Compliance Overview

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Cost-sharing Limit for Health Plans

The Affordable Care Act (ACA) requires most health plans to comply with an overall cost-sharing limit with respect to their coverage of essential health benefits (EHBs). Under the ACA, EHBs must reflect the scope of benefits covered by a typical employer plan and must include items and services in ten general categories, including emergency services, hospitalization, prescription drugs and maternity and newborn care.

The ACA's cost-sharing limit is an overall annual limit (or an out-of-pocket maximum). Once the out-of-pocket maximum is reached for the year, the enrollee cannot be responsible for additional cost sharing for EHB for the remainder of the year. According to the Department of Health and Human Services (HHS), the ACA's out-of-pocket maximum ensures that health plans pay for significant health expenses and limits the risk of medical debt or bankruptcy for insured individuals.

This Compliance Overview summarizes the ACA's out-of-pocket maximum for EHB.

Updates to Limits

The ACA requires the cost-sharing limit to be updated annually based on the percent increase in average premiums per person for health insurance coverage.

2021	2022	2023	2024	2025
$8,550 for self-only coverage and **$17,100 for family coverage**	**$8,700 for self-only coverage** and **$17,400 for family coverage**	**$9,100 for self-only coverage** and **$18,200 for family coverage**	**$9,450 for self-only coverage** and **$18,900 for family coverage**	**$9,200 for self-only coverage** and **$18,400 for family coverage**

Affected Plans

The ACA's out-of-pocket maximum applies to all non-grandfathered health plans. This includes, for example, self-insured health plans and insured health plans of any size.

Cost-sharing Limit

The ACA's cost-sharing limit is an overall annual limit (or an out-of-pocket maximum) on enrollee expenditures for EHB.

Once the ACA's out-of-pocket maximum is reached for the year, the enrollee cannot be responsible for additional cost sharing for EHB for the remainder of the year. Because the cost-sharing limit applies only to EHB, plans are not required to apply the annual out-of-pocket maximum to benefits that are not EHB.

Cost sharing includes any expenditure required by or on behalf of an enrollee with respect to EHB, such as deductibles, co-payments, co-insurance and similar charges. It excludes premiums and spending for non-covered services. Also, plans using provider networks are not required to count an enrollee's cost sharing for out-of-network benefits toward the cost-sharing limit.

Out-of-pocket Maximum

Effective for plan years beginning in 2014, the ACA places an annual limit on total enrollee cost sharing for EHB, known as an out-of-pocket maximum. The out-of-pocket maximum limits in recent years are as follows:

- For plan years beginning in 2021, $8,550 for self-only coverage and $17,100 for family coverage
- For plan years beginning in 2022, $8,700 for self-only coverage and $17,400 for family coverage
- For plan years beginning in 2023, $9,100 for self-only coverage and $18,200 for family coverage
- For plan years beginning in 2024, $9,450 for self-only coverage and $18,900 for family coverage

- For plan years beginning in 2025, $9,200 for self-only coverage and $18,400 for family coverage

Federal tax law also imposes an out-of-pocket maximum on high deductible health plans (HDHPs) that are compatible with contributions to health savings accounts (HSAs). The HDHP out-of-pocket maximum is less than the ACA's out-of-pocket maximum. For example, for plan years beginning in 2024, the HDHP out-of-pocket maximum is $8,050 for self-only coverage and $16,100 for family coverage. For a health plan to qualify as an HDHP, the plan must comply with the lower out-of-pocket maximum for HDHPs.

Essential Health Benefits

The ACA's out-of-pocket maximum only applies to a health plan's coverage of EHB. Under the ACA, EHB must reflect the scope of benefits covered by a typical employer and cover at least the following **10 general categories** of items and services:

- Ambulatory patient services (outpatient care)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder benefits, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

HHS developed a state-specific benchmark approach to more specifically define the items and services that comprise EHB. Under this approach, each state selects a benchmark insurance plan that reflects the scope of services offered by a typical employer plan in the state. Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health insurance plans in the individual and small group markets are required to cover EHB, as defined in the applicable state-specific benchmark plan.

