



LEGISLATIVE BRIEF

Health Care Reform: Application of Annual Limit Restrictions to HRAs

The Patient Protection and Affordable Care Act (PPACA) generally prohibits group health plans and group health coverage issuers from imposing lifetime or annual limits on the dollar value of essential health benefits, effective for plan years beginning on or after **Sept. 23, 2010**. Although annual limits are generally prohibited, “restricted annual limits” are permitted for essential health benefits for plan years beginning before Jan. 1, 2014.

[Interim final regulations](#) provide that the annual limit requirements may be waived by the Department of Health and Human Services (HHS) if compliance with the restrictions would result in a significant decrease in access to benefits or a significant increase in premiums. In 2010, HHS released guidance on how to apply for a waiver of the annual limit requirements. In June 2011, HHS announced that it will conclude the annual limit waiver application process on **Sept. 22, 2011**. Annual limit waivers expire effective for plan years beginning on or after Jan. 1, 2014, when all annual limits are prohibited.

On Aug. 19, 2011, HHS issued [supplemental guidance](#) describing how PPACA’s annual limit requirements apply to health reimbursement arrangements (HRAs). Under this guidance, stand-alone HRAs that are subject to PPACA’s annual limit requirements and were in existence prior to Sept. 23, 2010, automatically receive a waiver of the restricted annual limits, provided they comply with the annual notice and record retention requirements.

This Tailor Made Benefit Solutions Legislative Brief provides an overview of HHS’s guidance on annual limit restrictions for HRAs and includes a model annual notice.

APPLICATION OF ANNUAL LIMIT REQUIREMENTS

HRAs Integrated with Other Coverage

The interim final regulations distinguish between stand-alone HRAs and HRAs integrated with other group health coverage. The regulations indicate that an HRA integrated with other group health coverage is not required to satisfy the annual limit restrictions if the other coverage alone satisfies PPACA’s annual limit restrictions. If an annual limit waiver is obtained for the other coverage that is integrated with an HRA, the waiver applies to the combined coverage and no separate waiver is needed for the HRA.

Stand-Alone HRAs and Waiver Exemption

Some stand-alone HRAs are not subject to PPACA’s annual limit restrictions because they fall under an exception, such as retiree-only HRAs, vision-only or dental-only HRAs and certain HRAs that qualify as health flexible spending accounts (FSAs). For other stand-alone HRAs, it has been somewhat unclear how PPACA’s annual limit restrictions apply, and whether these HRAs are required to receive waivers of the annual limit restrictions for plan years beginning before Jan. 1, 2014. HHS’s supplemental guidance provides some clarity on these issues.



Health Care Reform: Application of Annual Limit Restrictions to HRAs

In its supplemental guidance, HHS recognizes that, in general, all HRAs set annual limits lower than PPACA's restricted annual limit amounts and applying PPACA's annual limit restrictions to HRAs would result in a significant decrease in access to HRA benefits. **To provide relief, the supplemental guidance provides that HRAs that were in effect prior to Sept. 23, 2010, and are subject to PPACA's annual limit requirements do not need to file an extension for a previously granted waiver or file a new waiver application.** Rather, all of these HRAs will be deemed to satisfy the waiver requirements for plan years beginning prior to Jan. 1, 2014, subject to the annual notice and record retention requirements discussed below. Thus, these HRAs are exempt from the annual limit waiver process and may continue to impose annual limits for plan years beginning prior to Jan. 1, 2014.

ANNUAL NOTICE AND RECORD RETENTION REQUIREMENTS

In order for the annual limit waiver exemption to apply, HRAs must comply with the waiver program's record retention and annual notice requirements. According to HHS, the annual notice requirement is necessary for consumers to understand the value and quality of their health coverage. The record retention provision requires HRA sponsors to retain information regarding plan benefits and coverage. For more information on these requirements, please refer to the ["Technical Instructions for the Waiver Extension and Waiver Application Process."](#)

HHS drafted alternate annual notice language for HRAs. The notice applies to HRA applicants who have already received a waiver as well as to HRAs exempt from applying for an annual waiver. An HRA that has already received a waiver and issued the annual notice, as updated by HHS in June 2011, does not need to re-issue the new notice.

The following criteria apply to the notice:

- It must be printed in 14-point, bold font on the front of plan materials; and
- It must be provided to new eligible participants and subscribers and at the beginning of the plan year. If the plan year has already begun and notice has not been issued, it must be provided within 60 days of the date of HHS's supplemental guidance, or **Oct. 18, 2011**.

MODEL ANNUAL NOTICE

The following language must be used to satisfy the annual notice requirement:

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least [\$750,000/\$1.25 million/\$2 million as applicable].

Your health coverage offered by [name of group health plan/applicant], does not meet the minimum standards required by the Affordable Care Act described above. Your employer makes an annual contribution of:

**[Dollar amount] to your Health Reimbursement Arrangement (HRA).
This means your health coverage may not pay for all the health care expenses you may incur.**

The U.S. Department of Health and Human Services has granted your HRA a waiver from the requirement that it provide [\$750,000/\$1.25 million/\$2 million] in benefits until

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[the end date of the last plan or policy year beginning before Jan. 1, 2014] because it would cause a significant decrease in your access to this benefit.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact [provide contact information for plan administrator]. [For plans offered in States with a Consumer Assistance Program] Additionally, you can contact [contact information for Consumer Assistance Program].

Source: Department of Health and Human Services