



Waiver of Restricted Annual Limits

September 21, 2010

On September 3, 2010, the Department of Health and Human Services released Bulletin 2010-1 which details the process for limited benefit health plans and “mini-med” plans to request a waiver from the restricted annual dollar limit requirements imposed by the Patient Protection and Affordable Care Act. The waiver is designed to ensure that individuals with these types of coverage would not be denied access to needed services or experience more than a minimal impact on premiums.

Annual Dollar Limits

The Affordable Care Act prohibits annual dollar limits on essential benefits for plan years beginning on or after January 1, 2014. Prior to 2014, plans are permitted to have restricted annual dollar limits. These limits are as follows:

- \$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 January 1, 2014.

Waiver Procedure and Rules

Group health plans that were in existence prior to September 23, 2010 may apply for a waiver if compliance with the restricted annual limit would result in a significant decrease in access to benefits under the plan or a significant increase in premiums. Waivers are applicable for only one plan year at a time and new applications are required for each subsequent plan year. Availability of the waiver expires for plan years beginning on or after January 1, 2014, when no annual limits will be allowed.

Applications must be submitted 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 waiver application must include the following:

- 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 submitted,
- A brief description of why compliance with the rules would result in a significant decrease in access to benefits for those currently covered by such plan, or significant increase in premiums paid by those covered by such plan, along with any supporting documentation, and

- An attestation, signed by the plan administrator or the Chief Executive Officer of the issuer of the coverage certifying that the plan was in force prior to September 23, 2010 and that the application of restricted annual limits to such plan would result in a significant decrease in access to benefits or a significant increase in premiums paid by those covered by such plan.

Waiver applications should be e-mailed to healthinsurance@hhs.gov (use "waiver" as the subject of the email) or mailed to the following HHS address in Washington DC:

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

HHS expects to process waiver applications within 30 days of receipt. Applications submitted for plan years beginning before November 2, 2010 will be processed no later than five days in advance of the beginning of that plan year.

The full text of Bulletin 2010-1 can be found at http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf. For additional information, please contact your Lawley Benefits Consultant.

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