

HHS To Cease Accepting New Applications For Annual Limit Waivers

As described in our September 2010 Action Memo, the Patient Protection and Affordable Care Act of 2010 (the “Act”) generally prohibits all group health plans and health insurance issuers (including grandfathered plans) from imposing annual or lifetime dollar limits with respect to certain “essential health benefits” (as defined in Section 1302(b) of the Act) for plan years beginning on or after September 23, 2010. For plan years beginning prior to January 1, 2014, however, plan sponsors may apply certain “restricted annual limits” (“RAL”) in accordance with the interim final regulations, issued jointly by the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services (“HHS”) on June 28, 2010.¹

Background. The RALs are intended to provide transitional relief to certain group health plans and health insurance issuers that currently impose annual limits on essential health benefits. However, in recognition of the difficulties that the annual limit requirements would create for existing limited benefit plans, or “mini-med” plans (e.g., a temporary health insurance plan with a \$10,000 annual limit on essential health benefits), the Act authorized HHS to establish an annual limit waiver program for eligible plans or policy issuers. The waiver program is described in the June 28, 2010 interim final regulations (“IFR”).

On September 3, November 5, and December 9, 2010, HHS’s Center for Consumer Information and Insurance Oversight (“CCIIO”) issued guidance, which explains the requirements for the annual limit waiver application process. Waivers previously granted in accordance with that guidance are valid for one year.

September 22, 2011 Deadline. On June 17, 2011, the CCIIO issued supplemental guidance, which includes procedures for obtaining an extension of existing waivers, and revisions to the application process for new applicants. Additionally, the supplemental guidance requires plans or policy issuers to provide eligible participants and policy subscribers with an “Annual Notice,” provide HHS with an annual update, and retain waiver-related records in case of an HHS audit, as described below. *Significantly, HHS announced that all waiver extension requests and new applications for waivers must be received on or before September 22, 2011.* New application and extension request forms are available on the CCIIO’s website (see <http://cciio.cms.gov/resources/other/index.html#alw>). Plans or policy issuers that do not receive approval for an extension or waiver will be required to come into compliance with the annual limit rules under the Act and the IFR.

¹ For a more detailed discussion of the Departments’ jointly issued interim final regulations regarding (among other things) the prohibition on annual dollar limits with respect to essential health benefits, see the Employee Benefits Law Action Memo (September 2010), available at <http://www.bsk.com/archives/detail.cfm?archive=publication&ID=1223>. The Restricted Annual Limits for plan years beginning before January 1, 2014 are:

- \$750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;
- \$1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and
- \$2 million for plan years beginning on or after September 23, 2012, but before September 23, 2013.

Extensions for Plans or Policy Issuers with Existing Waivers. Plans and policy issuers that wish to extend existing waivers (i.e., those received for the plan or policy year beginning on or after September 23, 2010, but before September 23, 2011) must request a waiver extension by submitting the extension request form described above. The request should include updated contact information, enrollment information for the plan or policy, the plan's or policy's current annual limit, and a signed attestation that the plan or policy continues to satisfy the eligibility criteria for obtaining a waiver. Once the initial waiver extension is granted, plans or policy issuers must submit the same information at the end of each applicable calendar year (i.e., December 31, 2012 and December 31, 2013).

Existing waivers may be extended until January 1, 2014, so long as the plan or policy issuer: (1) provides the information described above by the end of each calendar year for which the extension applies; and (2) retains all records pertaining to the waiver application in the event of an HHS audit (see discussion below).

For New Waiver Applicants. Under the supplemental guidance, a plan or policy issuer is eligible to apply for a new waiver if: (1) the plan or policy was issued prior to September 23, 2010; (2) the plan or policy issuer (with respect to the policy) has never applied for or been granted a waiver; and (3) the plan or policy coverage does not exceed the RAL amount for the applicable plan year (see footnote 1). New applications will be reviewed using factors listed in the CCIIO's November 5, 2010 guidance (available at http://cciio.cms.gov/resources/files/annual_limits_waiver_guidance.pdf). Applicants may also submit optional supplemental information to demonstrate how the plan's or policy issuer's compliance with the IFR (in the absence of a waiver) would result in a "significant decrease in access to benefits" or a "significant increase in premiums."

Annual Notice Requirement. Under the CCIIO's December 9, 2010 guidance, plans or policy issuers with existing annual limit waivers must provide an "Annual Notice" informing all eligible participants and subscribers that the plan or policy does not satisfy the minimum restricted annual limits for essential health benefits and has received a waiver of the requirement. Mandatory language for the Annual Notice is provided in the June 17, 2011 supplemental guidance. Plans or policy issuers may not use other notice language to satisfy this requirement, unless the plan or issuer obtains permission from the CCIIO. The Annual Notice must be provided each year the annual limit requirements are waived,² and must be provided conspicuously, in bold 14-point font, on the front of plan or policy materials that describe the plan's or policy's terms of coverage (e.g., summary plan descriptions).

Record Retention. Plans or policy issuers with existing waivers must retain all waiver-related records (including documentation used in supporting the plan's or issuer's original waiver application). If, during audit, HHS determines the waiver data provided by an applicant contains material mistakes or omissions, HHS may withdraw the waiver or extension, and require the plan or policy issuer to come into compliance with the annual limit rules under the Act and IFR.

ACTION REQUIRED → *Plans or policy issuers seeking to extend existing waivers or to apply for new waivers should prepare (or have prepared) extension requests or new applications in accordance with the requirements and procedures contained in the CCIIO's June 17, 2011 supplemental guidance, for submission on or before September 22, 2011.*

2 The Annual Notice must be provided to enrollees:

- for any new applicant approved after June 17, 2011, for a plan or policy year beginning on or after September 23, 2010 but before September 23, 2011 that does not meet the \$750,000 restricted annual limit;
- each plan or policy year for a new applicant or recipient of a waiver extension beginning on or after September 23, 2011 but before September 23, 2012 that does not meet the \$1.25 million restricted annual limit; and
- each plan or policy year for a new applicant or recipient of a waiver extension beginning on or after September 23, 2012 but before September 23, 2013 that does not meet the \$2 million restricted annual limit.

Plans or policy issuers that have been granted a waiver or extension should review the revised compliance requirements described in the supplemental guidance, which include providing an annual update to HHS, providing an Annual Notice to all eligible participants and policy subscribers, and retaining all waiver-related records to avoid issues that could arise in an HHS audit.

If you have any questions about this memorandum, please contact Susie Dahline in our Syracuse office (315.218.8227, sdahline@bsk.com) or any of the other members of our Employee Benefits and Executive Compensation Practice Group listed below:

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