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HEALTHCARE BULLETIN

November 4, 2010

HHS WAIVER PROGRAM

On September 3, 2010, the Department of Health and Human Services ("HHS") issued a bulletin on the process for obtaining waivers from the minimum annual limit requirements contained in the Patient Protection and Affordable Care Act (the "Act"). In general, the waiver program is designed to provide relief to health insurers that offer plans known generally known as "limited benefit" or "mini-med" plans.

A. Background

The Act generally prohibits group health plans, and group and individual health insurance issuers, from imposing lifetime or annual limits on the dollar value of essential health benefits, effective for plan years beginning on or after September 23, 2010. Although annual limits are generally prohibited, "restricted annual limits" are permitted for essential health benefits for plan years beginning before January 1, 2014. Under interim final regulations published on June 28, 2010, restricted annual limits on the dollar value of essential health benefits cannot be lower than:

- $750,000 for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011.

- $1,250,000 for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012.

- $2,000,000 for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014.

For plan or policy years beginning on or after January 1, 2014, a health plan or insurer generally may not impose any annual limit on essential health benefits.

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."

B. Waiver process.

The HHS bulletin indicates that a group health plan or health insurer may apply for a waiver from the restricted annual limits set forth in the interim final regulations if the plan or the coverage offered by the insurer was offered prior to Sept. 23, 2010, for the plan or policy year beginning between Sept. 23, 2010, and Sept. 23, 2011, by submitting an application not less than thirty (30) days before the beginning of that plan or policy year, or in the case of a plan or policy year that begins before Nov. 2, 2010, not less than ten (10) days before the beginning of that plan or policy year. The application must include the following information:

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, or significant increase in premiums paid by, those currently covered by, those 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 that: (i) the plan was in force prior to Sept. 23, 2010; and (ii) the application of restricted annual limits to such plans or policies would result in a significant decrease in access to benefits for, or a significant increase in premiums paid by, those currently covered by those plans or policies.

The bulletin indicates that HHS will process complete waiver applications within thirty (30) days of receipt, except that complete applications submitted for plan or policy years beginning before Nov. 2, 2010 will be processed no later than five (5) days in advance of that plan or policy year.

A waiver approval granted under this process applies only for the plan or policy year beginning between Sept. 23, 2010, and Sept. 23, 2011. A group health plan or health insurer must reapply for any subsequent plan or policy year prior to Jan. 1, 2014, when the waiver expires according to future guidance from HHS.

C. Where to send application.

Plans may apply for the waiver by sending the required items within the specified timeframes 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 by emailing the items to healthinsurance@hhs.gov (use "waiver" as the subject of the email).

If you have any questions regarding the waiver program or would like assistance determining if your health insurance plan may qualify for the program, please contact Jack B. Levy at (205) 226-8750 or e-mail at jlevy@balch.com or Laura Schiele Robinson at (205) 226-8751 or e-mail at lrobinson@balch.com.

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