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HHS Sets Out Process for Requesting Waiver of the Annual Dollar Limit Requirements under PPACA

The Department of Health and Human Services (HHS) has issued guidance on the process that group health plans and health insurance issuers may use to request a waiver of the annual dollar limit requirements of the Patient Protection and Affordable Care Act (PPACA). Sponsors of limited benefit or mini-med plans that obtain a waiver will be able to maintain these plans and be in compliance with health care reform mandates prior to 2014.

Background

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, includes restrictions on the imposition of annual dollar limits on essential health benefits. Interim final regulations issued in June, 2010 provide that for plan or policy years beginning on and after September 23, 2010, group health plans subject to PPACA and health insurance issuers may only impose "restricted annual limits" on essential health benefits. (See our July 2, 2010 *For Your Information*.) Under the regulations, restricted annual limits on the dollar value of essential health benefits cannot be lower than –

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

No annual limits on essential health benefits will be permitted for plan or policy years beginning on or after January 1, 2014.

Some employers offer low-cost "limited benefit" plans or "mini-med" plans to part-time workers, seasonal workers, and other segments of the workforce who otherwise may not be able to afford coverage at all. These plans often have overall annual limits well below the restricted annual limits set out in the interim final regulations. To ensure that individuals with coverage under these plans would not be adversely affected, the regulations contemplated a waiver process for plan or policy years beginning prior to January 1, 2014 for cases in which compliance with the regulations' restricted annual limit provisions "would result in a significant decrease in access to benefits" or "would significantly increase premiums."

On September 3, 2010, HHS issued sub-regulatory guidance in the form of a memorandum that sets out the process for requesting a waiver from the restricted annual limit requirement.

The Waiver Application Process

The guidance details a process through which a group health plan or health insurance issuer may apply for a waiver from the restricted annual limits established by the interim final regulations. To qualify, the plan or coverage must have been offered prior to September 23, 2010. The waiver, if granted, will apply for the plan or policy year beginning between September 23, 2010 and September 23, 2011. A plan or health insurance issuer will have to reapply for the waiver for any subsequent plan or policy year prior to January 1, 2014.

Content of Application. There is no specific waiver application form that must be used. The guidance simply specifies that an application for a waiver include –

- the terms of the plan or policy form(s) for which a waiver is sought

  BUCK COMMENT. *Although the precise requirement is not clear, it appears that a certificate of coverage should be submitted for an insured plan and a summary plan description should be submitted for a self-funded plan.*

- the number of individuals covered by the plan or policy forms(s)
- the annual limit(s) and rates applicable to the plan or policy form(s)
- a brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by the plans or policies, or significant increase in premiums paid by those covered by the plans or policies, along with any supporting documentation, and
- an attestation, signed by the plan administrator or chief executive officer of the issuer of the coverage, that certifies –
  - the plan was in force prior to September 23, 2010, and
  - the application of restricted annual limits to the plans or policies would result in a significant decrease in access to benefits for, or a significant increase in premiums paid by, individuals covered by such plans or policies.

The guidance states that the plan administrator or chief executive officer of the issuer should retain documents in support of this application for potential examination by the Secretary.

BUCK COMMENT. *The guidance does not address whether the Secretary can approve a waiver from an insurer or administrator that would apply to multiple group health plans, or whether an application must be submitted separately for each group health plan. However, several of the insurance carriers are submitting the applications for their clients with group health plans.*

Timing of Submission. Generally, the waiver application must be submitted not less than 30 days before the beginning of the plan or policy year. However, a waiver application for a plan or policy year that begins before November 2, 2010 may be submitted not less than 10 days before the beginning of the plan or policy year. According to the guidance, HHS will process complete waiver applications within 30 days of receipt, but complete applications submitted for plan or policy years beginning before November 2, 2010 will be processed no later than 5 days in advance of the plan year.

How to Submit. Waiver applications should be submitted to HHS, Office of Consumer Information and Insurance Oversight, Office of Oversight, Attention: James Mayhew, Room 737-F-04, 200 Independence Ave. SW, Washington, DC 20201 or emailed to healthinsurance@hhs.gov. Applicants are directed to use "waiver" as the subject of the email.

> ***BUCK COMMENT.*** *With open enrollments looming for many plan sponsors, this application should be made as soon as possible.*

Conclusion

Buck's consultants are available to assist in the financial analysis of existing plans and completion of the waiver application.