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HHS Sets Termination Date for Annual Limit Waiver Program, Details Process for Waiver Extensions and New Waiver Applicants

On June 17, 2011, HHS released supplemental guidance that (1) sets a September 22, 2011 termination date for the annual limits waiver program under health care reform; (2) provides that waiver recipients can extend existing waivers for plan or policy years beginning before January 1, 2014; (3) imposes a time limit on the submission of new waiver applications; and (4) requires old and new waiver recipients to provide annual notices to eligible participants and beneficiaries.

Background

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively "PPACA"), generally prohibits 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 essential health benefits. However, for plan or policy years beginning before January 1, 2014, group health plans and health insurance issuers may impose the following annual limits with respect to essential health benefits:

- $750,000 for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011;
- $1.25 million for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012; or
- $2 million for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014.

In June 2010, the Department of Health and Human Services (HHS) established a waiver program that allows group health plans or health insurance issuers that offer a limited benefit ("mini-med" plans) to receive a waiver of the restricted annual limit requirements if they satisfy certain conditions. In guidance issued in September, November, and December 2010, HHS set out the program's application process and requirements. (See our September 17, 2010, November 11, 2010 and December 21, 2010 *For Your Informations*.)

Supplemental Guidance

On June 17, 2011, HHS released additional supplemental guidance relating to the waiver program.

Waiver Extensions

The supplemental guidance provides that group health plans or health insurance issuers previously granted waivers may elect to extend their waivers for plan or policy years beginning before January 1, 2014. To do so, group health plans or health insurance issuers must complete a Waiver Extension Form and provide the following information:

- Updated contact information for both the applicant and the individual who prepares the applicant's annual update;
- Up-to-date enrollment information for the plan or policy;
- The plan or policy's current annual limit; and
- A signed attestation certifying that (1) the plan existed before September 23, 2010; (2) compliance with the interim final regulations would result in a "significant decrease in access to benefits" or a "significant increase in premiums"; and (3) the plan or issuer will comply with the requirement to provide annual notice to consumers.

A waiver extension can only apply to plan years beginning on or after September 23, 2011. While a waiver election can be made for multiple years, plans must submit the information described above by the end of each calendar year. In addition, plans and issuers receiving waiver extensions must retain all records relating to the waiver applications so HHS may audit the applications. The supplemental guidance provides that if, during an audit, HHS finds material mistakes or omissions, it may withdraw the waiver or waiver extension and require that the plan or issuer immediately comply with PPACA's annual limit requirements.

Waiver recipients electing to extend their waivers must submit the Waiver Extension Form and signed attestation to HHS by email. The agency began accepting elections for waiver extensions on June 24, 2011. The deadline to submit a waiver extension form is September 22, 2011; applications received after that date will not be accepted.

New Applicants

The supplemental guidance provides that a plan or issuer that had not previously applied for or been granted a waiver may submit an application for an annual limit waiver if the plan:

- Was offered before September 23, 2010; and
- Does not meet the restricted annual limits set forth in the interim final regulations.

A new applicant must submit a New Application Form (as of June 17, 2011, HHS is no longer accepting waiver applications using the old application forms) by email and a signed attestation certifying that:

- The plan or policy existed before September 23, 2010;
- Compliance with the interim final regulations would result in a "significant decrease in access to benefits" or a "significant increase in premiums" (new applicants may submit supplemental information demonstrating that either or both of these two circumstances exist); and
- The plan or issuer will comply with the requirement to provide annual notice to consumers.

The waiver program is accepting new applications from June 24, 2011 to September 22, 2011. After September 22nd, the waiver application process is closed.

BUCK COMMENT. *HHS reasons that the plans that would benefit most from the waiver program (i.e., plans with very low annual dollar limits) have already received a waiver, and plans with higher annual limits are less likely to qualify for a waiver because they are less likely to establish that compliance with the interim final regulations would result in a "significant decrease in access to benefits" or a "significant increase in premiums."*

Under the supplemental guidance, a new waiver approval applies to plan or policy years beginning before January 1, 2014.

BUCK COMMENT. *Under the September 3, 2010 supplemental guidance, the Secretary of HHS could only waive the restricted annual dollar limits for one year at a time.*

Like plans and issuers extending existing waivers, new applicants granted waivers must submit updated plan information annually and retain all records relating to the waiver application. HHS has discretion to withdraw a waiver or waiver extension if the recipient fails to comply with the above detailed requirements.

Annual Notice Obligation

Prior supplemental guidance requires plans and issuers receiving a waiver of the annual limit requirements to provide a notice informing eligible participants and subscribers that the plan or policy does not meet the minimum annual limits for essential health benefits and has received a waiver of the requirement. The most recent guidance requires plans and issuers extending a waiver and those receiving new waivers to distribute an updated annual notice to eligible participants and subscribers for each plan or policy year in which a waiver is in effect. This notice must be provided in plan or policy materials that describe the terms of coverage, such as a summary plan description. An updated model notice is included in the supplemental guidance. If a plan or issuer wants to use alternative notice language, it must receive written permission from HHS.

BUCK COMMENT. *The model notice included in the supplemental guidance is substantially different from the model notice contained in the previous supplemental guidance issued in December 2010.*

Conclusion

Because of the fast approaching deadline for extending a waiver application or applying for a new waiver, plans and issuers will want to move quickly to process their applications. Plan sponsors with insured plans should confirm that their insurer is filing the required waiver application.

Buck's consultants are available to assist you with submitting a waiver extension application, applying for a new waiver, and understanding the impact of the supplemental guidance on your plans.