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From: Gary Cohen, Acting Director, Office of Oversight

Title: Insurance Standards Bulletin Series--INFORMATION

Subject: CCIIO Supplemental Guidance (CCIIO 2011 – 1D): Concluding the Annual Limit Waiver Application Process

Markets: Group and Individual

I. Purpose

The annual limits waiver program was established in the June 28, 2010 interim final regulations (IFR) (codified at 26 C.F.R. § 54.9815-2711T; 29 C.F.R. § 2590.715-2711; and 45 C.F.R. §147.126), that implemented section 2711 of the Public Health Service Act (PHS Act), as amended by the Affordable Care Act.¹ Section 2711 of the PHS Act generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime or annual limits on the dollar value of health benefits, but allows “restricted annual limits” with respect to essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for plan years (in the individual market, policy years) beginning before January 1, 2014. The regulations provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the IFR would result in a significant decrease in access to benefits or a significant increase in premiums.

The Center for Consumer Information and Insurance Oversight² (CCIIO) has previously published guidance, on September 3, 2010, November 5, 2010, and December 9, 2010, setting out the process that a group health plan or health insurance issuer that offers a limited benefit, or “mini-med” plan, should follow to apply for a waiver of the restrictions on annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for plan years (in the individual market, policy years) beginning on or after September 23, 2010 but before September 23, 2011. CCIIO will conclude the annual limit waiver application process on September 22, 2011.

¹ The Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Public Law 111-152, was enacted on March 30, 2010. 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 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 Formerly the Office of Consumer Information and Insurance Oversight.

Group health plans and health insurance issuers offering policies with low annual limits (e.g., \$10,000) on essential health benefits are the most likely type of plan to need waivers to prevent a significant increase in premiums or decrease in access to coverage to comply with the current limit of \$750,000. Many of these plans have already received a waiver. Group health plans and health insurance issuers offering policies with higher annual limits are less likely to qualify for a waiver because complying with section 2711 of the PHS Act and the IFR is unlikely to lead to a significant increase in premiums or decrease in access to benefits. Nevertheless, the Bulletin gives all plans and issuers with restricted annual limits below \$2 million a reasonable opportunity to apply for a waiver.

The purpose of this supplemental guidance is to: 1) set forth the waiver extension process for existing waiver recipients; 2) describe the conclusion of the waiver program for new applicants; and 3) revise the compliance requirements for applicants granted a waiver approval or electing a waiver extension. Elections for waiver extensions and applications for new waivers received after September 22, 2011 will not be accepted. Therefore, a plan or policy that has not elected a waiver extension or has not received a waiver approval will be required to come into compliance with section 2711 of the PHS Act and the IFR, as applicable.

II. Background

Section 2711 of the PHS Act, as amended by the Affordable Care Act, and the IFR allow the imposition of “restricted annual dollar limits” on essential health benefits for plan years (for group health plans and group health insurance coverage), and policy years (for new non-grandfathered individual health insurance coverage), beginning before January 1, 2014. No annual dollar limits on essential health benefits are permitted with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2014, except in the case of grandfathered individual market policies. Excepted benefits, as defined in section 2791(c) of the PHS Act, section 733(c) of Employee Retirement Income Security Act (ERISA), or section 9832(c) of the Internal Revenue Code (the Code), are not governed by this Bulletin.

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

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

Lifetime limits on essential health benefits are prohibited for all group health plans and health insurance issuers offering group or individual health insurance coverage, whether or not the plan qualifies as a grandfathered health plan, for plan years (or policy years in the individual market) beginning on or after September 23, 2010.

CCIIO published guidance on September 3, 2010 establishing the waiver program for plan or years (in the individual market, policy years) beginning on or after September 23, 2010 and before September 23, 2011 and granted waivers for a single year. In order to be eligible to receive a waiver, a group health plan or health insurance issuer must have been in existence prior to September 23, 2010. The waiver authority does not cover plan years (or policy years in the individual market) beginning on or after January 1, 2014, when no annual dollar limits are permitted, except in the case of grandfathered individual market policies. On November 5, 2010 and December 9, 2010, CCIIO published supplemental guidance for the waiver process.

III. Extension of Existing Waivers

A group health plan or health insurance issuer that has received a waiver of the restricted annual limit of \$750,000 for a plan years (in the individual market, policy years) beginning on or after September 23, 2010 but before September 23, 2011 and elects to extend its waiver must complete the Waiver Extension form available at:

<http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>. A group health plan or health insurance issuer electing to extend its waiver should provide the information enumerated below:

1. Updated contact information, including the name and contact information of the applicant, as well as the name and contact information of the person who prepared the annual update;
2. Enrollment information for the plan or policy at the time the annual update is sent;
3. Plan or policy current annual limit;
4. A signed attestation certifying that:
 - a. the plan or policy was in existence prior to September 23, 2010;
 - b. compliance with the IFR would result in a “significant decrease in access to benefits” or a “significant increase in premiums;” and
 - c. the plan or issuer understands and will comply with the requirement to provide annual notice to consumers as outlined in section V of this Bulletin. The attestation is available at:
<http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>

New applicants may, but are not required to, choose to submit supplemental information or document describing 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. An existing waiver recipient electing to extend its waiver must submit the Waiver Extension form and

attestation by e-mail to AnnualLimitExtension@cms.hhs.gov (use “Waiver Extension” as the subject of the e-mail).

