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February 2013 FAQ on Health Plan Annual Out-of-Pocket Maximums

For plan years beginning on or after January 1, 2014, all non-grandfathered employer-sponsored group health plans must comply with annual out-of-pocket maximums on essential health benefits.[1] Deductibles, copays, and coinsurance applied to essential health benefits all contribute to the out-of-pocket maximum. For the 2014 plan year, these amounts are $6,350 for self-only coverage and $12,700 for family coverage and are indexed after 2014. In a February 2013 FAQ, the DOL, IRS, and HHS (collectively, the Departments) provided a one year exception to aid plans that have to coordinate multiple service providers (e.g., a plan that has a third-party administrator for major medical coverage and a separate pharmacy benefit manager). For the first plan year beginning on or after January 1, 2014, the Departments will consider the annual limitation on out-of-pocket maximum to be satisfied by plans with multiple service providers if: (1) the plan complies with the out-of-pocket requirements as to its major medical coverage, and (2) to the extent the plan has an out-of-pocket maximum on non-major medical coverage (such as prescription drug coverage), such out-of-pocket maximum does not exceed the aforementioned dollar amounts.

Additionally, the February 2013 FAQs clarify that existing regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 remain applicable. Specifically, a group health plan cannot impose an out-of-pocket maximum on mental health or substance use disorder benefits that accumulates separately from an out-of-pocket maximum for medical and surgical benefits.

The February 2013 FAQs are available at: http://www.dol.gov/ebsa/faqs/faq-aca12.html.

[1] PHSA § 2707(b).