

## MODEL LANGUAGE FOR LIFETIME AND ANNUAL LIMITS

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Section 1. Definitions.

A. “Commissioner” means the commissioner of insurance.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some State agency other than the insurance department, or if there is dual regulation, a State should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. “Covered benefits” or “benefits” mean those health care services to which an individual is entitled under the terms of a health benefit plan.

C. (1) “Essential health benefits” has the meaning under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations.

(2) “Essential health benefits” include:

(a) Ambulatory patient services,

(b) Emergency services;

(c) Hospitalization;

(d) Laboratory services;

(e) Maternity and newborn care;

(f) Mental health and substance abuse disorder services, including behavioral health treatment;

(g) Pediatric services, including oral and vision care;

(h) Prescription drugs;

(i) Preventive and wellness services and chronic disease management; and

(j) Rehabilitative and habilitative services and devices.

D. “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

E. “Group health plan” means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in subsection K, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

- F. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

**Drafting Note:** The Patient Protection and Affordable Care Act (Affordable Care Act) uses the term “health insurance coverage.” The definition of “health benefit plan” is intended to be consistent with the definition of “health insurance coverage” contained in HIPAA. Paragraphs (2), (3), (4), and (5) below track the language of HIPAA that addresses “excepted benefits,” i.e., those benefits that are excepted from the requirements of the Affordable Care Act.

- (2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
- (3) “Health benefit plan” does not include:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
  - (b) Coverage issued as a supplement to liability insurance;
  - (c) Liability insurance, including general liability insurance and automobile liability insurance;
  - (d) Workers’ compensation or similar insurance;
  - (e) Automobile medical payment insurance;
  - (f) Credit-only insurance;
  - (g) Coverage for on-site medical clinics; and
  - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;
  - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
  - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
  - (b) Hospital indemnity or other fixed indemnity insurance.
- (6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

- (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
  - (c) Similar supplemental coverage provided to coverage under a group health plan.
- G. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- H. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

**Drafting Note:** The Affordable Care Act uses the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” is consistent with the term “health insurance issuer.”

- I. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for the covered person’s responsibility for copayments, coinsurance or deductibles.
- J. (1) “Individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance.
- (2) For purposes of this subsection, a health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.
- K. “Medical care” means amounts paid for:
- (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
  - (2) Transportation primarily for and essential to medical care referred to in paragraph (1); and
  - (3) Insurance covering medical care referred to in paragraphs (1) and (2).

**Section 2. Applicability and Scope**

- A. Except as provided in subsection B, these sections apply to any health carrier providing coverage under an individual or group health benefit plan.
- B. (1) The prohibition on lifetime limits applies to grandfathered plan coverage providing individual health insurance coverage or group health insurance coverage.
- (2) The prohibition and limits on annual limits applies to grandfathered plan coverage providing group health insurance coverage, but it does not apply to grandfathered plan coverage providing individual health insurance coverage.
- (3) For purposes of this subsection, “grandfathered plan coverage” means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with federal regulations.

**Section 3. Prohibition on Lifetime and Annual Limits.**

- A. (1) Except as provided in subsection B, a health carrier offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any individual.

- (2) (a) Except as provided in subparagraph (b) of this paragraph and subsections B and C, a health carrier shall not establish any annual limit on the dollar amount of essential health benefits for any individual.
  - (b) A health flexible spending arrangement (FSA), as defined in section 106(a)(2)(i) of the Internal Revenue Code, a medical savings account (MSA), as defined in section 220 of the Internal Revenue Code, and a health savings account (HSA), as defined in section 223 of the Internal Revenue Code are not subject to the requirements of subparagraph (a) of this paragraph.
- B. The provisions of subsection A shall not prevent a health carrier from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or State law.
- C. Nothing in this section prohibits a health carrier from excluding all benefits for a given condition.

