

COST SHARING LIMITS FACT SHEET



INFORMED ON REFORM

Overview

The Affordable Care Act (ACA) requires limits for consumer spending on in-network essential health benefits (EHBs) covered on most health plans. These are known as out-of-pocket maximum limits. The out-of-pocket limits apply to all non-grandfathered plans, regardless of size or funding type, including all plans sold through a public exchange/marketplace.

Annual out-of-pocket (OOP) maximum limits

› In-network OOP maximums have annual consumer cost-share limits for all non-grandfathered plans:

2018 OOP maximums

- › \$7,350 for individual
- › \$14,700 for family

2019 OOP maximums

- › \$7,900 for individual
- › \$15,800 for family

- › OOP expenses typically include deductibles, copays and coinsurance costs paid by a consumer.
- › Health plan premium payments and expenses from out-of-network services or balances owed to non-network care providers are examples of consumer costs not included in OOP maximums.
- › All in-network OOP expenses for EHBs covered under the same health plan or insurance policy must accumulate to a single OOP maximum. Even if such benefits are administered by different vendors, such as prescription drug, mental health/substance abuse (MH/SA), and not-excepted dental and vision (see the excepted benefits section below for more details). Such expenses can have separate annual OOP limits as long as they do not exceed the ACA OOP maximum when added all together. MH/SA expenses must accumulate with medical expenses.
- › Effective 1/1/2016, plans that have a family OOP limit higher than the ACA individual OOP maximum must apply an individual OOP limit for each person enrolled in family coverage. This is referred to as an “embedded” individual OOP maximum, and means:
 - Once a person covered under a family plan reaches the individual OOP limit, all covered expenses for that person must be reimbursed at 100%, even when the family OOP limit has not been met;OR
 - Once the family OOP limit is reached, the plan must pay 100% of all covered expenses for every person under the family coverage no matter how much each person has accumulated in OOP expenses.

Benefits administered by multiple vendors such as pharmacy and MH/SA services

- › If dental and vision are considered excepted benefits, they do not accumulate with medical expenses toward the OOP limits (see the excepted benefits section below for more details).
- › EHB requirements include mental health parity on individual and small group plans.
 - Plans that carve-out behavioral health benefits must comply with MH/SA Parity regulations – MH/SA expenses cannot have separate annual deductibles and OOP limits from medical benefits.
 - Plans subject to MH/SA Parity must cross accumulate (combine) with medical. If not subject to Parity, non-grandfathered plans must either:
 1. Keep the OOP limits separate and ensure the annual total of all OOP expense does not exceed the allowed maximum, or
 2. Combine the out-of-pocket maximums
 - Grandfathered plans are not required to cover (MH/SA) disorder services. However, since these services are considered EHB, plans cannot apply any annual or lifetime dollar limits.

Special considerations for High-Deductible Health Plans (HDHPs) with

Health savings accounts (HSAs)

The ACA “embedded” individual OOP maximum rule may pose a challenge for HSA-compatible HDHPs, as these plans are also subject to IRS rules which:

- › Require deductible thresholds to be met before a plan begins to pay a coinsurance amount – the thresholds are set for 1) self-only coverage for individuals, and 2) family coverage for an entire family, including any individual with family coverage,

AND

- › Have lower individual and family OOP maximum amounts than the ACA OOP maximums.

HSA family plans can have a separate individual deductible that is higher than the IRS minimum family deductible threshold as long as it does not exceed the ACA individual OOP maximum.

IRS and ACA Regulatory Considerations for HSA Plans

- › The IRS rules require minimum deductibles for single (\$1,300 in 2017, \$1,350 in 2018) and family (\$2,600 in 2017, \$2,700 in 2018) coverage – simply put, there cannot be an individual deductible under family coverage, unless the individual deductible is more than minimum family deductible.
- › The ACA rules require the individual OOP maximum apply to people with family coverage. Any person with family coverage cannot pay more on covered expenses than the individual OOP maximum – even if the family OOP limit has not been met.

An overview of 2018 HSA deductible thresholds and OOP maximums with ACA OOP maximums:

Self-only coverage		Individual within family coverage		Family coverage	
				\$13,300 OOP limit	The highest amount a family will spend on in-network expenses
\$6,650 OOP limit	The highest amount a person will spend on in-network expenses	The highest amount a person will spend on in-network expenses	\$7,350 OOP limit		
\$1,350 minimum deductible	The lowest deductible amount	\$2,700 minimum deductible* The lowest deductible amount for any person or family			

*There is not a stated IRS minimum deductible threshold for individuals with family coverage. However, if a plan has a separate individual deductible amount for individual family members, that amount must also be at least as high as the minimum family deductible threshold.

Excepted benefits

Excepted benefits are not subject to ACA requirements such as the expense limitations of OOP maximums. The following explains how to determine whether dental or vision benefits are excepted benefits for:

Insured plans

- › Dental and vision benefits offered under a **separate** insurance policy from the medical coverage **are** excepted benefits.
- › Dental and vision benefits that are **incorporated into** the medical insurance policy **are not** excepted benefits.

Self-funded plans

- › Dental and vision benefits **are** excepted benefits if they are offered under a **separate** plan from the medical insurance policy.
- › Also, dental or vision benefits **are** excepted if the individual can elect or reject these benefits separately from medical benefits.
- › Dental and vision benefits that are **incorporated into** the self-funded plan **are not** excepted benefits if employees enrolling in a medical plan automatically get the vision/dental benefits.

