Treasury Decision 9491(II)(B)

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II. Overview of the Regulations

A. PHS Act Section 2704, Prohibition of Preexisting Condition Exclusions (26 CFR 54.9815-2704T, 29 CFR 2590.715-2704, 45 CFR 147.108)

Section 1201 of the Affordable Care Act adds a new PHS Act section 2704, which amends the HIPAA n4 rules relating to preexisting condition exclusions to provide that a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion. The HIPAA rules (in effect prior to the effective date of these amendments) apply only to group health plans and group health insurance coverage, and permit limited exclusions of coverage based on a preexisting condition under certain circumstances. The Affordable Care Act provision prohibits any preexisting condition exclusion from being imposed by group health plans or group health insurance coverage and extends this protection to individual health insurance coverage. This prohibition generally is effective with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition becomes effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010. Until the new Affordable Care Act rules take effect, the HIPAA rules regarding preexisting condition exclusions continue to apply.

n4 HIPAA is the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191).

HIPAA generally defines a preexisting condition exclusion n5 as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Based on this definition, PHS Act section 2704, as added by the Affordable Care Act, prohibits not just an exclusion of coverage of specific benefits associated with a preexisting condition in the case of an enrollee, but a complete exclusion from such plan or coverage, if that exclusion is based on a preexisting condition.

n5 Before the amendments made by the Affordable Care Act, PHS Act section 2701(b)(1); after the amendments made by the Affordable Care Act, PHS Act section 2704(b)(1). *See also* ERISA section 701(b)(1) and Code section 9801(b)(1).

The protections in the new PHS Act section 2704 generally apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014. The Affordable Care Act provides, however, that these protections apply with respect to enrollees under age 19 for plan years (in the individual market, policy years) beginning on or after September 23, 2010. An enrollee under age 19 thus could not be denied benefits based on a preexisting condition. In order for an individual seeking enrollment to receive the same protection that applies in the case of such an enrollee, the individual similarly could not be denied enrollment or specific benefits

based on a preexisting condition. Thus, for plan years (in the individual market, policy years) beginning on or after September 23, 2010, PHS Act section 2704 protects individuals under age 19 with a preexisting condition from being denied coverage under a plan or health insurance coverage (through denial of enrollment or denial of specific benefits) based on the preexisting condition.

These interim final regulations do not change the HIPAA rule that an exclusion of benefits for a condition under a plan or policy is not a preexisting condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage. This point is illustrated with examples in the HIPAA regulations on preexisting condition exclusions, which remain in effect. n6 (Other requirements of Federal or State law, however, may prohibit certain benefit exclusions.)

n6 *See* Examples 6, 7, and 8 in 26 CFR 54.9801-3(a)(1)(ii), 29 CFR 701-3(a)(1)(ii), 45 CFR 146.111(a)(1)(ii).

Application to grandfathered health plans. Under the statute and these interim final regulations, a grandfathered health plan that is a group health plan or group health insurance coverage must comply with the PHS Act section 2704 prohibition against preexisting condition exclusions; however, a grandfathered health plan that is individual health insurance coverage is not required to comply with PHS Act section 2704. See 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 regarding status as a grandfathered health plan.

B. PHS Act Section 2711, Lifetime and Annual Limits (26 CFR 54.9815-2711T, 29 CFR 2590.715-2711, 45 CFR 147.126)

Section 2711 of the PHS Act, as added by the Affordable Care Act, and these interim final regulations generally prohibit group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime or annual limits on the dollar value of health benefits.

The restriction on annual limits applies differently to certain account-based plans, especially where other rules apply to limit the benefits available. For example, under section 9005 of the Affordable Care Act, salary reduction contributions for health flexible spending arrangements (health FSAs) are specifically limited to $ 2,500 (indexed for inflation) per year, beginning with taxable years in 2013. These interim final regulations provide that the PHS Act section 2711 annual limit rules do not apply to health FSAs. The restrictions on annual limits also do not apply to Medical Savings Accounts (MSAs) under section 220 of the Code and Health Savings Accounts (HSAs) under section 223 of the Code. Both MSAs and HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and non-medical expenses. n7 Moreover, annual contributions to MSAs and HSAs are subject to specific statutory provisions that require that the contributions be limited.

n7 Distributions from MSAs and HSAs that are not used for qualified medical expenses are included in income and subject to an additional tax, under sections 220(f)(1), (4) and 223(f)(1), (4) of the Code.

