

Technical Instructions for the Waiver Extension and Waiver Application Process

The Center for Consumer Information and Insurance Oversight (CCIIO)¹ has published Supplemental Regulatory Guidance (CCIIO 2011-1D) describing the conclusion of the annual limit waiver program. That Guidance: 1) sets forth the waiver extension process for existing waiver recipients; 2) describes the conclusion of the waiver program for new applicants; and 3) revises the compliance requirements for applicants granted a waiver approval or electing a waiver extension.

The purpose of these Technical Instructions is to explain the process of applying for a waiver or waiver extension in detail, to anticipate and answer common questions, and to provide as much assistance as possible to health insurance issuers, employers, and other potential applicants. It is intended to supplement the June 17, 2011 Supplemental Guidance and other application materials, all of which are available at:

<http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>.

I. How Do I Obtain a Waiver Extension?

An applicant who has applied for, and has been granted, a waiver prior to June 17, 2011 for plan years (in the individual market, policy years) between September 23, 2010 and September 22, 2011 may apply for an extension of the existing waiver. Waiver extensions are valid until the plan or policy year beginning on or after January 1, 2014, when the restricted annual limits expire (i.e., when no annual dollar limits are permitted on any essential health benefits). An existing waiver recipient must submit a complete Waiver Extension by September 22, 2011 in order to elect the waiver extension.

The process for doing so is described below.

1. Obtain a copy of the Excel spreadsheet entitled “Annual Limit Waiver – Waiver Extension” from the Annual Limit Waivers website at the following URL:
<http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>.
 - a. This simplified form requests updated contact information, including the name and contact information of the applicant,² as well as the name and contact information of the person who prepared the annual update; enrollment information for the plan (or in the individual market, policy) at the time the update is sent; and the plan or policy’s current overall annual limit.
 - b. When filling out this application, existing waiver recipients must use the same applicant name that was published in CCIIO’s public waiver list, which can be found via the following URL (list is broken out by type of applicant, i.e., Self-

¹ Formerly the Office of Consumer Information and Insurance Oversight (OCIIO).

² The name of the applicant must match the name of the applicant listed on the public list of approvals. This list can be found at http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

Insured Employer, Issuer, etc.):

http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

2. In a separate document, the applicant should also provide the language from the attestation in section V of these Technical Instructions, using the “Waiver Extension” language. The attestation certifies:
 - a. Your 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 an annual notice to consumers as outlined in section V of CCIIO’s June 17, 2011 Supplemental Guidance.
3. In accordance with CCIIO’s September 3, 2010 Guidance, the signature of the attestation must be provided by:
 - a. the Chief Executive Officer of the issuer if the application is prepared on behalf of a Fully-Insured plan or policy; or
 - b. the plan administrator if the application is prepared on behalf of a Self-Insured plan.
4. If the attestation is prepared by a third-party administrator (TPA) or consultant, the same attestation rules apply. **A TPA or consultant may not sign the attestation.** An officer or benefits administrator at the client company must sign the attestation instead.
5. Email complete elections to: AnnualLimitExtension@cms.hhs.gov and make “**Waiver Extension**” the subject heading. (Note: this is a different email address from that used by New Applicants).
 - a. A complete election consists of (1) the Waiver Extension form spreadsheet; and (2) a signed attestation.
 - b. Only electronic submissions will be accepted. Spreadsheets will only be accepted in .xls or .xlsx format. CCIIO will not accept the spreadsheet in a .pdf format.
6. CCIIO will begin accepting elections for Waiver Extensions on **June 24, 2011**. The deadline to submit elections is **September 22, 2011**.

Existing waiver recipients opting to submit an election will receive an email message confirming receipt of the application. Group health plans and health insurance issuers should not expect to be contacted by CCIIO unless the election for the Waiver Extension is incomplete. Upon receipt of complete Waiver Extension materials, CCIIO will consider the waiver extension valid until

the plan or policy year beginning on or after January 1, 2014. No letter of acknowledgment will be issued to this effect.

No waivers will be extended for Waiver Extension elections received after September 22, 2011. These waiver recipients' plans or policies must come into compliance with section 2711 of the PHS Act, as amended by the Affordable Care Act, and the 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) when their current plan year ends.

As a condition of extending the waiver, a health insurance issuer or group health plan electing a Waiver Extension must file two Annual Limit Updates: the first is due by December 31, 2012; and the second is due by December 31, 2013. The Annual Limit Update must include the same materials as are required for a Waiver Extension; the recipient of the Waiver Extension must update the information requested in the "Waiver Extension Form" document and provide an updated attestation (see Attestation in section V of these Technical Instructions).

