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Title: Insurance Standards Bulletin Series—INFORMATION

Subject: OCIO Sub-Regulatory Guidance (OCIO 2010 – 1A)
SUPPLEMENTAL GUIDANCE.

Markets: Group and Individual

I. Purpose

On September 3, 2010, OCIO published sub-regulatory guidance setting out the process that a group health plan or health insurance issuer should follow to apply for a waiver for plans with low annual limits, or “mini-med” plans, from the restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in Section 1302(b) of the Affordable Care Act). The waiver program was provided for in the interim final regulations (“IFR”) (codified at 26 CFR §54.9815-2711T; 29 CFR §2590.715-2711; and 45 CFR §147.126) published on June 28, 2010, that implemented Section 2711 of the Public Health Service Act (PHSA). Since publishing the September 3, 2010 Bulletin, we have received questions regarding the scope and applicability of the waiver program implemented in that guidance, who can apply for a waiver, and whether some similar process might be available with respect to the medical loss ratio (MLR) provisions of the Affordable Care Act with respect to mini-med plans. In addition, after review of the waiver applications to date, we have concluded that certain additional clarifications of the waiver process are appropriate. This Bulletin addresses these questions and clarifications. Specifically, this Bulletin:

1. Establishes transparency and disclosure requirements for plans that receive waiver approvals;
2. Clarifies that states can apply for a waiver on behalf of health insurance issuers in the state under certain circumstances, and establishes a process for a state waiver request;
3. Describes factors that are considered in analyzing a waiver application;
4. Discusses the application of the medical loss ratio provisions of Section 2718 of the PHSA; and
5. Reiterates the requirement that waiver applicants are subject to record retention and audit requirements.

II. Requirements for a Group Health Plan or Health Insurance Issuer to Provide Notice of a Waiver of the Annual Limit Requirement

The September 3, 2010 Bulletin did not address the issue of approved applicants informing enrollees of the fact that they had obtained a waiver and that, as a result, coverage under the plan does not comply with the standards provided in the IFR. HHS believes that the communication of this information is necessary in order for consumers to understand the value and quality of the coverage they have, and do not have expectations that the limits in Section 2711 will apply. Therefore, as a condition of receiving a waiver of the annual limits requirements under Section 2711, a group health plan or health insurance issuer will be required to provide a notice informing each participant or subscriber that the plan or policy does not meet the restricted annual limits for essential benefits set forth in the IFR because it has received a waiver of the requirement. The notice will be required to include the dollar amount of the annual limit along with a description of the plan benefits to which it applies, and will be required to be prominently displayed in clear, conspicuous 14-point bold type. In addition, the notice will be required to state that the waiver was granted for only one year. HHS will establish model notice language for issuers which will be posted on the website in the near future at: <http://www.hhs.gov/ociio/regulations/index.html>.

Pending compliance with the Paperwork Reduction Act with respect to this notice requirement, the notice would apply to waivers that have been granted pursuant to the Bulletin of September 3, 2010, as well as to future waivers. Issuers receiving a waiver under the process described in Section III below relating to state-mandated policies will also be required to provide the notice required here.

III. Process for a State to Apply for a Waiver of Restricted Annual Limits in State-Mandated Policies

In some states, issuers offer policies with annual limits below the minimum requirements established in the IFR published on June 28, 2010, in order to comply with state laws. These state laws require issuers to market a standardized policy that includes an annual limit well below the restricted annual limits set out in the IFR (“state-mandated policy”). This Bulletin provides supplemental guidance to clarify that a state may apply for a waiver of the restricted annual limits on behalf of issuers of state-mandated policies in the state if state law required the policies to be offered by the issuers prior to September 23, 2010. Although the state may apply on the issuers’ behalf, the application must still satisfy the standard established in the IFR that compliance by the issuers would result in a “significant decrease in access to benefits” or a “significant increase in premiums.”

The waiver application process for states submitting a waiver request is as follows:

1. Submit electronically to the OCIIO mailbox at OCIIOOversight@hhs.gov:

- a. The state law requirements, specifying the annual limits of less than the restricted annual limit in the IFR for essential health benefits, of the state-mandated policy for which a waiver is sought;
 - b. The name(s) of the issuer(s) required to offer the state-mandated policy submitted;
 - c. For each issuer, the number of individuals covered by the state-mandated policy submitted;
 - d. The annual limit(s), benefit design, and rates applicable to the state-mandated policy submitted; and
 - e. The state's estimate or analysis of how compliance with the IFR by the issuer(s) 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.
2. In lieu of an attestation from each issuer's Chief Executive Officer that compliance with the annual limit requirements of Section 2711 of the PHSA would result in a significant decrease in access to benefits or a significant increase in premiums, the state may submit a statement from the state's insurance commissioner or another state official that compliance with Section 2711 of the PHSA 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.

