



Benefit Advisors Network Legal eBlast



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Health Care Reform: HHS Releases Guidance Regarding the Annual Limit Waiver Program September 13, 2010

On September 3, 2010, the U.S. Department of Health and Human Services (HHS) issued a bulletin regarding the program under which a health plan or insurer may obtain a waiver from the minimum annual limit requirements contained in the Affordable Care Act (the Act).[1] In general, the waiver program is designed to provide relief to individuals who are covered under “limited benefit” or “mini-med” plans by permitting low annual limits to remain in place notwithstanding the Act’s requirements, so that the covered individuals do not incur a significant reduction in benefits or increase in premiums.

The Act’s Restricted Annual Limit Requirements

As we have discussed in earlier client alerts, the Act generally permits group health plans and insurers to include restricted annual limits on essential health benefits until 2014. These restricted annual limits may not be less than:

- \$750,000 for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011
- \$1,250,000 for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012
- \$2,000,000 for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014

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

Notwithstanding the above requirements, the Interim Final Regulations (the Regulations) published on June 28, 2010 provided for the Secretary of HHS to establish a program under which the requirements relating to restricted annual limits may be waived if compliance with the requirements would result in a significant decrease in access to benefits under the plan or policy or a significant increase in premiums. The regulations did not include any details regarding the program, but stated that HHS was expected to issue guidance in the near future.

HHS Issues Guidance on the Waiver Program

As recognized by HHS in the bulletin issued on September 3, 2010, “limited benefit” or “mini-med” plans, which typically have annual limits that are well below the restricted annual limits permitted by the Act, serve the purpose of providing some level of lower-cost health coverage to part-time, seasonal and other workers who may not be able to afford coverage at all. Accordingly, in order to ensure that these individuals would not be denied access to coverage or experience more than a minimal premium increase, the regulations created a waiver process whereby a plan may not have to comply with the restricted annual limits of the Act if compliance would result in a significant decrease in access to benefits or would significantly increase premiums.

As stated in the bulletin, a group health plan or insurer may apply for a waiver from the restricted annual limit requirements (for plan years prior to January 1, 2014) if the plan or coverage offered by the insurer was in effect prior to September 23, 2010, by submitting an application that includes the following:

1. The terms of the plan or policy form(s) for which a waiver is sought;
2. The number of individuals covered by the plan or policy form(s);
3. The annual limit(s) and rates applicable to the plan or policy form(s);
4. A brief description of why compliance with the regulations would result in a significant decrease in access to benefits for those currently covered by the plan or policy, or a significant increase in premiums paid by those covered by the plan or policy, along with any supporting documentation; and
5. An attestation, signed by the plan administrator or chief executive officer of the insurer, certifying that (i) the plan or policy was in force prior to September 23, 2010, and (ii) the application of restricted annual limits to the plan or policy would result in a significant decrease in access to benefits for those currently covered by the plan or policy, or a significant increase in premiums paid by those covered by the plan or policy.

The bulletin further provides that the administrator or chief executive officer should retain documents in support of the application for potential examination by HHS.

It is noteworthy that HHS states in the bulletin that the waiver process does not impact any state law requirement regarding annual benefit limits in group health plans or group and individual health insurance coverage.

Application Process: Timing and Method of Submission

For plan or policy years beginning between September 23, 2010 and September 23, 2011, the application must be submitted to HHS **not less than 30 days before the beginning of the plan or policy year** or, if the plan or policy year begins before November 2, 2010, **not less than 10 days before the beginning of the plan or policy year**.

A waiver granted for the plan or policy year beginning between September 23, 2010 and September 23, 2011 applies only for that year; accordingly, the plan or insurer must reapply for any subsequent year. For future applications, plans and insurers should bear in mind that HHS has indicated that it may modify the waiver process in future guidance.

Applications may be submitted by mail or email. If by mail, the application should be sent to U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, Office of Oversight, Attention James Mayhew, Room 737-F-04, 200 Independence Avenue SW, Washington, D.C. 20201. If by email, it should be sent to healthinsurance@hhs.gov, with "waiver" as the subject of the email.

Processing/Approval

HHS has stated that it will process complete waiver applications within 30 days of receipt, or within five days of the beginning of the plan or policy year for applications relating to plan or policy years that begin before November 2, 2010.

Other than the above list of items that must be included in the waiver application, the bulletin does not offer any more specific guidance regarding the contents of the application and the standards for approval. However, questions may be directed to the Office of Consumer Information and Insurance Oversight at (301) 492-4100 or by email to healthinsurance@hhs.gov (with "waiver" as the subject of the email).

[1] The "Affordable Care Act" means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA). For more information about the Act, please visit our Health Care Reform Task Force website at <http://www.proskauer.com/practices/health-reform-task-force>.