In addition, waiver recipients electing Waiver Extensions must retain all records pertaining to their applications to permit HHS to conduct an audit of the waiver applications. HHS may, in its discretion, withdraw a waiver based on the failure of the waiver recipient to comply with any of these conditions.

State Waiver Recipients

The process for applying for a State-mandated limited benefit plan was outlined in CCIIO's November 5, 2010 Guidance (CCIIO 2010-1A). States that have applied for and been granted a waiver on behalf of issuers offering state-mandated limited benefits are also eligible for waiver extensions. States should follow the procedure outlined above for submitting the Waiver Extension form.

In lieu of an attestation from each issuer's Chief Executive Officer, the State may submit a statement from the State's insurance commissioner or another State official that the State-mandated policy was in existence prior to September 23, 2010, and that compliance with section 2711 of the PHS Act would result in a significant decrease in access to benefits or a significant increase in premiums for each issuer on whose behalf the State is applying.

II. How Do I Apply For A New Waiver?

A New Applicant is a group health plan or health insurance issuer that was in existence prior to September 23, 2010 and has not yet applied for, or has not yet received, a waiver of annual limits prior to June 17, 2011, with:

- 1) A plan year (or policy year, in the individual market) beginning on or after September 23, 2010 but before September 23, 2011 that is unable to meet the \$750,000 annual limit requirement; or
- 2) A plan year (or policy year, in the individual market) beginning on or after September 23, 2011 but before September 23, 2012 that is unable to meet the \$1.25 million annual limit requirement; or

- 3) A plan year (or policy year, in the individual market) beginning on or after September 23, 2012 but before January 1, 2014 that is unable to meet the \$2 million annual limit requirement.

New Applicants must follow the steps below when applying for a waiver of their annual limits.

1. Obtain a copy of the Excel spreadsheet entitled “Annual Limit Waiver - New Application” from the Annual Limit Waivers website at the following URL:
<http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>.
 - a. Every cell of a row of this spreadsheet must have an entry for each plan or policy, and each tier thereof, as described in the document entitled “Data Dictionary.” The Data Dictionary is also available at the Annual Limit Waivers website at:
<http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html>.
 - b. The spreadsheet requests information about the applicant, including contact information; benefit structure; current annual limit(s); and, if applicable, a description of the decrease in access to benefits that would occur if the waiver is not granted.
 - c. The categories of “Essential Health Benefits” are based on section 1302(b) of the Affordable Care Act. Because the specific services and benefits falling within the ten general categories have not yet been defined, CCIIO will accept a group health plan or health insurance issuer’s good-faith determination as to whether a particular benefit is an essential health benefit.
 - d. If the plan or policy benefit design includes lifetime limits on essential health benefits, applicants must state in their submission emails that they are waiving all lifetime limits on essential health benefits pursuant to section 2711 of the Affordable Care Act. **No lifetime limits on essential health benefits are permissible.** A waiver application will not be processed if there are lifetime limits of essential health benefits on a plan or policy and this acknowledgment is not made in the application.
2. In a separate document, the applicant should also provide the language from the attestation in section V of these Technical Instructions, using the "New Applicant" language. The attestation certifies:
 - a. A group health plan or issuer’s 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 annual notice to consumer requirements as outlined in section V of CCIIO’s June 17, 2011 Supplemental Guidance.

3. In accordance with CCIIO's September 3, 2010 Supplemental Guidance, the signature of the attestation must be provided by:
 - a. The Chief Executive Officer of the issuer if the application is prepared on behalf of a Fully-Insured plan or policy; or
 - b. The plan administrator if the application is prepared on behalf of a Self-Insured plan.
 - c. If the attestation is prepared by a third-party administrator (TPA) or consultant, the same attestation rules apply: **a TPA or consultant may not sign the attestation.** If the TPA is considered the plan administrator, an officer or benefits administrator at the client company must sign the attestation.
4. Applications may also provide supplemental information to evidence how compliance with the annual limit requirements of section 2711 of the PHS Act, as amended by the Affordable Care Act, and the IFR will lead to a significant decrease in access to benefits or significant increase in premiums for enrollees. This may take the form of a letter or statement describing how benefits may decrease or premiums will increase if a waiver is not granted. It should accompany the Annual Limit Waiver – New Application form and may be appended to the attestation. Supplementary materials are not mandatory but may be helpful to CCIIO to arrive at a decision.
5. Email complete applications to AnnualLimitWaiver@cms.hhs.gov and make “**New Waiver Application**” the subject heading. (Note: this is a different email address from that used by Waiver Extensions).
 - a. A complete application consists of: (1) the New Annual Limit Waiver Application form; (2) a signed attestation; and (3) any supplementary materials you wish to provide.
 - b. Only electronic applications will be accepted. Spreadsheets will only be accepted in .xls or .xlsx format. CCIIO will not accept the spreadsheet in a .pdf format.
 - c. 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 to submit applications is **September 22, 2011**.

