

# Health Care Reform Update

## Waiver Process for Mini-Meds Issued

As reported earlier, there is a prohibition on unreasonable annual limitations on essential benefits for plan years beginning on or after September 23, 2010. Effective for plan years beginning on or after January 1, 2014, there is a prohibition on all annual limitations.

Reasonable annual limitations are:

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, at least \$750,000.
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, at least \$1,250,000.
- For plan years beginning on or after September 23, 2012, but before January 1, 2014, at least \$2,000,000.

A class of group health plans called “limited benefit” or “mini-med” plans, often has annual limits well below these restricted annual limits. These group plans often offer lower-cost coverage to part-time workers, seasonal workers, and volunteers who otherwise may not be able to afford coverage.

Regulations provided that, for plan years beginning prior to January 1, 2014, these restricted annual limits may be waived by HHS if compliance 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.

On Friday, we were issued that guidance in the form of a memorandum.

Note that this waiver process does not impact any state law requirement addressing annual benefit limits in group health plans.

### THE WAIVER PROCESS

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A group health plan or health insurance carrier may apply for a waiver from the restricted annual limits set forth in the regulations if such plan was offered prior to September 23, 2010 for the plan 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 year, or in the case of a plan year that begins before November 2, 2010, not less than 10 days before the beginning of such plan year.

The application must include:

1. The terms of the plan for which a waiver is sought;
2. The number of individuals covered by the plan submitted;

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

The plan administrator or CEO should retain documents in support of this application for potential examination by HHS.

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

A waiver approval applies only for the plan year beginning between September 23, 2010 and September 23, 2011. A group health plan or health insurance carrier must reapply for any subsequent plan 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 carrier 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](mailto:healthinsurance@hhs.gov) (use “waiver” as the subject of the email).

For questions, contact the Office of Consumer Information and Insurance Oversight at (301) 492 4100 or [healthinsurance@hhs.gov](mailto:healthinsurance@hhs.gov) (use “waiver” as the subject of the email).

For the memorandum, visit: [http://www.hhs.gov/ociio/regulations/patient/ociio\\_2010-1\\_20100903\\_508.pdf](http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf).



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