Health Reform Update

An Ongoing Analysis Concerning the Direction of Healthcare Policy

Waivers from the Annual Limit Requirement - Update

On November 5, 2010, the Department of Health and Human Services (HHS) issued additional sub-regulatory guidance clarifying the process for a group health plan (or health insurance carrier) to seek a waiver from the annual limit requirement under the Patient Protection and Affordable Care Act (PPACA).

As an overview, the PPACA generally prohibits annual limits on essential benefits. However, for plan years that begin prior to January 1, 2014, a group health plan may impose approved annual limits on essential benefits, provided the limits are no less than the following:

- For plan years beginning on or after September 23, 2010 but before September 23, 2011, $750,000;
- For plan years beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000; and
- For plan years beginning on or after September 23, 2012, but before January 1, 2014, $2,000,000.

On September 3, 2010, HHS issued guidance creating a process where certain group health plans may apply for and receive a waiver from the annual limit requirement.[1] In order to qualify for a waiver, a plan must demonstrate, among other things, that compliance with the requirement would result in a "significant decrease in access to benefits" or a "significant increase in premiums" for affected individuals. This waiver program is particularly useful to mini-med plans, limited medical plans and stand-alone health reimbursement arrangements (HRA), as these plans typically have annual limits well below the permitted thresholds.

Subsequently, HHS issued additional guidance further clarifying the waiver program. Specifically, this guidance:

- Requires a group health plan to provide notice of an approved waiver;
- Allows states to apply for a waiver on behalf of insurance carriers when state law requires the sale of insurance coverage below the permitted thresholds;
- Describes the factors used by HHS when determining whether a waiver application will be approved or denied;
- Discusses the application of Medical Loss Ratios on mini-med plans; and
- Reiterates the requirement that plans receiving a waiver are subject to record retention and audit requirements.

This most recent guidance is discussed in more detail below.

Notice Requirement

In earlier guidance, HHS did not impose a disclosure requirement on group health plans that are approved for a waiver from the annual limit requirement. This new guidance indicates that a plan will be required to provide a notice informing each participant that the plan or policy does not satisfy the required annual limits under the PPACA because the plan received a waiver. The notice must:

- Include the dollar amount of the annual limit along with a description of the benefits to which it applies;
- Be prominently displayed in a clear, conspicuous 14-point bold faced type; and
- State that the waiver was granted for only one year.

A model notice will be available in the near future at http://www.hhs.gov/iciio/regulations/index.html.

This notice requirement will apply to all approved waivers, including waivers accepted prior to issuance of this guidance.

[1] See *OCII Sub-Regulatory Guidance: Process for Obtaining Waivers of the Annual Limits Requirements of the PHS Act Section 2711,* http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf. This guidance was summarized in an earlier *Health Care Reform Update* issued September 8, 2010.

Process for States to Apply for Waivers for State-Mandated Policies

Currently, some state laws require health insurance carriers to market a standardized policy that includes annual limits that are below the permitted thresholds. When state law mandates such coverage, the state may apply for a waiver on behalf of insurers offering the state-mandated policies if the policy was required to be offered prior to September 23, 2010.

Standards Used to Assess Waiver Applications

A waiver from the annual limit requirement may be available to a group health plan when the plan can demonstrate that compliance with the requirement would result in a "significant decrease in access to benefits" or a "significant increase in premiums." While this determination is made on a case-by-case basis, HHS provides several factors they consider when reviewing a waiver application. Examples of these factors include:

- The application's explanation as to how compliance with the restriction on annual limits would result in a significant decrease in access to benefits. Such a decrease in access could result from the dropping of coverage by a plan or plan insolvency if the waiver is not granted.
- The policy's current annual limits. Plans with higher annual limits would be expected to experience lower premium increases to become compliant with the restricted annual limit requirement than plans with lower limits.
- The change in premium in percentage terms. The lower the percentage increase estimated to achieve compliance, the less likely compliance with the annual limit requirement would be found to be "significant."
- The change in premium in absolute dollar terms. While the percentage increase noted above can be relevant to the determination of whether an increase is "significant," for policies with very low premiums, an increase in premiums on a percentage basis may still translate to a small increase in absolute dollar terms and therefore may not be "significant."
- The number and type of benefits affected by the annual limit. Some policies have limits on only some essential health benefits, such as prescription drugs. For example, while increasing the annual limits on prescription drugs to $750,000 may increase the portion of the premium related to drug coverage significantly, it may not significantly increase the overall cost of health insurance for enrollees.
- The number of enrollees under the plan seeking the waiver.

Medical Loss Ratio Provisions and Mini-Med Policies

The PPACA requires insured group health plans to maintain a specific Medical Loss Ratio (MLR) (80% in small market, 85% in the large market). Under this rule, insurance carriers must spend 80%/85% of the premiums they receive on health benefits and quality improving activities.

These thresholds create unique issues for mini-med plans because their premiums are very low relative to other types of group health plans and may not satisfy the required MLR percentages.

The guidance indicates that special rules will apply for mini-med plans in determining how to calculate the MLR. These rules are expected in future guidance.

Record Retention and Audits

HHS retains the authority over waiver applications. This means HHS may conduct an audit of data submitted by applicants approved for a waiver. If, in an audit, HHS finds material mistakes or omissions in the data collected, HHS may, in its discretion, deny any future waiver based on the applicant's failure to provide accurate information.

A copy of this recent guidance (OCIIO Supplemental Guidance on Waivers of the Annual Limits Requirements - November 5, 2010) is available at http://www.hhs.gov/ociio/regulations/annual_limits_waiver_guidance.pdf.