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From: Steve Larsen, Director, Office of Oversight

Title: Insurance Standards Bulletin Series--INFORMATION

Subject: OCIO Sub-Regulatory Guidance (OCIO 2010 - 1): Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711

Markets: Group and Individual

I. Purpose

Section 2711(a)(2) of the Public Health Service Act (PHS Act)¹, as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act)² for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a “restricted annual limit” that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. The preamble to those regulations further provided that guidance from HHS regarding the scope and process for applying for such a waiver would be issued in the near future. This memorandum constitutes that guidance.

¹ The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act, which includes PHS Act section 2711, into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans.

² The interim final regulations under PHS Act section 2711 defined “essential health benefits” by cross-reference to section 1302(b) of the Affordable Care Act and applicable regulations. Regulations under section 1302(b) of the Affordable Care Act have not yet been issued. The preamble to the interim final regulations provides that, for plan years (in the individual market, policy years) beginning before the issuance of regulations defining “essential health benefits”, the Departments of Health and Human Services, Labor and the Treasury (the Departments) will take into account good faith efforts to comply with a reasonable interpretation of the term “essential health benefits.”

II. Background

Section 2711 and the interim final regulations (26 CFR §54.9815-2719T; 29 CFR §2590.715-2719; and 45 CFR §147.126) allow the imposition of “restricted annual limits” on essential health benefits for plan years for group health plans and group health insurance coverage, and for policy years for new non-grandfathered individual health insurance coverage, beginning before January 1, 2014. No annual limits on essential health benefits are permitted with respect to plan or policy years beginning on or after January 1, 2014, except in the case of grandfathered individual market policies. **Group health plans and health insurance coverage that meet the definition of an excepted benefit pursuant to section 2791 of the PHS Act, section 732 of ERISA, or section 9831 of the Internal Revenue Code are not governed by this Memorandum.**

As set forth in the interim final regulations, the restricted annual limits on the dollar value of essential health benefits cannot be lower than:

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

A class of group health plans and health insurance coverage, generally known as “limited benefit” plans or “mini med” plans, often has annual limits well below the restricted annual limits set out in the interim final regulations. These group plans and health insurance coverage often offer lower-cost coverage to part-time workers, seasonal workers, and volunteers who otherwise may not be able to afford coverage at all. In order to ensure that individuals with certain coverage, including coverage under limited benefit or mini-med plans, would not be denied access to needed services or experience more than a minimal impact on premiums, the interim final regulations contemplated a waiver process for plan or policy years beginning prior to January 1, 2014 for cases in which compliance with the restricted annual limit provisions of the interim final regulations “would result in a significant decrease in access to benefits” or “would significantly increase premiums.” This waiver process does not impact any State law requirement addressing annual benefit limits in group health plans, or group and individual health insurance coverage.

III. The Waiver Process

A group health plan or health insurance issuer may apply for a waiver from the restricted annual limits set forth in the interim final regulations if such plan or the coverage offered by such issuer was offered prior to September 23, 2010 for the plan or policy year beginning between September 23, 2010 and September 23, 2011 by submitting an application not less than 30 days before the beginning of such plan or policy year, or in the case of a plan or policy year that begins before November 2, 2010 not less than 10 days before the beginning of such plan or policy year. The application must include:

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) submitted;

3. The annual limit(s) and rates applicable to the plan or policy form(s) submitted;
4. 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 such plans or policies, or significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation; and
5. An attestation, signed by the plan administrator or Chief Executive Officer of the issuer of the coverage, certifying 1) that the plan was in force prior to September 23, 2010; and 2) that the application of restricted annual limits to such plans or policies would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies.

The plan administrator or Chief Executive Officer should retain documents in support of this application for potential examination by the Secretary.

HHS will process complete waiver applications within 30 days of receipt, except that complete applications submitted for plan or policy years beginning before November 2, 2010 will be processed no later than 5 days in advance of such plan or policy year.

A waiver approval granted under the process set forth in this memorandum applies only for the plan or policy year beginning between September 23, 2010 and September 23, 2011. A group health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process after reviewing the information provided in connection with the waiver process set forth in this memorandum and other relevant information.

A group health plan or health insurance issuer that provides coverage that would meet the above criteria and that wishes to obtain a waiver of the restricted annual limit requirements should apply for such waiver by submitting the items referenced above within the timeframe described above 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 emailing the items to healthinsurance@hhs.gov (use “waiver” as the subject of the email).

Where to get more information:

If you have any questions regarding this Bulletin, please contact the Office of Consumer Information and Insurance Oversight at (301) 492 4100 or email at healthinsurance@hhs.gov (use “waiver” as the subject of the email).