



## Health Care Reform News

### **Health Care Reform — Annual dollar limits, lifetime dollar limits, and pre-existing exclusions for individuals under age 19**

**July 30, 2010** — The U.S. Departments of the Treasury, Labor, and Health and Human Services (HHS) recently issued Interim Final Rules concerning **benefit limits and pre-existing condition exclusions** requirements under health care reform.

#### **DOLLAR LIMITS ON BENEFITS**

The Patient Protection and Affordable Care Act (PPACA or Affordable Care Act) **prohibits group health plans from imposing annual and lifetime limits on the dollar value of health benefits.**

#### **When does this requirement take effect?**

Plans must remove these limits with the start of plan years that begin on or after September 23, 2010.

#### **Are “grandfathered” plans exempt?**

No. Grandfathered plans must comply as of the start of the first plan year that begins on or after September 23, 2010.

A group health plan may exclude *all* benefits for a condition. Excluding all benefits for a condition is not considered an annual or lifetime dollar limit. However, ***if a plan provides any benefits for a condition, it cannot limit the dollar value of the benefit.***

A plan may impose annual or lifetime per-individual dollar limits on specific covered benefits if they are ***not*** “Essential Health Benefits.” (See *Essential Health Benefits* below.)

#### **Lifetime Limits**

##### **Notification requirement and enrollment opportunity**

If a plan member reached a lifetime limit under a group health plan before this requirement took effect, and he or she is otherwise still eligible under the plan, the **plan must notify** the member that the lifetime limit no longer applies.

If that individual is no longer enrolled in the plan, the plan must give him or her an **opportunity to enroll** in the plan. The plan must treat anyone who is eligible for the enrollment opportunity as a special enrollee. That means they have the opportunity to enroll in all of the benefit packages available to similarly situated individuals at the time they first enroll.

The plan must provide these notices and the enrollment opportunity beginning no later than the first day of the first plan year beginning on or after September 23, 2010.

#### **Essential Health Benefits**

The provision allows “**restricted annual limits**” on **essential health benefits** for plan years that begin **before January 1, 2014.**

The rules have not yet defined essential health benefits fully. PPACA defines essential benefits to include the following general categories and the items and services covered within those categories:

- ambulatory patient services
- emergency services
- hospitalization, including behavioral health treatment
- maternity and newborn care

- 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

For plan years that begin before HHS issues regulations defining “essential health benefits,” the governing departments will take into account a plan’s **good faith efforts** to comply with a reasonable interpretation of essential health benefits.

However, a plan must apply the definition of essential health benefits consistently. For example, a plan could not apply a lifetime limit to a benefit — taking the position that it was not an essential health benefit — **and** treat the same benefit as an essential health benefit when applying a restricted annual limit.

**Restricted Annual Limits**

Group health plans may set restricted annual limits temporarily. This provision is meant to minimize the effect on plan members’ premiums while ensuring they have access to needed services. Plans generally may not impose restricted annual limits on essential health benefits for plan years that begin after December 31, 2013.

**Dollar value of annual limits**

If a group health plan applies a restricted annual limit to an essential health benefit during a plan year that starts before 2014, the limit **may not be less** than the following amounts:

<b>For plan years that begin between September 23, 2010, and September 23, 2011...</b>	<b>the annual dollar limit must be at least \$750,000 per person</b>
<b>For plan years that begin between September 23, 2011, and September 23, 2012...</b>	<b>the annual dollar limit must be at least \$1.25 million per person</b>
<b>For plan years that begin between September 23, 2012, and January 1, 2014...</b>	<b>the annual dollar limit must be at least \$2 million per person</b>

**Health Accounts**

The restriction on annual limits applies differently to certain account-based plans. Annual limit restrictions do not apply to health Flexible Spending Accounts (FSAs), Medical Savings Accounts (MSAs), and Health Savings Accounts (HSAs).

Salary reduction contributions for health **FSAs** are specifically limited to \$2,500 (indexed for inflation) per year, beginning with taxable years in 2013.

When **HRAs** are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements, a limit on benefits under the HRA — by itself — does not violate the requirements. A stand-alone retiree-only HRA is generally not subject to the annual limit rules.

**Waiver**

These interim final regulations provide for HHS’s establishment of a program to allow a waiver of compliance with the restricted annual limits requirements **if** complying would result in a significant decrease in access to benefits or a significant increase in premiums. The waiver is meant to prevent members in certain types of plans, including limited benefit plans or so-called “mini-med” plans, from being denied access to needed services or experiencing more than a minimal effect on their premiums.

The Secretary of HHS is expected to issue guidance about the scope of the waiver and process for applying for a waiver in the near future.

## **NO PRE-EXISTING EXCLUSIONS FOR INDIVIDUALS UNDER AGE 19**

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The Affordable Care Act's new *Patient's Bill of Rights* prohibits group health plans from denying coverage to individuals under age 19 based on a pre-existing condition. This ban includes both benefit limitations and outright coverage denials.

### **When does this requirement take effect?**

With the start of plan years that begin on or after September 23, 2010. These protections will extend to individuals of all ages with plan years starting on or after January 1, 2014.

### **Are "grandfathered" group health plans exempt?**

No. Grandfathered **group** health plans must comply as of the start of the first plan year that begins on or after September 23, 2010. However grandfathered **individual** insurance policies are exempt until 2014.

## **NEXT STEPS FOR PLAN SPONSORS**

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### ***Be sure to take these important steps:***

- **Plan documents.** It is very important that you amend your plan documents to reflect any changes you make.
- **Stop loss coverage.** Be sure to notify your stop loss carrier promptly of any changes you make.

## **FOR MORE INFORMATION**

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You can find information about health care reform online:

- [View the Affordable Care Act's \*Patient's Bill of Rights\*.](#)
- [View the provisions of the Affordable Care Act arranged by year.](#)

*This communication is not intended to provide either legal or tax advice. Please consult with your legal counsel or professional advisors to determine the effects of the statutes and regulations regarding health care reform on you and your plan members.*

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