Because this guidance is being issued after September 23, 2010, state waiver applications that receive approval under the process set forth in this Bulletin will be effective retroactive to September 23, 2010. Consistent with the waiver process set forth in prior guidance, a waiver approval under the process set forth in this Bulletin applies only for the plan year (in the individual market, policy year) beginning between September 23, 2010, and September 22, 2011. A state must reapply when this waiver expires for any subsequent plan year (in the individual market, policy year) prior to January 1, 2014, in accordance with this or any future guidance from the Department of Health and Human Services (HHS).

A state that wishes to apply for a waiver of the restricted annual limit requirements should submit the items referenced above electronically to the OCIO mailbox at OCIOOversight@hhs.gov (use "State Annual Limit Waiver Request" as the subject of the message).

IV. Description of Standards Used to Assess Waiver Applications

As set out in the September 3, 2010 Bulletin, the IFR implementing Section 2711 of the PHSA provided that the restricted annual limits may be waived by the Secretary of HHS if compliance with the IFR would result in a "significant decrease in access to benefits" or a "significant increase in premiums." The question has arisen how these terms are applied to waiver applications. While the waiver applications are reviewed on a case-by-case basis, several factors related to the test established in the IFR may be considered as each application is reviewed. Examples of these factors include:

1. 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.
2. The policy's current annual limits. Plans with higher annual limits would be expected to experience lower premium increases to become compliant with the IFR's restricted annual limit requirement than plans with lower limits.
3. The change in premium in percentage terms. The lower the percentage increase estimated to achieve compliance, the less likely compliance with the IFR would be found to be "significant."
4. The change in premium in absolute dollar terms. While the percentage increase noted in item 3 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."
5. 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.
6. The number of enrollees under the plan seeking the waiver.

V. Special Rules for Application of MLR Provisions to Mini-Med Policies

OCIIO has received requests from plans granted a waiver of the annual limits requirements for additional special treatment under another provision of the Affordable Care Act, the medical loss ratio (MLR) provisions of new PHS Section 2718. Specifically, some plans with low annual limits have asked that they also be exempted from the MLR requirements if they fail to spend on health benefits and quality improving activities at least 80 cents of each premium dollar (85 cents of each premium dollar for issuers in the large group market). Those requesting this exemption argue that the administrative costs of mini-med plans are the same as those of other types of plans, but their premium base is very low relative to other types of plans, resulting in low MLRs by definition. Accordingly, it is argued that the application of the MLR standards in the Affordable Care Act to mini-med plans without taking into account the special circumstances of those plans could cause some carriers to discontinue their offerings, and therefore could result in a loss of coverage prior to the implementation of State exchanges in 2014.

HHS intends to promulgate, in the near future, regulations implementing the MLR provisions of Section 2718 including a special methodology that takes into account the special circumstances of mini-med plans in determining how administrative costs are calculated for MLR purposes (and thus how MLR ratios are calculated for such plans). The special methodology for mini-med plans would apply at least for the first year for which the MLR provisions are effective. Because little data are available to adequately

assess and validate the assertions of the industry presented in support of special treatment for these plans under Section 2718, HHS intends to collect data on an accelerated basis to inform its determination whether mini-med plans should be accorded similar treatment for the second and third years preceding 2014.

VI. Record Retention and Audits

As provided in the September 3, 2010 Bulletin, HHS retains audit authority over applicants as a condition for obtaining a waiver. HHS may conduct audits of data submitted by applicants pursuant to this Bulletin and the September 3, 2010 Bulletin. If, upon the audit of data submitted to HHS, it is determined that the data contain material mistakes or omissions, HHS may in its discretion deny future waiver requests based on the failure of the applicant to provide accurate information.

Where to get more information:

If you have any questions regarding this Bulletin, please e-mail the OCIO mailbox at OCIOOversight@hhs.gov (use “State Annual Limit Waiver Request” as the subject of the email).