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Lifetime and Annual Limits

The Affordable Care Act (ACA) prohibits health plans from imposing lifetime and annual limits on the dollar value of essential health benefits. This mandate became effective for plan years beginning on or after Sept. 23, 2010. However, "restricted annual limits" were permitted for essential health benefits for plan years beginning before **Jan. 1, 2014**.

On June 28, 2010, the Departments of Health and Human Services, Labor and the Treasury issued interim final rules regarding the ACA's prohibition on lifetime and annual limits.

COVERED PLANS

The prohibition on lifetime and annual limits applies to both **non-grandfathered and grandfathered group health plans**. However, it does not apply to grandfathered individual policies.

The restrictions on annual limits do not apply to health flexible spending arrangements (health FSAs) offered under a cafeteria plan, medical savings accounts (MSAs) and health savings accounts (HSAs).

Health reimbursement arrangements (HRAs) are generally subject to the ACA's annual limit requirements. However, an HRA that is **integrated with other group health coverage** is not required to satisfy the annual limit requirement if the other coverage alone satisfies the ACA's prohibition on annual limits. Technical Release 2013-03 provides detailed guidance on when an HRA will be considered integrated with other group health coverage. Also, some stand-alone HRAs are not subject to the ACA's annual limit requirement because they fall under an exception, such as retiree-only HRAs.

ESSENTIAL HEALTH BENEFITS

The ACA's prohibition on lifetime and annual dollar limits only applies to a health plan's coverage of essential health benefits. The ACA specifically provides that plans may impose annual or lifetime limits on specific covered benefits that are not essential health benefits.

Under the ACA, essential health benefits 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

Lifetime and Annual Limits

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 essential health benefits. The requirement to cover essential health benefits does not apply to:

- Grandfathered health plans;
- Self-insured group health plans; and
- Health insurance plans offered in the large group market.

The ACA directed the Department of Health and Human Services (HHS) to more specifically define the items and services that comprise essential health benefits. HHS developed a state-specific **benchmark approach** for defining essential health benefits. Under this approach, each state selected a benchmark insurance plan that reflects the scope of services offered by a typical employer plan in the state. If a state did not select a benchmark plan, HHS selected the small group plan with the largest enrollment in the state as the state's default benchmark plan.

As a general rule, the items and services included in a state's benchmark plan comprise the essential health benefits that insured health plans in the state's individual and small group markets must cover.

In order to determine which benefits are essential health benefits for the purpose of removing annual and lifetime dollar limits, a self-insured group health plan, large group market health plan, or grandfathered group health plan may choose **any benchmark plan from any state** that was approved by HHS.

Also, self-insured group health plans, large group market health plans and grandfathered health plans can still exclude all benefits for a condition. This type of exclusion will not be considered an annual or lifetime limit as long as no benefits are provided for the condition.

ENROLLMENT OPPORTUNITIES

The interim final rules included a transition rule for re-enrolling individuals who previously met a plan's lifetime limit. Eligible individuals who lost plan coverage as a result of a lifetime limit must have received an enrollment notice and an opportunity to re-enroll in the plan.

The notice and enrollment opportunity must have been provided no later than the first day of the first plan year beginning on or after **Sept. 23, 2010**. Anyone who was eligible for the enrollment opportunity must have been treated as a special enrollee eligible to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

RESTRICTED ANNUAL LIMITS

The interim final rules established a three-year phased approach for restricted annual limits. Annual limits could not be less than the following amounts for plan years beginning before Jan. 1, 2014:

- **$750,000** for plan years beginning on or after Sept. 23, 2010, but before Sept. 23, 2011;
- **$1.25 million** for plan years beginning on or after Sept. 23, 2011, but before Sept. 23, 2012; and
- **$2 million** for plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014.

These were minimums for plan years; plans were permitted to use higher annual limits or impose no limits. The limits applied on an individual-by-individual basis, so that any annual limit on benefits applied to families could not cause an individual to be denied the minimum annual benefit for the plan year.

In addition, the interim final rules allowed HHS to develop a temporary waiver program for plans that could demonstrate that complying with the restrictions would result in:

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- A significant decrease in access to benefits; or
- A significant increase in premiums.

HHS granted a number of waivers and then closed the waiver program to new applications effective **Sept. 22, 2011**. Waivers and/or extensions received before that date could be effective until plan years beginning on or after Jan. 1, 2014, when all annual limits for essential health benefits are prohibited.

Waiver recipients were required to provide an annual notice informing each participant that the plan or policy did not meet the restricted annual limits for essential benefits because it received a waiver of that requirement, as well as annual updates to HHS regarding plan information and benefits.

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