
- Mental health and substance use disorder services
- Laboratory services
- Pediatric services
- Preventive services and devices
- Rehabilitative services and devices
- Wellness services and devices

For a chart of annual limits that affect group health plans, see the PPI publication **Employee Benefits Annual Limits**.

PLANS SUBJECT TO THE OUT-OF-POCKET MAXIMUM LIMIT

The ACA places annual OOP maximum limits on single and family coverage for essential health benefits for non-grandfathered plans. (A group health plan will lose its grandfathered status if, after March 23, 2010, its plan design or cost-share contribution model is modified beyond certain regulatory parameters.) Once the OOP maximum limit is reached for the medical plan year, the participant is not responsible for additional cost-sharing for the remainder of the year. This is meant to ensure that health plans pay for significant health expenses and limit the risk of medical debt or bankruptcy for insured individuals.

The OOP maximum limits are set annually by the Department of Health and Human Services (HHS). For plan years beginning after 2014, the OOP maximum limit is increased by the premium adjustment percentage, as announced by HHS.

Employers should keep in mind that the ACA OOP maximums differ from the OOP maximums for qualified High Deductible Health Plans (HDHPs) as set by the IRS. While the ACA OOP maximums cap the amount individuals can pay per plan year for essential health benefits for non-grandfathered plans, the OOP maximums set by the IRS for qualified HDHPs impact plan design for purposes of HSA eligibility. In addition, the ACA OOP maximums only apply to essential health benefits provided in-network, while the IRS HDHP limits generally include all covered in-network benefits payable under the terms of the plan.

The ACA OOP limit requires that the single limit is "embedded" in the family maximum. This means that no single individual within a family can experience out-of-pocket expenses greater than the single limit (even if the family has not collectively reached the family out-of-pocket limit). By contrast, HDHPs can have a non-embedded deductible, which means that eligible expenses (other than preventative care) are not paid until the entire family deductible is met. For details on the OOP limits for HDHP and non-HDHP plans in recent years, see Appendix A, **HDHP/HSA and Non-HDHP Limits**.

EXPENSES SUBJECT TO THE OUT-OF-POCKET MAXIMUM LIMIT

Expenses subject to the OOP maximum limit include cost-sharing such as deductibles, copayments, coinsurance and similar charges. For plans that use networks, the OOP maximum limit applies only to in-network visits. Thus, a participant's cost-sharing for out-of-network benefits does not count toward the OOP maximum limit. Similarly, a participant's OOP costs for non-covered items or services (such as cosmetic services) do not count toward the OOP maximum limit, regardless of whether the services are rendered by in-network or out-of-network providers.

SUMMARY

In summary, a group health plan's OOP maximum for the plan year cannot exceed the annual OOP maximum limitation. Further, while group health plans may divide the annual OOP maximum limit across multiple categories of benefits, the combined amount of any separate out-of-pocket limits cannot exceed the annual OOP maximum for that plan year.

RESOURCES

DOL FAQs About Affordable Care Act Implementation Part XII

DOL FAQs About Affordable Care Act Implementation Part XVIII

Final Regulations

Public Law No. 113-93

PPI BENEFIT SOLUTIONS

APPENDIX A

HDHP/HSA and Non-HDHP Limits

IRS Limits on Health Savings Accounts (HSAs)	2023	2022	2021
HSA maximum contributions			
Single	$3,850	$3,650	$3,600
Family	$7,750	$7,300	$7,200
HSA catch-up contributions (age 55 and older)	$1,000	$1,000	$1,000
Minimum high deductible health plan (HDHP) deductible			
Single	$1,500	$1,400	$1,400
Family*	$3,000	$2,800	$2,800
Out-of-pocket (OOP) maximum			
Single	$7,500	$7,050	$7,000
Family**	$15,000	$14,100	$14,000

See **www.irs.gov** for more information.
*An embedded individual deductible can be no less than the minimum family deductible.
**Must include an embedded individual (single) OOP maximum not greater than the non-HDHP single OOP maximum.

Out-of-Pocket Limits (Non-HDHP)	2023	2022	2021
Out-of-pocket maximum			
Single	$9,100	$8,700	$8,550
Family*	$18,200	$17,400	$17,100

*Must include an embedded individual (single) OOP maximum not greater than the non-HDHP single OOP maximum.

For a more comprehensive chart of annual limits that affect group health plans, see the PPI publication **Employee Benefits Annual Limits**.

PPI BENEFIT SOLUTIONS