Health Reimbursement Arrangements (HRAs) are another type of account-based health plan and typically consist of a promise by an employer to reimburse medical expenses for the year up to a certain amount, with unused amounts available to reimburse medical expenses in future years. *See* Notice 2002-45, *2002-28 IRB 93; Rev. Rul. 2002-41, 2002-28 IRB 75.* When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2711, the fact that benefits under the

HRA by itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies the requirements. Also, in the case of a stand-alone HRA that is limited to retirees, the exemption from the requirements of ERISA and the Code relating to the Affordable Care Act for plans with fewer than two current employees means that the retiree-only HRA is generally not subject to the rules in PHS Act section 2711 relating to annual limits. The Departments request comments regarding the application of PHS Act section 2711 to stand-alone HRAs that are not retiree-only plans.

The statute prohibits annual limits on the dollar value of benefits generally, but allows "restricted annual limits" with respect to essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for plan years (in the individual market, policy years) beginning before January 1, 2014. Grandfathered individual market policies are exempted from this provision. In addition, the statute provides that, with respect to benefits that are not essential health benefits, a plan or issuer may impose annual or lifetime per-individual dollar limits on specific covered benefits. These interim final regulations define "essential health benefits" by cross-reference to section 1302(b) of the Affordable Care Act n8 and applicable regulations. Regulations under section 1302(b) of the Affordable Care Act have not yet been issued.

n8 Section 1302(b) of the Affordable Care Act defines essential health benefits to "include at least the following general categories and the items and services covered within the 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."

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. For example, a plan could not both apply a lifetime limit to a particular benefit--thus taking the position that it was not an essential health benefit--and at the same time treat that particular benefit as an essential health benefit for purposes of applying the restricted annual limit.

These interim final regulations clarify 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.

The statute and these interim final regulations provide that for plan years (in the individual market, policy years) beginning before January 1, 2014, group health plans and health insurance issuers offering group or individual health insurance coverage may establish a restricted annual limit on the dollar value of essential health benefits. The statute provides that in defining the term restricted annual limit, the Departments should ensure that access to needed services is made available with a minimal impact on premiums. For a detailed discussion of the basis for determining restricted annual limits, see section IV.B.3 later in this preamble.

In order to mitigate the potential for premium increases for all plans and policies, while at the same time ensuring access to essential health benefits, these interim final regulations adopt a three-year phased approach for restricted annual limits. Under these interim final regulations, annual limits on the dollar value of benefits that are essential health benefits may not be less than

the following amounts for plan years (in the individual market, policy years) 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, 2012, $ 1.25 million; and

. For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $ 2 million.

As these are minimums for plan years (in the individual market, policy years) beginning before 2014, plans or issuers may use higher annual limits or impose no limits. Plans and policies with plan or policy years that begin between September 23 and December 31 have more than one plan or policy year under which the $ 2 million minimum annual limit is available; however, a plan or policy generally may not impose an annual limit for a plan year (in the individual market, policy year) beginning after December 31, 2013.

The minimum annual limits for plan or policy years beginning before 2014 apply on an individual-by-individual basis. Thus, any overall annual dollar limit on benefits applied to families may not operate to deny a covered individual the minimum annual benefits for the plan year (in the individual market, policy year). These interim final regulations clarify that, in applying annual limits for plan years (in the individual market, policy years) beginning before January 1, 2014, the plan or health insurance coverage may take into account only essential health benefits.

The restricted annual limits provided in these interim final regulations are designed to ensure, in the vast majority of cases, that individuals would have access to needed services with a minimal impact on premiums. So that individuals with certain coverage, including coverage under a limited benefit plan or so-called "mini-med" plans, would not be denied access to needed services or experience more than a minimal impact on premiums, these interim final regulations provide for the Secretary of Health and Human Services to establish a program under which the requirements relating to restricted annual limits may be waived if compliance with these interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Guidance from the Secretary of Health and Human Services regarding the scope and process for applying for a waiver is expected to be issued in the near future.

Under these interim final regulations, 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. n9

That is, they must be given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

n9 *See* 26 CFR 54.9801-6(d), 29 CFR 2590.701-6(d), and 45 CFR 146.117(d).

Application to grandfathered health plans. The statute and these interim final regulations relating to the prohibition on lifetime limits apply to all group health plans and health insurance issuers offering group or individual health insurance coverage, whether or not the plan qualifies as a grandfathered health plan, for plan years (in the individual market, policy years) beginning on or after September 23, 2010. The statute and these interim final regulations relating to the prohibition on annual limits, including the special rules regarding restricted annual limits for plan years beginning before January 1, 2014, apply to group health plans and group health insurance coverage that qualify as a grandfathered health plan, but do not apply to grandfathered health plans that are individual health insurance coverage. The interim final regulations issued under section 1251 of the Affordable Care Act provide that:

. A plan or health insurance coverage that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits.

. A plan or health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.

. A plan or health insurance coverage that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

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