CCIIO will begin accepting elections for Waiver Extensions on June 24, 2011. The deadline for receipt of Waiver Extension forms is September 22, 2011. Elections for a Waiver Extension received after September 22, 2011 will not be accepted. Plans or issuers that do not elect a Waiver Extension will be required to come into compliance with section 2711 of the PHS Act and the IFR.

Under this guidance, an applicant may elect to extend an existing waiver until January 1, 2014. A Waiver Extension applies only to plan years (or policy year in the individual market) beginning on or after September 23, 2011 but before January 1, 2014. For plan years (policy years in the individual market) beginning on or after January 1, 2014 all group health plans and new individual policies may not impose any annual dollar limits on essential health benefits.

In addition, applicants for a Waiver Extension must re-submit the information described above on an annual basis by the end of each calendar year (Annual Limit Update). Specifically, the first Annual Limit Update must be submitted by December 31, 2012 and the second Annual Limit Update must be submitted by December 31, 2013. Further, as a condition of receiving an extension of the waiver of the restricted annual limit requirements under section 2711 of the PHS Act and the IFR, a group health plan or health insurance issuer will be required to retain all records pertaining to the application to permit HHS to conduct an audit of the waiver application, as described in section VII of this Bulletin.

HHS may, in its discretion, withdraw an existing waiver or Waiver Extension based on the failure of the waiver recipient to comply with any of these conditions.

IV. Waiver Application Process Concluding September 22, 2011

A group health plan or health insurance issuer is eligible to apply for a new waiver from the restricted annual limits set forth in the IFR (New Applicant): 1) if the plan or policy was offered prior to September 23, 2010, 2) if the plan or policy has not yet applied for or has not been granted a waiver, and 3) if the plan or policy coverage does not meet the restricted annual limit of:

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

As set out in the September 3, 2010 guidance, the IFR implementing section 2711 of the PHS Act provided that the restricted annual dollar limits may be waived by the Secretary of HHS for

one year if compliance with the IFR would result in a “significant decrease in access to benefits” or a “significant increase in premiums.” The November 5, 2010 supplemental guidance set forth several factors related to the test established in the IFR that may be considered in the review of each application. These factors continue to apply to the review of New Applicants.

Under this guidance, a waiver approval will be granted until January 1, 2014. A waiver approval granted under this process applies only to each applicable plan year (policy year in the individual market), beginning on or after September 23, 2010 but before January 1, 2014. For plan years (policy years in the individual market) beginning on or after January 1, 2014 all group health plans and new individual policies may not impose any dollar limits on essential health benefits.

A group health plan or health insurance issuer applying for a new waiver must complete and submit the waiver application available at:

<http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>. In addition, a New Applicant must provide a signed attestation certifying that:

- a. the plan or policy was in existence prior to September 23, 2010;
- b. compliance with the IFR would result in a “significant decrease in access to benefits” or a “significant increase in premiums;” and
- c. the plan or issuer understands and will comply with the requirement to provide annual notice to consumers as outlined in section V of this Bulletin. The attestation is available at <http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>

A New Applicant applying for a waiver should submit the waiver application form, attestation, and any supplemental information by e-mail to AnnualLimitWaiver@cms.hhs.gov (use “New Waiver Application” as the subject of the email). As of June 17, 2011, CCIIO will stop accepting waiver applications based on prior CCIIO application forms.

CCIIO will begin accepting applications from New Applicants on June 24, 2011. The deadline for receipt of new waiver applications is September 22, 2011. Waiver applications received from a New Applicant after September 22, 2011 will not be accepted. Plans or issuers that do not receive a waiver approval will be required to come into compliance with section 2711 of the PHS Act and the IFR.

As a condition of receiving a waiver of the annual limits requirements under section 2711, a group health plan or health insurance issuer will be required to: (1) submit information required for the Annual Limit Update described in section III of this Bulletin by December 31 of each subsequent year (i.e., by December 31, 2012 and December 31, 2013); and (2) retain all records pertaining to the application to permit HHS to conduct an audit of the waiver application, as described in section VII of this Bulletin.

HHS may, in its discretion, withdraw a waiver based on the failure of the applicant to comply with any of these conditions.

V. Requirements for a Waiver Recipient to Provide Annual Notice of a Waiver from the Annual Limit Requirement

The November 5, 2010 supplemental guidance specified that, as a condition of receiving a waiver from the annual limit requirements under section 2711 of the PHS Act, a group health plan or health insurance issuer must provide a notice informing eligible participants and subscribers that the plan or policy does not meet the minimum annual limits for essential health benefits and has received a waiver of the requirement. The December 9, 2010 supplemental guidance required each waiver recipient to send notice to its eligible participants and subscribers, informing them that their plan has received a waiver of the annual limit requirements. The December 9, 2010 supplemental guidance also provided model notice language.

