



WEDNESDAY, SEPTEMBER 15, 2010  
HEALTH CARE REFORM UPDATE

**HEALTH AND HUMAN SERVICES PROVIDES GUIDELINES  
ON THE APPLICATION PROCESS FOR WAIVER OF ANNUAL LIMITS**

On September 3, 2010, the Department of Health and Human Services (HHS) issued a memo outlining the process for obtaining a waiver of the employer requirement to eliminate annual limits on medical plans. This is most important for companies that offer limited benefit plans or "mini med" plans, as they will need to apply for and receive the waiver to continue offering plans with their current annual dollar limits between now and 2014.

Employers may apply for a waiver if compliance with the annual limit would result in a significant decrease to their employees' access to benefits; or a significant increase in premium costs. For fully insured plans, either the employer sponsoring the plan or the insurer can apply for the waiver. Employers interested in the waiver should contact your plan administrator or insurer for assistance with the application.

Below we have highlighted the basic eligibility and application requirements for your review. To view the HHS memo in its entirety please visit: [http://www.hhs.gov/ociio/regulations/patient/ociio\\_2010-1\\_20100903\\_508.pdf](http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf).

**To be eligible to apply for a waiver:**

- The plan or policy must have been in effect before September 23, 2010.
- The application must be submitted at least 30 days before the first day of the plan year for which a waiver is being requested. Applications will be processed within 30 days after they are received.
- For plan years beginning before November 2, 2010, the waiver request must be submitted at least 10 days before the first day of the plan year. HHS will process these applications at least 5 days before the first day of the plan year.

**Application Materials:**

There is no application form. Rather, HHS directs that an application must include the following items:

1. The terms of the plan or policy
2. The number of individuals covered by the plan
3. The annual dollar limit(s) and the rates
4. A brief description with supporting documentation of the anticipated decreased access to benefits and/or premium increases
5. An attestation statement signed by the plan administrator or the Chief Executive Officer (CEO) of the issuer of coverage (the insurer) certifying that the plan was in force prior to September 23, 2010 **and** that compliance with restricted annual dollar limits would result in decreased access to benefits and/or premium increases. HHS notes that the plan administrator or issuer's CEO should retain copies of the documentation for potential examination by HHS in the future.

Application materials may be mailed to HHS's Office of Consumer Information and Oversight or emailed to [healthinsurance@hhs.gov](mailto:healthinsurance@hhs.gov).

Note: A waiver is valid for one plan year only, so a separate application must be submitted for each plan year until 2014. For plan years beginning on or after January 1, 2014, waivers will no longer be allowed.

As your partner, we remain committed to working closely with you to help you understand and comply with the guidelines pertaining to the health care reform legislation. We hope you find this information helpful and invite you to view past issues of our Health Care Reform Update at <http://www.trion.com/healthreform>. Finally, we encourage you to continue to share you questions and comments by emailing us at [health.reform@trion.com](mailto:health.reform@trion.com) or calling 610.945-1198. Thank you.

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