New Applicants should also consult CCIIO's November 5, 2010 Supplemental Guidance, which sets forth the factors that are considered when determining whether an application demonstrates a “significant increase in premium” or a “significant decrease in access to benefits.” This Guidance is available at the following URL:

http://cciio.cms.gov/resources/files/annual_limits_waiver_guidance.pdf.

No waivers will be granted for new Waiver Applications received after September 22, 2011. Applications received after September 22, 2011 will not be accepted, and those applicants'

plans or policies must come into compliance with section 2711 of the PHS Act, as amended by the Affordable Care Act, and the IFR.

If a New Applicant is granted a waiver, the waiver is valid until the plan or policy year beginning on or after January 1, 2014, provided the applicant comply with the Annual Limit Update and Annual Notice requirements detailed in the June 17, 2010 Supplemental Guidance. New Applicants, as a condition of extending their waivers, must file two annual updates of the Annual Limit Update: the first is due by December 31, 2012; and the second is due by December 31, 2013 (as detailed in Section II above).

In addition, New Applicants must retain all records pertaining to their applications to permit HHS to conduct an audit of the waiver applications. HHS may, in its discretion, withdraw a waiver based on the failure of the applicant to comply with any of these conditions.

New State Applicants

If a State wishes to obtain a waiver for a State-mandated limited benefit plan, it should follow the above procedures. Special guidance for States may also be found in CCIIO's November 5, 2010 Guidance, available at the following URL:

http://cciio.cms.gov/resources/files/annual_limits_waiver_guidance.pdf.

In lieu of an attestation from each issuer's Chief Executive Officer, the State may submit a statement from the State's insurance commissioner or another State official that the State-mandated policy was in existence prior to September 23, 2010, and that compliance with section 2711 of the PHS Act would result in a significant decrease in access to benefits or a significant increase in premiums for each issuer on whose behalf the State is applying.

III. Is My Plan or Policy a New Applicant or an Existing Waiver Recipient?

If it is unclear whether a group health plan or issuer's policy should follow the guidelines for a New Applicant or for an Existing Waiver recipient, please review the following scenarios to determine whether you should comply with the New Application Process or Waiver Extension Process.

A. What If I Applied For a Waiver on Behalf of My Plan or Policy with an Annual Limit Below \$750,000, and the Waiver was Denied?

If you are a group health plan or health insurance issuer that applied for a waiver, and a waiver was denied for your plan or policy year beginning between September 23, 2010 and September 22, 2011, you may either apply for a waiver of the annual limits requirement of \$1.25 million or \$2 million, or come into compliance with section 2711 of the PHS Act and the IFR. If you choose to apply for a waiver of the restricted annual limits requirement of \$1.25 million, for plan years (or, in the individual market, policy years) beginning between September 23, 2011 and September 22, 2012, and \$2 million for plan years (or, in the individual market, policy years) beginning between September 23, 2012 and December 31, 2013, you will be considered a New Applicant. Please follow the application instructions detailed above for New Applicants (or see the chart in Section IV of these Technical Instructions, summarizing all requirements).

B. What If My Plan or Policy With an Annual Limit Below \$750,000 Has Some Plans or Policies That Were Approved and Some Plans or Policies That Were Denied?

If you are a group health plan or health insurance issuer that applied for a waiver, and were approved and denied for some plans or policies, you should file both a New Application and a Waiver Extension form.

For plans or policies that were denied for plan years beginning between September 23, 2010 and September 22, 2011, you may either apply for a waiver of the annual limits requirement of \$1.25 million or \$2 million for those plans (as outlined in Section III. A above), or come into compliance with section 2711 of the PHS Act and the IFR. If you choose to apply for a waiver of the restricted annual limits requirement of \$1.25 million, for the plan years (or in the individual market, policy years) beginning between September 23, 2011 and September 22, 2012, and \$2 million for plan years (or in the individual market, policy years) beginning between September 23, 2012 and December 31, 2013, you will be considered a New Applicant. Please follow the application instructions detailed above for New Applicants for the denied plans or policies.

