SIHO INSURANCE SERVICES

Health Care Reform

Interim Final Regulations: Annual and Lifetime Limitations

General Information

- PPACA prohibits group health plans and a health insurance issuer offering group or individual coverage from establishing lifetime limits and annual limits on the dollar value of "essential health benefits".
- Plan years beginning prior to January 1, 2014, group health plans and health insurance issuers may establish a "restricted annual limit" on the $ value of "essential health benefits" for any participant.

What are "essential health benefits"?

- PPACA defines these to include at least the following general categories and the items and services covered within the categories:
  - Ambulatory patient services
  - Emergency services
  - Hospitalizations
  - Maternity & Newborn care
  - Mental Health & Substance Abuse disorder services (including: behavioral health treatment, prescription drugs)
  - Rehabilitative & Habilitative services and devices
  - Lab services
  - Preventive & Wellness services
  - Chronic disease management
  - Pediatric Services, including oral & vision care

- Plans are not prevented from excluding all benefits for a condition, but if any benefits are provided for a condition, then the annual and lifetime prohibitions apply. (NOTE: Other Federal rules prevent plans from excluding all benefits for a condition, such as the ADA and Medicare Secondary Payer rules for ESRD).

Individual Health Insurance Coverage

- Prohibition on annual limits, including the special rules on "restricted annual limits" for plan years beginning before January 1, 2014, do not apply to grandfathered individual market policies.

Three Year Plan

- Three year plan phased approach for restricted annual limits along with a waiver program from the annual limits would result in a significant decrease in access to benefits or a significant increase in premiums.
- Annual limits on the dollar value of benefits that are "essential health benefits" may not be less than the following amounts for plan years (policy years in the individual market) beginning before January 1, 2014:
    - 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, 2010: $1,250,000
    - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014: $2,000,000

      (January 1, 2014 all annual dollar limits will be prohibited)

- The three year phased approach for restricted annual limits applies on an individual-by-individual basis. Family coverage would be required to provide the total annual limit amount to each family member, and not just the limit applied to the whole family. The per person approach gently increases the overall exposure for family coverage.

Waiver Program

- To qualify for the waiver program, a plan must demonstrate that compliance with the annual limit rules will result in one of two outcomes:
    - A significant decrease in access to benefits under the plan; OR
    - A significant increase in the plan's premiums.
- Guidance on the waiver program is expected to be issued in the near future. There are currently no clarifications on how the waiver program will operate at this time.

New Notice and Enrollment Opportunity

- Individuals who reached a lifetime limit under a plan prior to the effective date of these rules, dropped coverage, and are otherwise still eligible under the plan must be provided with a notice that the lifetime limit no longer applies, as well as an enrollment opportunity (reinstatement for individual market, provided the policy is renewed).
- Notices and enrollment opportunities must be provided beginning not later then the first day of the first plan year beginning on or after September 23, 2010. Enrollment opportunity must last 30 days.
- For those enrolling under the above transitional rule, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.
- Anyone eligible for an enrollment opportunity must be treated as a special enrollee and given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.
- Any difference in benefits/cost sharing requirements constitutes a different benefit package. These individuals can't be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit.
- Above notices can be provided to the employee on behalf of the employee's dependent.

HRAs

- HRAs that are integrated with other coverage (and the other coverage alone complies with the lifetime and annual limit requirements) are considered in compliance with the prohibition on lifetime and annual limits.
- Retiree-only HRAs are not subject to the prohibitions on lifetime and annual limits. (NOTE: A retiree-only plan must have a separate plan document and file a separate 5500 Form).

FSAs, HSAs, and MRAs

- Restrictions on annual limits do NOT apply.
- Specific statutory limitations apply to these account based plans.
    - Example: Beginning with taxable years in 2013, health FSAs are subject to annual limit of $2,500 (indexed for inflation).