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HHS Releases Further Guidance on Requesting Waivers of PPACA Annual Dollar Limit Restrictions

The Department of Health and Human Services (HHS) has issued supplemental sub-regulatory guidance on the process that group health plans and health insurance issuers may use to apply for a waiver of the annual dollar limit requirements of the Patient Protection and Affordable Care Act (PPACA).

Background

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, includes restrictions on the imposition of annual dollar limits on essential health benefits. Under interim final regulations issued in June, 2010, group health plans subject to PPACA and health insurance issuers may only impose certain "restricted annual limits" on essential health benefits for plan or policy years beginning prior to January 1, 2014. (See our July 2, 2010 *For Your Information*.)

To ensure that individuals with coverage under "limited benefit" plans or "mini-med" plans would not experience a significant decrease in access to benefits or a significant increase in premiums, HHS will allow plans and issuers to apply for relief from the restricted annual limits for plan or policy years beginning prior to January 1, 2014. On September 3, 2010, HHS issued an Information Bulletin on the scope and process for applying for such a waiver. (See our September 17, 2010 *For Your Information*.) On November 5, 2010, HHS issued another Information Bulletin (Bulletin) in its Insurance Standard Bulletin Series. This new sub-regulatory guidance addresses additional questions regarding the scope and applicability of the waiver program and provides certain clarifications.

The Supplemental Guidance

The Bulletin addresses the following notice requirements for plans that receive waiver approvals, state waiver requests, waiver application considerations, application of medical loss ratios, record retention and audits.

Notice Requirements. In the September 3, 2010 Bulletin, HHS did not impose any notice requirements on plans or issuers that received a waiver. However, the new guidance provides that, as a condition of granting a waiver, HHS will require a group health plan or issuer to provide a notice to each participant or subscriber advising them that the plan or policy does not meet the restricted annual limits for essential benefits otherwise required by the interim final regulations. The notice obligation also applies to plans and issuers to whom HHS already granted a waiver. The notice must include the dollar amount of the annual limit with a description of the plan benefits to

which it applies in clear, conspicuous 14-point bold type, and state that the waiver was granted for only one year. HHS has indicated that it will post model notice language on its website in the near future.

> ***BUCK COMMENT.*** *The Bulletin does not expressly address who is responsible for providing the notice. Although we would expect that issuers would be responsible for providing notice for insured plans and that plan sponsors would be responsible for providing notice for their self-funded group health plans, further guidance would be helpful. The guidance also makes clear that issuers receiving a waiver through a state waiver request (discussed below) will also be subject to the notice requirement.*

State Waiver Requests. To comply with applicable laws in some states, issuers must market standardized state-mandated policies that include annual limits below the minimum requirements set out in the interim final regulations. The Bulletin clarifies that a state that required issuers to offer such policies prior to September 23, 2010 may apply for a waiver of the restricted annual limits on behalf of all issuers of the state-mandated policies, and provides details on submitting such applications.

Assessing Waiver Applications. Although HHS will review waiver applications on a case-by-case basis, HHS identifies in the Bulletin the following factors as examples of the factors it will consider in determining whether compliance with the interim final regulations would significantly decrease access to benefits or significantly increase premiums:

- the plan's or policy's current annual limits,
- the percentage increase in premium,
- the premium increase in absolute dollars,
- the number and type of benefits affected by the annual limit (e.g., whether the limit applies to all benefits or just to the prescription drug portion), and
- the number of enrollees under the plan.

Application of MLR Provisions to Mini-Med Policies. HHS notes that some plans that have been granted a waiver of the annual dollar limit requirements have also requested exemption from PPACA's Medical Loss Ratio (MLR) provisions. The MLR provisions, which apply only to insured coverage, require an insurer in the large group market to spend at least 85 cents of each premium dollar on health benefits and quality improving activities. Fully-insured limited benefit plans have expressed concern about their ability to satisfy these requirements. In response, HHS includes in the Bulletin an announcement that it will be issuing regulations in the near future implementing the MLR provisions, and those regulations will include a special methodology that will take into account the special circumstances of mini-med plans in determining how administrative costs (and thus MLR ratios) are calculated for MLR purposes. HHS states that it will apply that special methodology for mini-med plans for at least the first year for which the MLR provisions are in effect, and will consider extending similar treatment for the second and third years prior to 2014.

Record Retention and Audits. HHS confirms that it retains audit authority over applicants as a condition for obtaining a waiver, and may audit data submitted by them in seeking a waiver. If, upon audit, HHS finds material mistakes or omissions, HHS retains discretion to deny future waiver requests from the applicant.

Conclusion

Waiver applications generally must be submitted not less than 30 days before the beginning of the plan or policy year. Thus, calendar year group health plans and health insurance issuers that have not already done so must quickly consider whether they will seek a waiver for the 2011 plan or policy year. Although HHS will review waiver applications on a case-by-case basis, it has now identified certain factors it will consider in determining whether to grant a waiver and new notice requirements for plans or issuers that receive a waiver.

Buck's consultants are available to assist in the financial analysis of existing plans, completion of the waiver application, and compliance with applicable notice requirements.