Employer Compliance Alert

REGULATIONS ISSUED ON LIFETIME AND ANNUAL LIMITS

Close on the heels of their regulations concerning grandfathered plans, the Departments of Labor, Health and Human Services (HHS), and Treasury have now released interim final regulations relating to preexisting condition exclusions, lifetime and annual limits, rescissions, and other patient protections under the Affordable Care Act (the "Act"). This article focuses exclusively on the guidance relating to lifetime and annual limits.

Lifetime Limits

Under the Act, a group health plan may not establish any lifetime limit on the dollar amount of "essential health benefits" provided to any individual. This requirement is effective for plan years beginning on or after September 23, 2010. It applies to both grandfathered and non-grandfathered plans, although *not* to health FSAs or health savings accounts.

According to the Act, essential health benefits include, *at a minimum*, items and services in the following categories: ambulatory patient services; emergency services; hospitalization, maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Interestingly, the regulations provide no further guidance on the definition of "essential health benefits" -- except to say that, until HHS issues such guidance, the regulatory agencies will take into account good-faith efforts to comply with the "guidelines" set forth in the Act.

A group health plan may still impose lifetime limits on *non*-essential health benefits. Thus, the key will be to determine which benefits are "essential." For example, would treatment for autism be considered a "mental health service"? If so, it would be an essential health benefit.

Annual Limits

With respect to plan years beginning before January 1, 2014, a group health plan, including a grandfathered plan, may establish a "restricted" annual limit on the dollar amount of essential

health benefits for any individual. The new regulations define "restricted" by providing for a three-year phase-out of annual limits. Under this phase-out, the annual limit may not be less than:

- $750,000 for any plan year beginning on or after September 23, 2010, but before September 23, 2011;
- $1.25 million for any plan year beginning on or after September 23, 2011, but before September 23, 2012; and
- $2 million for any plan year beginning on or after September 23, 2012, but before January 1, 2014.

For plan years beginning on or after January 1, 2014, a plan may not impose *any* annual limit on essential health benefits.

When determining whether an individual has reached one of these annual limits, only *essential* health benefits may be taken into account. The regulations make clear that a plan is free to lower its current annual limit to these levels. However, as discussed in our recent Alert on grandfathered plans, lowering a plan's annual limit (or imposing such a limit for the first time) may result in the plan's loss of grandfathered status.

Limited Benefit or "Mini-Med" Plans

Subsequent to the Act becoming law, many in the industry have wondered about the fate of limited benefit (or "mini-med") plans. Such plans typically provide benefits that are capped at relatively low annual amounts. As a result, many benefits consultants and advisors have speculated that such plans would cease to exist once the Act's restrictions on lifetime and annual limits take effect.

Surprisingly, however, the regulations provide that HHS may establish a program (for years prior to 2014) under which the minimum annual limit requirement will be waived if establishing such a limit would result in either a significant decrease in access to benefits or significantly increased premiums. This program may provide temporary relief for mini-med plans. HHS is expected to issue additional guidance on this waiver process in the near future.

Notice of Special Enrollment Opportunity

All group health plans must provide written notice to any individual who has already effectively lost coverage because he or she reached a lifetime limit on benefits. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. It must explain that the lifetime limit no longer applies and that the

individual -- assuming he or she is still otherwise eligible -- has a 30-day special enrollment period in which to enroll in any benefit option under the plan that is available to similarly situated employees.

This notice may be included with other enrollment materials, and notice to an employee will satisfy the notice requirement for the employee's dependents, as well. Model language for this notice has just been issued by the Department of Labor and is available on the EBSA website.

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