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Volume 33 | Issue 81 | December 21, 2010

HHS Issues Additional Guidance on Mini-Med Health Plans

HHS has issued two additional pieces of sub-regulatory guidance relating to waivers of PPACA's restrictions on plans and issuers imposing annual dollar limits on essential health benefits. The guidance includes the notice that plans and issuers granted a waiver must provide to participants and subscribers and sets out the limited circumstances under which issuers receiving waivers may sell new policies that do not comply with PPACA's annual dollar limit restrictions.

Background

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA) restricts a plan or issuer from imposing annual dollar limits on essential health benefits in excess of the limits specified in regulations for a plan or policy year beginning on or after September 23, 2010. PPACA prohibits the imposition of any annual dollar limits on essential health benefits for a plan or policy year beginning on or after January 1, 2014.

Interim final regulations, issued by the Departments of Health and Human Services (HHS), Labor, and the Treasury specify the restricted annual dollar limits that a group health plan or health insurance issuer may impose on essential health benefits for a plan or policy year beginning before January 1, 2014. (See our July 2, 2010 *For Your Information*.) The interim final regulations also provide that HHS will establish an administrative process under which a plan or issuer can apply each year before 2014 to receive HHS annual approval to continue to offer a plan or policy that has annual limits below the permissive limit (a "mini-med").

On September 3, 2010, HHS issued guidance on the administrative process for applying for such waivers. (See our September 17, 2010 *For Your Information*.) On November 5, 2010, HHS issued supplemental guidance (OCIIO 2010 – A) that addresses questions regarding the scope and applicability of the waiver program, provides clarifications relating to medical loss ratios for mini-meds and the extent of HHS's audit authority over waiver applicants, and requires a plan or policy to provide a notice of the limited coverage to covered individuals. (See our November 11, 2010 *For Your Information*.)

On December 9, 2010, HHS issued two additional pieces of supplemental guidance. OCIIO 2010-B provides required notice language for plans receiving a waiver. OCIIO 2010-C addresses the sale of new policies by issuers who have been granted a waiver.

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The Supplemental Guidance (OCIIO 2010 B and C)

OCIIO 2010-B: Notice Requirements

Under OCIIO 2010-A, a group health plan or issuer, as a condition of being granted a waiver, must provide notice to current and eligible participants and subscribers. The notice must advise them that the plan or policy does not meet the restricted annual dollar limits for essential benefits otherwise required by the interim final regulations and has received a waiver of this requirement.

OCIIO 2010-B contains a "model notice" that plans and issuers must use to satisfy the notice requirement. The model notice requires the plan or issuer to specify the dollar amount of the plan's or policy's annual dollar limit and to describe the plan benefits to which the limit applies. The notice must also state that the waiver was granted for only one year.

> ***BUCK COMMENT.*** *Despite its designation as a model notice, use of the HHS notice is required. Plans and issuers may not use a substitute notice even if the substitute contains all the elements of the HHS notice.*

OCIIO 2010-B also sets out the deadlines by which a plan or issuer must send the notice to participants and subscribers. If the waiver is for a plan or policy year that begins before February 1, 2011, the plan or issuer must provide the notice to current and eligible participants and to subscribers no later than February 7, 2011 (60 days from December 9, 2010, the date the guidance was issued). If the waiver is for a plan or policy year that begins on or after February 1, 2011, no separate notice is required; however, the plan or issuer must provide the notice to eligible participants and subscribers as part of any informational or educational materials and as part of any plan or policy document, such as a summary plan description, relating to coverage. The notice must be prominently displayed on the front of such materials.

OCIIO 2010-C: Waiver Availability and New Sales

OCIIO 2010-C makes clear that the HHS program for waivers of the annual limit restrictions is available only if the mini-med coverage was already in place before September 23, 2010.

> ***BUCK COMMENT.*** *While HHS is willing to allow employers to continue mini-med coverage before 2014 if the alternative is no coverage at all, it also does not want to allow the expansion of mini-med coverage.*

OCIIO 2010-C carves out two narrow exceptions to the requirement that health insurance issuers may not sell new mini-med policies to group health plans or in the individual market after September 23, 2010. The exceptions are for state-mandated policies and group policies.

- *State-Mandated Policies*. Some states require issuers in the state to offer standardized state-mandated policies that have annual limits below the minimum requirements set out in the interim final regulations.

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OCIIO 2010-A allowed a state that required such policies prior to September 23, 2010 to apply for a waiver of the restricted annual limits on behalf of all issuers of the state-mandated policies. OCIIO 2010-C allows issuers in a state that receives a waiver on behalf of its issuers to continue to sell such policies through September 23, 2011. The issuers cannot sell such policies after September 23, 2011 unless the state or issuer obtains a new waiver from HHS.

BUCK COMMENT. *The exception does not apply to state laws that were enacted after September 23, 2010.*

- *Group Policies*. HHS allows a sponsor of a group health plan with a policy for which the annual dollar limit requirements have been waived to purchase a new policy after December 9, 2010 from a different issuer that has also obtained a waiver of the annual dollar limit restrictions if all of the following conditions are satisfied: (a) the plan sponsor offered group health insurance to its employees before September 23, 2010 and the issuer obtained a waiver of the annual limits requirement with respect to the coverage; (b) the new issuer obtained a waiver for the new policy; (c) the annual limits of the new policy are not lower than the annual limits of the previous policy unless an issuer is no longer offering the coverage the plan sponsor had before September 23, 2010, in which case, the plan sponsor can obtain a replacement policy with a lower annual limit but only if other comparable coverage with the same level of annual limits as the previous policy is unavailable.

  BUCK COMMENT. *Although a plan that satisfies these conditions may purchase a policy with a lower annual dollar limit than it previously had in certain conditions, the plan will lose grandfather status if it does so.*

The issuer of the new coverage must obtain an attestation from the plan sponsor that the above requirements are met. The attestation must be saved with a copy of the previous policy pursuant to related HHS guidance.

BUCK COMMENT. *The allowance of new policies conforms with the November 15, 2010 amendment to the interim final regulations on grandfathered health plans. That guidance provides that a benefit option under a group health plan will not lose its grandfathered status merely because the sponsor enters into a new insurance policy or changes health carriers. (See our November 23, 2010* For Your Information*.)*

Conclusion

HHS has recognized the need to allow mini-med policies in existing situations, but will continue to put conditions on their expansion beyond those in effect before September 23, 2010.

Buck's consultants are prepared to assist you with understanding how this new waiver guidance might impact your plans.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.

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