# ANNUAL OUT-OF-POCKET MAXIMUM LIMITS

The Patient Protection and Affordable Care Act (PPACA) requires health plans to comply with an overall annual out-of-pocket (OOP) maximum limit on cost sharing, effective for plan years beginning on or after Jan. 1, 2014. Previously, PPACA also included an annual deductible limit, but that PPACA provision was repealed on April 1, 2014, by Public Law No. 113-92.

The OOP maximum limit applies only to "essential health benefits," which is 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

**Beginning in 2014, group health plans must comply with a new out-of-pocket maximum limit on cost sharing.**

## WHAT PLANS ARE SUBJECT TO THE OUT-OF-POCKET MAXIMUM LIMIT?

The OOP maximum limit applies broadly to all non-grandfathered plans, including both self-insured and fully insured health plans of any size, regardless of whether the plan is offered inside or outside a state health insurance exchange.

Grandfathered plans are not subject to the OOP maximum limits on cost sharing. In addition, plans that are otherwise exempt from PPACA also would not need to comply with the cost-sharing limits (e.g., HIPAA-excepted benefits, including stand-alone vision and dental plans, and retiree-only plans.

The below chart illustrates the application of these limits:

| | Out-of-pocket Maximum Limit |
|---|---|
| Fully Insured, Small Group, Grandfathered | No |
| Fully Insured, Small Group, Non-grandfathered | Yes |
| Fully Insured, Large Group, Grandfathered | No |
| Fully Insured, Large Group, Non-grandfathered | Yes |
| Self-insured, Small Group, Grandfathered | No |
| Self-insured, Small Group, Non-grandfathered | Yes |
| Self-insured, Large Group, Grandfathered | No |
| Self-insured, Large Group, Non-grandfathered | Yes |

## DETAILS ON THE OUT-OF-POCKET MAXIMUM LIMIT

PPACA places annual OOP maximum limits on coverage for essential health benefits. Once the limit is reached for the year, the enrollee 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 to limit the risk of medical debt or bankruptcy for insured individuals.

The OOP maximum limit generally relates to the maximum OOP expense limits for health savings account-compatible high-deductible health plans for tax years beginning in 2014, as released by the Internal Revenue Service. For 2014, those limits are $6,350 for self-only coverage and $12,700 for family coverage. For 2015, those limits are $6,600 for self-only coverage and $13,200 for family coverage. For plan years beginning after 2015, the OOP maximum limit will be increased by the premium adjustment percentage, as announced by the federal government.

Importantly, cost sharing includes deductibles, copayments, coinsurance and similar charges, but does not include premiums and spending for non-covered services. In addition, for plans using provider networks, the OOP maximum limit applies only to in-network visits. Thus, an enrollee's cost sharing for out-of-network benefits does not count toward the OOP maximum limit. Similarly, an enrollee's OOP costs for non-covered items or services (such as cosmetic services) do not count toward the OOP maximum limit.

Finally, plans may divide the annual OOP maximum limit across multiple categories of benefits (rather than reconcile claims across multiple service providers), so long as the combined OOP maximum for the year does not exceed the annual OOP maximum limitation. For plans with multiple service providers, there is an additional transition rule for 2014 plan years, described below.

Based on the above, non-grandfathered plans that begin in 2014 may not have an OOP maximum that exceeds $6,350 for self-only coverage or $12,700 for family coverage. Non-grandfathered plans that begin in 2015 may not have an OOP maximum that exceeds $6,600 for self-only coverage and $13,200 for family coverage.

### Special Transition Rule for Plans with Multiple Service Providers

For plans that use multiple service providers (for example, a third-party administrator for the major medical portion of the plan and a separate pharmacy benefit manager for the prescription drug portion of the plan), there is a special one-year transition period. The transition period relates to the fact that separate plan service providers may impose different levels of OOP maximums and may utilize different methods for crediting participant expenses against the OOP maximums. To give plans more time to implement processes and coordinate information, for the first plan year beginning on or after Jan. 1, 2014, where a plan or insurer utilizes more than one service provider to administer benefits that are subject to the PPACA OOP annual limitations, the OOP maximum limit requirement will be satisfied if two conditions are met:

1. The plan complies with the OOP maximum limit with respect to its major medical coverage (excluding, for example, prescription coverage); and
2. To the extent there is an OOP maximum on other coverage (including prescription coverage), such an OOP maximum does not exceed the allowed dollar amounts for OOP maximums.

Note that if the other coverage currently has no OOP maximum, then the second condition would be satisfied (since the second condition applies only to the extent that there is currently an OOP maximum on that other coverage).

This special rule applies only for the first plan year beginning on or after Jan. 1, 2014, so it would not be an indefinite rule; rather it would be a one-time event. If a plan meets the transition rule, then the plan would not be subject to the overall annual OOP maximum limit until the plan year beginning in 2015.

**Transition Rule Example:** A plan has one provider for medical coverage and a separate provider for pharmacy coverage. The medical and prescription expenses have separate OOP maximums. To meet the transition rule in 2014, the medical portion could not have an OOP maximum greater than the statutory limits ($6,350 for single coverage and $12,700 for family coverage). In addition, if the pharmacy coverage currently has an OOP maximum limit, it could not be greater than the statutory limit in 2014. If the pharmacy carve-out plan does not currently have an OOP maximum, it would not be required to impose one in 2014. But in 2015, the plan must have one combined OOP maximum limit with both medical and prescription expenses included.

## ADDITIONAL RESOURCES

**DOL FAQs About Affordable Care Act Implementation Part XII**
**DOL FAQs About Affordable Care Act Implementation Part XVIII**
**Final Regulations**
**Public Law No. 113-92**

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119645 | 09/16 | BP-19480-16 | 