The requirement to cover EHB does not apply to grandfathered health plans, self-insured group health plans and health insurance plans offered in the large group market. However, the ACA requires all non-grandfathered health plans to comply with an overall cost-sharing limit with respect to their coverage of EHB.

Group health plans (and health insurance coverage offered in connection with these plans) that are not required to provide EHB may select among any of the 51 EHB base-benchmark plans selected by a state or the District of Columbia, plus the three base-benchmark options under the Federal Employees Health Benefit Program (FEHBP), for purposes of determining which benefits are subject to certain ACA market reforms, including the out-of-pocket maximum.

Related Issues

Family Coverage—Embedded Out-of-pocket Maximum

In a final rule, HHS clarified that the self-only annual limit on cost sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage. This effectively embeds an individual out-of-pocket maximum in family coverage so that an individual's cost sharing for EHB cannot exceed the ACA's out-of-pocket maximum for self-only coverage.

In an FAQ, HHS provides guidance on how this ACA rule affects HDHPs with family deductibles that are higher than the ACA's cost-sharing limit for self-only coverage.

> *According to HHS, an HDHP plan that has a $10,000 family deductible must apply the annual limitation on cost sharing for self-only coverage ($9,450 in 2024) to each individual in the plan, even if this amount is below the $10,000 family deductible limit. Because the $9,450 self-only maximum limitation on cost sharing exceeds the 2024 minimum annual deductible amount for HDHPs ($3,200), it will not cause a plan to fail to satisfy the requirements for a family HDHP.*

Plans with Multiple Service Providers

A set of FAQs addresses how the ACA’s out-of-pocket maximum applies to plans that use more than one service provider to administer benefits (such as a third-party administrator for major medical coverage, a separate pharmacy benefit manager and a separate managed behavioral health organization). Separate service providers may impose different out-of-pocket limits and use different methods for crediting participants’ expenses against out-of-pocket maximums. The FAQs note that these processes must be coordinated to comply with the ACA’s out-of-pocket maximum, which may require regular communications between service providers.

An additional set of FAQs provides that some health plans, such as those with multiple service providers, may find it easier to divide the annual out-of-pocket limit across multiple categories of benefits, rather than reconcile claims across multiple service providers. Plans and issuers may structure a benefit design using separate out-of-pocket limits, provided that the combined amount of any separate out-of-pocket limits applicable to all EHB under the plan does not exceed the annual out-of-pocket maximum limit for that year.

Out-of-network Cost Sharing

A health plan may, but is not required to, count out-of-pocket spending for out-of-network items and services towards the plan's annual out-of-pocket maximum limit.

An FAQ clarifies that a plan that counts out-of-network spending towards the out-of-pocket maximum may use any reasonable method for doing so. For example, if the plan covers 75% of the usual, customary and reasonable amount (UCR) charged for services provided out-of-network and the participant pays the remaining 25% plus any amount charged by the out-of-network provider in excess of UCR, the 25% of UCR paid by the participant may reasonably be counted, in full or in part, toward the out-of-pocket maximum without including any amount charged above UCR paid by the participant.

Patient Protections - Surprise Medical Billing

Effective for plan years beginning on or after Jan. 1, 2022, the No Surprises Act (NSA) provides federal protections against surprise medical billing by limiting out-of-network cost sharing and prohibiting “balance billing” for three categories of medical services—emergency services, nonemergency services provided by an out-of-network provider during a visit at an in-network health care facility, and air ambulance services. With respect to these categories of services, the NSA limits cost sharing for out-of-network services to in-network levels, requires the cost sharing to count toward any in-network deductibles and out-of-pocket maximums, and prohibits balance billing in most situations.

FAQs from July 2023 explain how the NSA’s protections apply to the ACA’s cost-sharing limit. According to these FAQs:

- Cost sharing for services provided by a nonparticipating provider are considered out-of-network for purposes of the ACA’s cost-sharing limit; and
- Health care providers or facilities that have a contractual relationship with the plan or issuer are considered in-network for purposes of the NSA and the ACA’s cost-sharing limit.

