Proskauer

Revised Waiver Application Process

June 20, 2011

On June 17, 2011, the U.S. Department of Health and Human Services (HHS) issued a guidance bulletin modifying certain terms of 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] As described below, recipients of these waivers must take action by September 22, 2011 in order to preserve those waivers through the end of 2013.

Background

Generally, Section 2711 of the Public Health Service Act, as amended by the Act, prohibits annual dollar limitations on essential health benefits for plan or policy years beginning on or after January 1, 2014. Prior to that date, the law permits only restricted annual limits on essential health benefits. The restricted limits are $750,000 (plan/policy years beginning on or after September 23, 2010 but before September 23, 2011), $1,250,000 (plan/policy years beginning on or after September 23, 2011 but before September 23, 2012) and $2,000,000 (plan/policy years beginning on or after September 23, 2012 but before January 1, 2014).

As discussed in earlier Client Alerts, the Interim Final Regulations issued under these rules authorized HHS to waive the restricted annual limit requirements for limited benefit, or "mini-med" plans if compliance with the restricted annual limits would result in a significant increase in participant premiums or significant decrease in access to benefits. HHS developed a program pursuant to which plans and issuers could apply annually for a waiver that would be effective for one year.

Recent Changes

In a fact sheet issued on June 17, 2011, HHS's Centers for Medicare & Medicaid Services made the following changes to the program:

- The waiver process will conclude September 22, 2011 and no new applications will be accepted after that time. (Most plans that require a waiver should already have applied for one by that date.)

- Health plans and issuers will no longer need to apply for a waiver each year. Instead, a health plan that received a waiver for the first plan year beginning on or after September 23, 2010 will need to apply for an extension of that waiver by completing a waiver extension form (found here under the Other Resources link: http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html) and providing certain information, as well as a required attestation. Detailed instructions (which also contain the required attestation language) can be found at that link. **This must be done between June 24, 2011 and September 22, 2011 or else the plan or issuer will need to comply with the restricted annual limit requirements starting with the plan or policy year beginning on or after September 23, 2011.** Plan sponsors and issuers should carefully review the instructions for completing the extension forms, as the requirements are quite specific (and provide a new e-mail address for submission).
- As a condition of the extension, updates must be filed by December 31, 2012 and December 31, 2013 providing the same materials as are required for the extension (including an updated extension form and attestation).
- New applicants (including those who applied for, but did not yet receive, a waiver by June 17, 2011) will need to complete a spreadsheet (revised from the previously required spreadsheet) providing the required information and submit an attestation consistent with the June 17, 2011 guidance. The spreadsheet and detailed application instructions can be found at the link above. **Since a plan or issuer that applied for, but had not received, a waiver prior to June 17, 2011 is considered a new applicant, it appears that such plans and issuers must update their applications with the new excel spreadsheet and attestation.** Waivers granted for new applicants will be effective through the end of 2013, without the need to apply for an extension (although the annual updates and notices are provided as required for those who apply for an extension).
- Plans and issuers that received a waiver must now distribute a notice **annually** to all eligible participants and subscribers informing them of the waiver. HHS has issued a new model notice that must be used unless written consent is obtained for alternative language.
- HHS confirmed that, except in the case of state-mandated policies addressed in previous guidance (and except as to new participants in existing group health plans), health insurance issuers may not rely on waivers to provide new policies to group health plans or sell new policies in the individual market after September 23, 2010 that do not satisfy the restricted annual limit requirements.
- HHS may withdraw waivers (i) for failure to submit annual update information by December 31, 2012 and December 31, 2013, (ii) for failure to retain records pertaining to the application sufficient for HHS to conduct an audit of the waiver

application, or (iii) due to material mistakes or omissions in an application.

The new HHS guidance (which can be found here http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf) contains important information and new deadlines for recipients and prospective recipients of annual limit waivers under the Act. Careful review of this new guidance is necessary in order to obtain and preserve these waivers.

[1] The Affordable Care Act refers to The Patient Protection and Affordable Care Act, Public Law 111-148, and the Health Care and Education Reconciliation Act, Public Law 111-152.

Related Professionals

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