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HHS Issues Guidance on Waiver of Annual Limit Restrictions on Health Plans Under PPACA

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The Patient Protection and Affordable Care Act (PPACA) prohibited all health plans, excluding grandfathered plans, from imposing annual limits on benefits received through the plan. On September 3, the Department of Health and Human Services' Office of Consumer Information and Insurance Oversight (OCIIO) issued guidance for obtaining waivers of the annual limits requirements. The guidance will allow health insurers that sell plans known as "limited benefits" or "mini-med" plans to apply for waivers to a rule that restricts the imposition of limits on annual benefits.

Section 1302(b) of PPACA and interim final regulations issued by HHS on June 28, 2010 restricted the imposition of annual limits on essential health benefits for plan years beginning before January 1, 2014. For plan years beginning on or after September 23, 2010, annual limits on the value of essential health benefits cannot be lower than $750,000. This amount rises over the next several years. As of 2014, annual benefit limits are prohibited for any amount except for "grandfathered" individual plans that were in effect as of March 23, 2010.

In the new waiver guidance, the OCIIO stated that these group health and health insurance plans generally known as "limited benefit" or "mini-med" plans often have annual limits below the restricted limits set out in the June 28 interim final regulations. The guidance said that those plans often offer low-cost coverage to part-time workers, seasonal workers and volunteers who would not otherwise have coverage. To ensure that people with limited benefits plans are not denied coverage and do not experience a significant increase in premiums, the guidance allows for waivers from the restricted annual limit requirement until 2014.

Pursuant to the guidance, health plans or health insurers may apply for waivers from the annual limit requirements if the plans were offered before September 23, 2010 for plan years beginning on or after that date. A waiver approval granted under this process only applies for the plan or policy year beginning between September 23, 2010 and September 23, 2011. A plan or issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when the waiver expires. Applications for the waiver must include the terms of the plans for which the waiver is sought, the number of individuals covered, the annual limits and rates for the plan, and a description of why compliance with the interim final rules would result in a significant decrease in access to benefits or a significant increase in premiums.

For more information about the OCIIO's guidance or other PPACA-related issues, please contact your Baker Donelson attorney or any of the attorneys or advisors in the Baker Donelson Health Care Reform group.