This means that, for services covered by the NSA’s protections against surprise medical billing, either the NSA’s cost-sharing protections apply because the services are furnished by a nonparticipating provider, or the ACA’s cost-sharing limit applies because the services are furnished by an in-network provider.

Brand Name Prescription Drugs

A set of FAQs clarifies how health plans should treat an individual's out-of-pocket costs for a brand name prescription drug, in circumstances in which a generic was available and medically appropriate. Note that large group health plans and self-insured health plans have more discretion than small group health plans to define EHB.

For example, a health plan defines EHB to include only generic drugs (where medically appropriate and available), while providing a separate option (not as part of EHB) of electing a brand name drug at a higher cost sharing amount. If, under this type of plan design, a participant or beneficiary selects a brand name drug in circumstances in which a generic was available and medically appropriate (as determined by the individual's personal physician), the plan may provide that all or some of the amount paid by the participant or beneficiary (for example, the difference between the cost of the brand name drug and the cost of the generic drug) is not required to be counted towards the annual out-of-pocket maximum. For ERISA plans, the summary plan description (SPD) must explain which covered benefits will not count towards an individual's out-of-pocket maximum.

Plans Using Reference-based Pricing

Instead of using traditional provider networks to help control costs, health plans using reference-based pricing (RBP) place a fixed limit on how much they will pay for specific health care services, regardless of how much providers charge for those services. This fixed limit is typically based on an established benchmark, such as Medicare’s reimbursement rate, with a percentage added.

A set of FAQs provides guidance to ensure that health plans without traditional provider networks, such as plans that use RBP, cannot avoid the ACA's out-of-pocket maximum. According to these FAQs, for purposes of the ACA's cost-sharing limit, a plan that utilizes RBP can treat providers who accept the reference-based price as in-network providers and all other providers as out-of-network as long the plan uses a reasonable method for ensuring that participants have adequate access to quality providers at the reference price. The following factors are used to determine whether the plan provides access to quality health care providers at the reference price:

- **Types of health care services subject to RBP**—In general, services that are subject to RBP should only be those where participants have enough time to make an informed choice about the provider.
- **Reasonable access to providers**—An adequate number of providers who accept the reference price should be available to participants.
- **Quality of providers**—An adequate number of providers accepting the reference price should meet reasonable quality standards.
- **Exceptions process**—Plans should have an easily accessible exceptions process for special circumstances that allows out-of-pocket costs for services rendered by providers who do not accept the reference price to be applied to the out-of-pocket maximum limit.
- **Disclosures**—Plans should provide disclosures regarding RBP to plan participants free of charge, including information regarding the pricing structure and a list of services to which the pricing structure applies and the exceptions process, and a list of providers who will accept the reference price for each service.

If a plan using RBP does not ensure that participants have adequate access to quality providers that will accept the reference price as payment in full, all providers of health care services subject to RBP must be treated as in-network for purposes of applying the ACA's out-of-pocket maximum limit.

Drug Manufacturers' Coupons

In a final rule from 2020, HHS clarified how direct support offered by drug manufacturers to enrollees for specific prescription brand drugs (drug manufacturers' coupons) count toward the annual cost sharing limit. Specifically, the final rule provided health plans with flexibility to determine if and how to factor in drug manufacturers' coupons towards the ACA's annual limit on cost-sharing. However, on Sept. 29, 2023, a federal district court vacated this clarification, directing HHS to interpret how drug manufacturers' assistance applies to the ACA's definition of cost sharing. Since then, HHS has not issued any additional guidance on this topic.

Links and Resources

- On Feb. 25, 2013, HHS issued a final rule on EHB addressing the ACA's cost-sharing limit for health plans.
- HHS maintains a webpage on EHB-benchmark plans for the 50 states and District of Columbia
- On Nov. 15, 2023, HHS released the maximum limit on cost-sharing for plan years beginning in 2025.

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