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HHS Launches “Mini-Med” Annual Limit Waiver Process

HHS has released guidance on the process for health plans and/or insurers to request a waiver from the restricted annual limit requirements of PPACA for so-called “limited” or “mini-med” plans. Under the program, the plan or insurer can request a waiver from the annual limit requirements if complying with the annual limit requirement would result in a significant decrease in the access to such benefits or if it would result in a significant increase to the cost of the coverage.

Background

Starting in 2014, PPACA prohibits annual limits on benefits that are deemed “essential benefits.” For plan years prior to 2014, the interim final regulations allow the imposition of “restricted annual limits” on essential health benefits as long as the annual limits on the dollar value of essential health benefits is not lower than:

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

The class of group health plans and health insurance coverage, generally known as “limited benefit” plans or “mini med” plans, often has annual limits well below the restricted annual limits described above. These plans often provide lower-cost coverage to part-time workers, seasonal workers, and volunteers who otherwise may not be able to afford coverage at all. In order to ensure that individuals with coverage under limited benefit or mini-med plans would not be denied access to needed services or experience more than a minimal impact on premiums, HHS has created a waiver process from the annual limit requirements for plan or policy years beginning prior to January 1, 2014. NOTE: This waiver only applies to the annual limit restriction. All the other health insurance reform provisions of PPACA apply to limited benefit or mini-med plans on the same basis as any other group health plan or policy.

Waiver Process

A group health plan or insurer may apply for a waiver from the restricted annual limits if:

1. The plan or the coverage was offered prior to September 23, 2010, and
2. The plan or policy year begins between September 23, 2010 and September 23, 2011.

The plan or insurer must submit an application for the waiver to HHS. The application must be filed at least 30 days before the beginning of the plan or policy year. In the case of a plan or policy year that begins before November 2, 2010, the application must be submitted at least 10 days before the beginning of the plan or policy year. For calendar year plan years, the application must be filed by December 1, 2010.

The application for the waiver must include all of the items listed below:

1. The terms of the plan or policy for which a waiver is sought;

2. The number of individuals covered by the plan or policy submitted;

3. The annual limit(s) and rates applicable to the plan or policy submitted;

4. A brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits or significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation; and

5. An attestation, signed by the plan administrator or Chief Executive Officer of the issuer of the coverage, certifying 1) that the plan was in force prior to September 23, 2010; and 2) that the application of restricted annual limits to such plans or policies would result in a significant decrease in access to benefits or a significant increase in premiums paid by those covered by such plans or policies.

The plan administrator or Chief Executive Officer should retain documents in support of this application for potential examination by the Secretary. HHS did not release a specific form or sample application to obtain the waiver.

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

Each waiver approval granted under the initial process applies only for the plan or policy year beginning between September 23, 2010 and September 23, 2011. A group health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 unless HHS decides in future guidance to waive the annual waiver process.

The address for submitting the items listed above is:

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

The items can also be emailed to HHS at: healthinsurance@hhs.gov (use “waiver” as the subject of the email).

Action Steps

Plan sponsors of "limited benefit" or mini-med" plans should review their options with their insurers and determine which party will apply for the waiver. If the insurer will not be applying for their plans, then it will be the responsibility of the plan sponsor to submit the waiver application.

Please contact your Gallagher Benefit Services representative if you have any questions.