CONNER STRONG

Legislative Update

September 13, 2010

Guidance Issued for Annual Dollar Limit Waivers

Certain limited benefit plans or "mini-med"health plans can now apply for waivers from health care reform's restricted annual dollar limits on essential benefits. Under the new health reform law, the restricted annual limits on the cost of essential benefits were intended to ensure that individuals would have access to needed services with a minimal impact on premiums. Mini-med plans offer lower-cost coverage to workers who otherwise might not be able to afford coverage at all, and have annual limits well below the restricted annual limits set out in the regulations. If these plans must remove annual dollar limits to comply with health care reform's rules, premiums are likely to increase significantly.

To ensure that individuals with certain coverage - including coverage under mini-med plans - would not be denied access to needed services or experience more than a minimal impact on premiums, the rule provides that the Department of Health and Human Services (HHS) has the discretion to waive restrictions on these annual limits for plan years beginning on or after September 23, 2010 and prior to January 1, 2014, if the restricted annual limits would force significant benefit cuts or premium hikes. Under the newly released guidance, plans first offered after September 23, 2010 are ineligible for waivers.

"Mini-med" plans can e-mail their waiver applications or questions to healthinsurance@hhs.gov (use "waiver" as the subject of the email), or call the Office of Consumer Information and Insurance Oversight at (301) 492-4100. Applications must include:

- The terms of the plan for which a waiver is sought;
- The number of individuals covered by the plan;
- The annual limit(s) and rates applicable to the plan;
- A brief description of the plan's reason for seeking the waiver (i.e., why compliance with the rules would result in a significant decrease in access to benefits or a significant increase in premiums paid), along with any supporting documentation; and
- An attestation, signed by the plan administrator, certifying that the plan was in force prior to September 23, 2010, and that the application of restricted annual limits to the plan would result in a significant decrease in access to benefits or a significant increase in premiums paid by those covered by the plan.

HHS must receive waiver requests at least 10 days in advance of a plan year starting before November 2, 2010 and at least 30 days before a plan year starting after November 2, 2010. HHS will process complete waiver applications within 30 days of receipt, with the exception that complete applications submitted for plan years beginning before November 2, 2010, will be processed no later than five days in advance of such plan year. A waiver approval granted under the process will apply only for the plan year beginning between September 23, 2010, and September 23, 2011. Plans may apply annually for waivers for plan years beginning before January 1, 2014 (for calendar year plans, 2013 is the last permissible year to apply for waivers).

As new information is issued on health reform, Conner Strong will issue alerts and updates. Should you have any questions, please **contact your Conner Strong representative toll-free at 1-877-861-3220.**