Limitations on Lifetime and Annual Limits

Summary: Prohibits all plans from establishing lifetime or unreasonable annual limits on the dollar value of benefits.

Status update: On November 5, 2010, the Department of Health and Human Services (HHS) offered additional guidance regarding a waiver for the annual limit requirement.

Next steps:
- June 22, 2010 -- The Departments of Health and Human Services (HHS), Labor, and Treasury released an interim final rule (IFR) regarding lifetime and annual limits among other items. The IFR was published in the Federal Register on June 28, 2010.
- Before August 27, 2010 – Comments due on IFR
- August 27, 2010 – effective date of new regulations
- September 30, 2010 – the Department of Health and Human Services (HHS) has approved a waiver for the limitation for the annual limits for a total of 30 applicants with nearly 1 million covered lives.

Additional information:
- November 5 HHS memo on waiver for the annual limit requirement (related to providing notice to applicants about the waivers, among other things) -- http://www.hhs.gov/ociio/regulations/11‐05‐2010annual_limits_waiver_bulletin.pdf
- HHS memo on receiving a waiver for the annual limit requirement related to “mini med” -- http://www.hhs.gov/ociio/regulations/patient/ociio_2010‐1_20100903_508.pdf
- Entities receiving a waiver for the annual limit requirement -- http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html
- President's remarks regarding the “patients' bill of rights” -- http://www.whitehouse.gov/the‐press‐office/remarks‐president‐affordable‐care‐act‐and‐new‐patients‐bill‐rights

Summary of Interim Final Rule (IFR):

Lifetime limits. No lifetime limits permitted.

Annual limits. Under the IFR, annual limits for essential health benefits may not be less than the following amounts for plan years (in the individual market, policy years) as follows:
- For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000;
- For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1.25 million;
• For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2 million; and
• For plan or policy years after December 31, 2012, no limit.

"Essential health benefits." For plan years (in the individual market, policy years) beginning before the issuance of regulations defining "essential health benefits", for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits". For this purpose, a plan or issuer must apply the definition of essential health benefits consistently.

**Application.** The annual and lifetime limit provisions also apply to “grandfathered” group health plans and group insurers. The IFR further provides that the requirements with respect to the prohibitions on lifetime limits, but not those with respect to annual limits, apply to individual insurance market grandfathered coverage.

**Special enrollees.** Individuals who reached a lifetime limit under a plan or health insurance coverage prior to the applicability date of these interim final regulations and are otherwise still eligible under the plan or health insurance coverage must be provided with a notice that the lifetime limit no longer applies. If such individuals are no longer enrolled in the plan or health insurance coverage, these interim final regulations also provide an enrollment (in the individual market, reinstatement) opportunity for such individuals. In the individual market, this reinstatement opportunity does not apply to individuals who reached their lifetime limits on individual health insurance coverage if the contract is not renewed or otherwise is no longer in effect. It would apply, however, to a family member who reached the lifetime limit in a family policy in the individual market while other family members remain in the coverage. These notices and the enrollment opportunity must be provided beginning not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. Anyone eligible for an enrollment opportunity must be treated as a special enrollee. That is, they must be given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

**Condition-specific exclusions.** The IFR clarifies that the prohibition under PHS Act section 2711 does not prevent a plan or issuer from excluding all benefits for a condition, but if any benefits are provided for a condition, then the requirements of the rule apply. Therefore, an exclusion of all benefits for a condition is not considered to be an annual or lifetime dollar limit.

**Specific exclusions.** The restriction on annual limits applies differently to certain account-based plans, especially where other rules apply to limit the benefits available. The IFR provides that the PHS Act section 2711 annual limit rules do not apply to health flexible spending accounts (FSAs), to Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs), or stand-alone Health Reimbursement Accounts (HRAs).

"Mini-med" plans. The Secretary of HHS may establish a waiver program under which issuers or plans may assert that adhering to the restricted annual limit provisions of IFR would result in a significant decrease in access to benefits or a significant premium increase. The Departments provided for this waiver in order to prevent the loss of coverage for enrollees in low-benefit plans (for example, "mini-med" plans) that have low annual limits. While the impact of this policy is not quantified, it, too, is intended to mitigate any unintended consequences given the paucity of data on the incidence and prevalence of annual limits in the markets today.
**Long summary:**

PHS Act sec. 2711. No lifetime or annual limits (as modified by sec. 10101 and sec. 2301 of HCERA).

Amends the Public Health Service Act (PHSA) to prohibit a group health plan and an issuer offering group or individual health insurance coverage from establishing lifetime limits on the dollar value of benefits for any participant or beneficiary; or impose annual limits on the dollar value of benefits for any participant or beneficiary.

Prior to January 1, 2014, a group health plan or issuer may only establish a restricted annual limit on the dollar value of benefits with respect to the scope of the essential benefit package. In defining the term “restricted annual limit,” the Secretary must ensure that access to needed services is made available with minimal impact on premiums. Clarifies that this provision does not prevent a group health plan or health insurance issuer from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under federal or state law.

**Legislative text:**

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SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

(a) PROHIBITION.—
(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—
(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or
(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.
(2) ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term ‘restricted annual limit’ for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.
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