HHS has determined that each waiver recipient – whether via a Waiver Extension or a new waiver application– will be required to distribute an updated annual notice to eligible participants and subscribers (Annual Notice). HHS believes that the communication of this information is necessary in order for consumers to understand the value and quality of the coverage they have, and to ensure that they do not have expectations that the prohibition on annual limits in section 2711 of the PHS Act applies to their policy.

This updated Annual Notice requirement applies to all plans and issuers of policies that have been granted waivers pursuant to the guidance of September 3, 2010 and the supplemental guidance of November 5, 2010 and which are subsequently extended, as well as to new applicants that have been granted waivers pursuant to this guidance. The Annual Notice must be provided to eligible participants and subscribers as plan or policy materials that describe the terms of coverage (e.g., summary plan descriptions) for each plan year (in the individual market, policy year) for which the waiver applies. Therefore, the Annual Notice must be provided to enrollees:

- for any New Applicant approved after June 17, 2011 for a plan or policy year beginning on or after September 23, 2010 but before September 23, 2011 that does not meet the \$750,000 annual limit requirement;
- each plan or policy year for any New Applicant or recipient of a Waiver Extension beginning on or after September 23, 2011 but before September 23, 2012 that does not meet the \$1.25 million annual limit requirement; and
- each plan or policy year for any New Applicant or recipient of a Waiver Extension beginning on or after September 23, 2012 but before January 1, 2014 that does not meet the \$2 million annual limit requirement.

The following language, which shall be prominently displayed in clear, conspicuous, 14-point bold type on the front of the materials, shall be used to satisfy the notice requirement:³

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least [\$750,000/\$1.25 million/\$2 million, as applicable].

Your health coverage, offered by [name of group health plan or health insurance issuer], does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

[dollar amount] on [all covered benefits]

and/or

[dollar amount(s)] on [which covered benefits – notice should describe all annual limits that apply].

This means that your health coverage might not pay for all of the health care you expenses you incur. For example, a stay in a hospital costs around \$1,853 per day. At this cost, your insurance would only pay for [insert amount] days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least [\$750,000/ \$1.25 million/ \$2 million, as applicable] this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until [the ending date of the plan or policy year beginning before January 1, 2014].

³ Sources for figures in model notice: Kaiser Family Foundation, “Expenses Per Inpatient Day,” *State Health Facts* (2009), available at <http://www.statehealthfacts.org/comparebar.jsp?yr=92&typ=4&ind=273&cat=5&sub=68> (\$1,853 per day for hospital cost average).

If you are concerned about your plan’s lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact [provide contact information for plan administrator or health insurance issuer]. [For plans offered in States with a Consumer Assistance Program] In addition, you can contact [contact information for consumer assistance program].

Waiver recipients must obtain written permission from CCIIO to use different notice language to satisfy the Annual Notice requirement.⁴

VI. Sale of New Business by Issuers Receiving Waivers

HHS has received reports that some health insurance issuers who have received or expect to receive a waiver of the annual limits requirements have issued or intend to issue new non-conforming policies after September 23, 2010. The purpose of the IFR authority to waive annual limit requirements was to minimize, during the period prior to 2014, disruption to existing coverage where the application of restrictions on annual limits would significantly decrease access to benefits, or significantly increase the cost of that coverage. Waivers are not intended to permit new, non-compliant insurance coverage to be offered. Accordingly, HHS has granted and will grant waivers of the annual limit requirements solely for the purpose of maintaining coverage that was offered before September 23, 2010, except in the case of state-mandated policies, as provided in the December 9, 2010 supplemental guidance.

Except in the limited exceptions provided in the December 9, 2010 supplemental guidance (and except as to new participants or beneficiaries in an existing group health plan), health insurance issuers may not provide new policies to group health plans or sell new policies in the individual market after September 23, 2010 that do not meet the requirements of section 2711 of the PHS Act.

VII. Record Retention and Audits

As provided in the September 3, 2010 and November 5, 2010 guidance, HHS retains audit authority over waiver applicants as a condition for obtaining a waiver, as well as applicants for Waiver Extensions under this Bulletin. HHS may conduct audits of data submitted by waiver applicants pursuant to the September 3, 2010 and November 5, 2010 guidance and this Bulletin.

⁴ Certain New Applicants and recipients of Waiver Extensions offering plans or policies that do not provide coverage for this inpatient care, or that do not have an annual limit on this benefit, may delete the following sentences from the Annual Notice: “For example, a stay in a hospital costs around \$1,853 per day. At this cost, your insurance would only pay for [insert amount] days.”

If HHS determines that the applicant waiver data contains material mistakes or omissions upon audit, HHS may, in its discretion, withdraw the waiver or the Waiver Extension based on the failure of the applicant to provide true and accurate information. Upon notice of an adverse audit finding by HHS, a waiver applicant will be required to come into compliance with section 2711 of the PHS Act, as amended by the Affordable Care Act.

Where to get more information:

If you have any questions regarding this Bulletin, please e-mail the CCIIO mailbox at AnnualLimitWaiver@cms.hhs.gov (use “Annual Limit Waiver Process Question” as the subject of the e-mail).