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REFORM Update

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CMS (Centers for Medicare & Medicaid Services) recently issued supplemental guidance to address the end of the annual limit waiver application process. To recap, one of the requirements of health care reform is that health plans can apply only "restricted" annual dollar benefit maximums to "essential benefits." This provision affects health plans on the first day of the first plan year following September 23, 2010. Restricted annual limits will increase incrementally over the next three years as follows:

1. Plan years on or after September 23, 2010 and before September 23, 2011 = $750,000
2. Plan years on or after September 23, 2011 and before September 23, 2012 = $1,250,000
3. Plan years on or after September 23, 2012 and before September 23, 2013 = $2,000,000

Annual dollar maximums on essential benefits will be prohibited for plan years beginning on or after January 1, 2014.

Understandably, this provision impacted many health plans. As part of the regulations, the Secretary of Health and Human Services was granted the authority to implement a waiver of this requirement if compliance would result in a significant decrease in access to benefits or a significant increase in premiums.

This issue has been addressed a number of times over the past year. For more details, please read any of the following Reform Updates:

- **Update 11** (http://www.mcwent.com/Reform_Update/Reform_Update_11.pdf) for a review of the limited annual benefit requirements.
- **Update 16** (http://www.mcwent.com/Reform_Update/Reform_Update_16.pdf) for initial details of the waiver application process.
- **Update 20** (http://www.mcwent.com/Reform_Update/Reform_Update_20.pdf) for additional details released on the waiver application process.
- **Update 22** (http://www.mcwent.com/Reform_Update/2011/Reform_Update_22.pdf) for a discussion of limited new business permitted and the rules addressing carrier changes.

The waiver process was designed to allow employers to maintain limited benefits plans established prior to September 23, 2010. In this way, employees eligible for these plans would not lose coverage because of the expense involved in increasing the benefits to the restricted limit amount. Many employers and carriers sponsoring limited benefit plans have already applied and been approved for a waiver of the annual restricted limits.

The guidance addresses the need of some group health plans or insurers, currently approved for the waiver, to extend that waiver beyond the initial year approved. A Waiver Extension Form can be found at http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html; the following information must be provided:

1. Updated contact information
2. Enrollment information for the plan or policy at the time the annual update is sent
3. Current annual benefit limits for the plan or policy
4. A signed attestation certifying that the plan was in existence prior to September 23, 2010, that compliance with the annual restricted limits would result in a significant decrease in access or increase in cost, and verification that the plan will comply with the annual notice requirements.

The completed extension form and attestation should be submitted via e-mail to AnnualLimitExtension@cms.hhs.gov, with the subject line "Waiver Extension." The government began accepting extension requests as of June 24, 2010, and **requests for extensions received after September 22, 2011 will not be accepted**. If a plan's waiver expires and an extension is not granted, then the plan must come into compliance with the annual restricted limits requirements.

Plans can extend an existing waiver for plan years beginning on or after September 23, 2011 but before January 1, 2014. To be granted an extension, the plan must resubmit the information described above on an annual basis by the end of each calendar year. Plans must also meet the record retention requirements outlined in previous guidance. The Department of Health and Human Services may withdraw an existing waiver or waiver extension at its discretion if a plan fails to comply with these conditions.

Plans that have not applied for an initial waiver of the annual restricted limit requirements still have until September 22, 2011 to apply. The application is available at http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html. In addition to the application, the plan must also submit the signed attestation referenced above. The application should be submitted via email to AnnualLimitExtension@cms.hhs.gov, with the subject line "New Waiver Application."

The guidance reiterates the requirement that an annual notice be distributed to eligible participants and subscribers describing the terms of the coverage and stating that the plan is not required to comply with the restricted annual limits of health care reform because it is has been granted a waiver. The new guidance includes model notice language that must be displayed in a clear, conspicuous 14-point bolded font on the front of the plan's descriptive materials. The model notice language is as follows:

> **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]. 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].

Your plan must obtain written permission from CCIIO (U.S. Center for Consumer Information & Insurance Oversight) to use different language for the annual notice requirement. But if your plan does not cover inpatient hospital services, the inpatient example can be removed without CCIIO's permission.

Finally, the guidance retains audit authority for the data submitted during the application or extension request process.

For many employers, their limited benefit plan carrier has applied and handled the waiver process. However, employers should verify that the carrier is requesting extensions annually as required, and that the correct model notice language is included in the plan materials. If employers have questions about the process, they can email the CCIIO at AnnualLimitExtension@cms.hhs.gov, with the subject line "Annual Limit Process Question."