Your approved plans and policies are eligible for a Waiver Extension. You must either elect to extend your waiver of the annual limits requirements or come into compliance with section 2711 of the PHS Act and the IFR when your waiver expires. Please follow the application instructions detailed above for Waiver Extensions for the approved plans or policies.

C. What if My Plan or Policy has an Annual Limit below \$750,000 and I Applied Prior to June 17, 2011, But I Receive a Waiver Approval *after* June 17, 2011?

If you are a group health plan or health insurance issuer that applied for a waiver prior to June 17, 2011, and you receive an approval after June 17, 2011, you will be considered a **New Applicant who has already submitted an application through the end of the plan or policy year beginning before January 1, 2014**. If approved for a waiver of annual limits, your remaining requirements to extend your waiver are the two annual submissions of the Annual Limit Updates (due by December 31, 2012 and December 31, 2013).

D. What if My Plan or Policy has an Annual Limit below \$750,000 and I Applied Prior to June 17, 2011, And I Received a Waiver Approval *before* June 17, 2011?

If you are a group health plan or health insurance issuer that applied for a waiver prior to June 17, 2011 and received an approval prior to June 17, 2011, you are eligible for an extension of your existing waiver. Please follow the application instructions detailed above for Waiver Extensions.

E. What if My Plan or Policy has an Annual Limit below \$750,000 and I Have Not Yet Applied For a Waiver?

If you are a group health plan or health insurance issuer with annual limit(s) below \$750,000, and you have not applied for a waiver for your plan or policy year beginning between September 23, 2010 and September 22, 2011, you are considered a New Applicant. You must either apply for a waiver of the annual limits requirements by September 22, 2011, or come into compliance with section 2711 of the PHS Act and the IFR. No new waiver applications will be accepted after September 22, 2011. Please follow the application instructions detailed above for New Applicants.

If you are granted a waiver for an application submitted after June 24, 2011 and before September 22, 2011, you will have satisfied the application deadline for New Applicants, and your remaining requirements to extend your waiver are the two submissions of the Annual Limit Updates (due by December 31, 2012 and December 31, 2013).

F. I'm a Non-Federal Governmental Plan. Do I Have to Apply for a Waiver?

A non-federal governmental plan, except for those offering excepted benefits, as defined in section 2791 of the PHS Act, must comply with the restricted annual limit requirements. If you have already received a waiver, please follow the Waiver Extension instructions. If not, please follow the New Applicant instructions.

IV. What are My Deadlines?

It is important to understand the deadlines that affect your plans and policies. The chart below summarizes important deadlines for New Applicants who have never applied for waivers, and for existing waiver recipients who elect to submit Waiver Extensions.

	DESCRIPTION	JUNE 24, 2011	SEPT. 22, 2011	DEC. 31, 2012	DEC. 31, 2013
New Applicant	<p>You are a New Applicant if you <u>have not</u> applied for and received a waiver from the \$750,000 annual limit requirement prior to June 17, 2011, but you would like a waiver from:</p> <ol style="list-style-type: none"> 1. the \$750,000 annual limit requirement for plan years (or in the individual market, policy years) beginning between September 23, 2010 and September 22, 2011; 2. the \$1.25 million annual limit requirement for plan years (or, in the individual market, policy years) beginning between September 23, 2011 and September 22, 2012; and 2. the \$2 million annual limit requirement for plan years (or, in the individual market, policy years) beginning between September 23, 2012 and December 31, 2013. <p>If you are granted a waiver, your waiver will last through your last plan year (or, in the individual market, policy year) beginning before January 1, 2014, provided that you file the required Annual Limit Updates.</p>	CCIIO Begins Accepting New Application Forms	Deadline to Submit a New Application Form	Deadline to Submit a First Annual Limit Update	Deadline to Submit a Second Annual Limit Update
Waiver Extension	<p>You are electing a Waiver Extension if you <u>have</u> received a waiver from the \$750,000 annual limit requirement prior to June 17, 2011 and would like a waiver from:</p> <ol style="list-style-type: none"> 1. The \$1.25 million annual limit requirement for plan year (or, in the individual market, policy years) beginning between September 23, 2011 and September 22, 2012; and 2. The \$2 million annual limit requirement for plan years (or, in the individual market, policy years) beginning between September 23, 2012 and December 31, 2013. <p>Your waiver extension will last through your last plan year (or, in the individual market, policy year) beginning before January 1, 2014, provided that you file the required Annual Limit Updates.</p>	CCIIO Begins Accepting Elections for Waiver Extensions	Deadline to Submit a Waiver Extension Form	Deadline to Submit a First Annual Limit Update	Deadline to Submit a Second Annual Limit Update

V. What Do I Need to Include in the Attestation?

The language of this attestation must be used by both New Applicants and existing waiver recipients. **With the exception of State applicants, the language in the Attestation must be used by applicants.** CCIIO no longer accepts attestation language developed by the applicant.