**Section 4. Annual Limits Prior to January 1, 2014**

- A. For plan or policy years beginning prior to January 1, 2014, for any individual, a health benefit plan may establish an annual limit on the dollar amount of benefits that are essential health benefits provided the limit is no less than the following:
- (1) For a plan or policy year beginning after September 22, 2010, but before September 23, 2011, \$750,000;
  - (2) For a plan or policy year beginning after September 22, 2011, but before September 23, 2012, \$1,250,000; and
  - (3) For a plan or policy year beginning after September 22, 2012, but before January 1, 2014, \$2,000,000.
- B. In determining whether an individual has received benefits that meet or exceed the allowable limits, as provided in subsection A, a health carrier shall take into account only essential health benefits.
- C. (1) For plan or policy years beginning prior to January 1, 2014, a health benefit plan is exempt from the annual limit requirements if the plan is approved for a waiver from such requirements by the U.S. Department of Health and Human Services but such exemption only applies for the specified period of time that the waiver from the U.S. Department of Health and Human Services is applicable.
- (2) (a) At the time a health benefit plan receives a waiver from the U.S. Department of Health and Human Services, the health benefit plan shall notify prospective applicants and affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside.
  - (b) At the time the waiver expires or is otherwise no longer in effect, the health benefit plan shall notify affected policyholders and the commissioner in each state where any affected insured is known to reside.

**Section 5. Reinstatement of Coverage**

- A. (1) Subject to paragraph (1), this section applies to any individual:
- (a) Whose coverage or benefits under a health benefit plan ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and
  - (b) Who, due to the provisions of this section, becomes eligible, or is required to become eligible, for benefits not subject to a lifetime limit on the dollar value of all benefits under the health benefit plan:
    - (i) For group health insurance coverage, on the first day of the first plan year beginning on or after September 23, 2010; or

- (ii) For individual health insurance coverage, on the first day of the first policy year beginning on or after September 23, 2010.
- (2) For individual health insurance coverage, an individual is not entitled to reinstatement under the health benefit plan under this section if the individual reached his or her lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, this section applies to a family member who reached his or her lifetime limit in a family plan and other family members remain covered under the plan.

**Drafting Note:** Paragraph (2) is consistent with the provisions in the interim final regulations on lifetime and annual limits published in the *Federal Register* June 28, 2010. However, for those individuals falling into the situation described in paragraph (2), States may consider providing for reinstatement in the same plan or a substantially similar plan. The Affordable Care Act's preemption standards permit States to impose more stringent, consumer protection requirements.

- B. (1) If an individual described in subsection A is eligible for benefits or is required to become eligible for benefits under the health benefit plan, the health carrier shall provide the individual written notice that:
    - (a) The lifetime limit on the dollar value of all benefits no longer applies; and
    - (b) The individual, if still covered under the plan, is again eligible to receive benefits under the plan.
  - (2) If the individual is not enrolled in the plan, or if an enrolled individual is eligible for, but not enrolled in any benefit package under the plan, the health benefit plan shall provide an opportunity for the individual to enroll in the plan for a period of at least thirty (30) days.
  - (3) The notices and enrollment opportunity under this subsection shall be provided beginning not later:
    - (a) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or
    - (b) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.
  - (4) (a) The notices required under this subsection shall be provided:
    - (i) For group health insurance coverage, to an employee on behalf of the employee's dependent; or
    - (ii) For individual health insurance coverage, to the primary subscriber on behalf of the primary subscriber's dependent.
  - (b) (i) For group health insurance coverage, the notices may be included with other enrollment materials that a health benefit plan distributes to employees, provided the statement is prominent.
  - (ii) In addition to subparagraph (i) of this paragraph, for group health insurance coverage, if a notice satisfying the requirements of this subsection is provided to an individual, a health carrier's requirement to provide the notice with respect to that individual is satisfied.
- C. For any individual who enrolls in a health benefit plan in accordance with subsection B, coverage under the plan shall take effect not later than:
    - (1) For group health insurance coverage, the first day of the first plan year beginning on or after September 23, 2010; or
    - (2) For individual health insurance coverage, the first day of the first policy year beginning on or after September 23, 2010.

**Section 6. Special Enrollment Requirement**

- A. An individual enrolling in a health benefit plan for group health insurance coverage in accordance with section 5 shall be treated as if the individual were a special enrollee in the plan, as provided under federal regulations 45 CFR §146.117(d).
- B. The individual:
  - (1) Shall be offered all of the benefit packages available to similarly situated individuals who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and
  - (2) Shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.
- C. For purposes of subsection B(1), any difference in benefits or cost-sharing constitutes a different benefit package.

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