Please ensure that the individual signing the attestation reads it thoroughly and is aware of what it is to which they attest, particularly if he or she is not the party who has prepared the application.

Required Attestation Language:

I, _____ [print name of attester], attest that the information contained in this application is accurate to the best of my knowledge, and that the following is true:

- 1. My plan(s) or polic(y)(ies) [was/were] in existence prior to September 23, 2010.
- 2. Compliance with 45 C.F.R. § 147.126 would result in [list one or both] a significant decrease in access to benefits [and/or] a significant increase in premiums.
- 3. The plan(s) or issuer understands and will comply with the updated annual notice requirements as outlined in section V of the June 17, 2011 Supplemental Guidance (CCIIO 2011-1D).

I am also aware that a material misrepresentation or misstatement in this application may result in the Department of Health and Human Services withdrawing a waiver if one is granted to the plan or issuer of the policy. If the plan or issuer on behalf of which I now attest receives a waiver, I am aware that failure to provide Annual Limit Updates, pursuant to the Center for Consumer Information and Insurance Oversight’s June 17, 2011 Supplemental Guidance, may result in the Department of Health and Human Services withdrawing a waiver.

(Signature)

(Date)

(Title)

VI. Update for Health Reimbursement Arrangements (HRAs)

Supplemental Guidance published on August 19, 2011 exempts as a class all HRAs that are subject to the requirements of section 2711 and that were in effect prior to September 23, 2010 from having to apply individually for an annual limit waiver for plan years beginning on or after

September 23, 2010 but before January 1, 2014.³ This exemption was granted because HRAs set limits on the amount that can be spent and, CCIIO believes, those limits would always be less than the applicable restricted annual limit amounts.

However, an HRA that is exempt from applying for an annual limit waiver still must comply with the record retention requirement and the Annual Notice requirement to participants and subscribers, which is necessary for consumers to understand the value and quality of the coverage they have. CCIIO has drafted alternate Annual Notice language for HRAs that have not yet issued their Annual Notice. The following criteria apply:

- The notice must be printed in 14-point, bold font on the front of plan materials.
- The notice applies to HRA applicants who have received a Waiver Extension as well as the HRAs exempt from applying pursuant to the August 18, 2011 Supplemental Guidance.
- The notice must be provided to new eligible participants and subscribers and at the beginning of the plan year. If the plan year has already begun and notice has not been issued, it must be provided within 60 days of the date of this publication.
- The following language shall be used to satisfy the notice requirement:

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/applicant], does not meet the minimum standards required by the Affordable Care Act described above. Your employer makes an annual contribution of:

[Dollar amount] to your Health Reimbursement Arrangement (HRA). This means your health coverage may not pay for all the health care expenses you may incur.

The U.S. Department of Health and Human Services has granted your HRA a waiver from the requirement that it provide [\$750,000/\$1.25 million/\$2 million] in benefits until [the end date of the last plan or policy year beginning before January 1, 2014] because it would cause a significant decrease in your access to this benefit.

³ An HRA that is integrated with other health coverage that complies with section 2711 and its implementing regulations would not need a waiver.

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]. [For plans offered in States with a Consumer Assistance Program] Additionally, you can contact [contact information for Consumer Assistance Program].

If an employer that maintains an HRA also maintains other coverage, whether or not that coverage is integrated with the HRA, that other coverage must meet the requirements of section 2711 of the PHS Act or obtain a waiver.⁴ If approved, the underlying group health plan would meet the notice requirement by printing the notice language from the June 17, 2011 guidance on its plan materials that describe the terms of coverage. Additionally, an HRA that has already received a waiver and issued the Annual Notice printed in the June 17, 2011 Guidance does not need to re-issue the new notice.

Finally, HRAs that have already applied for, and been granted, a waiver need not apply for an extension. This exemption will remain in effect through plan years beginning before January 1, 2014. If you have any questions regarding this update, please e-mail the CCIIO mailbox at AnnualLimitWaiver@cms.hhs.gov (use “HRA Exemption” as the subject of the email).

⁴ If a waiver is obtained for other coverage that is integrated with an HRA, the waiver applies to the combined coverage and no separate waiver is needed for the HRA.