McGraw Wentworth

REFORM Update

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The Department of Health and Human Services recently released an *Insurance Standards Bulletin* regarding waiving restrictions on annual dollar limits and applying medical loss ratios to mini-medical plans.

The health reform acts currently allow companies to maintain restricted annual dollar limits on the amount they will pay for essential benefits. The Acts, however, gradually phase out these limits. Plans must set annual dollar limits of at least $750,000 your first year of compliance and that amount will increase each year until 2014 when plans must remove any annual dollar limits.

Employers have been concerned about their mini-med plans or limited benefit plans. These plans are specifically designed with a restricted annual dollar benefit limit. Employers often offer these plans to employees that don't qualify for the comprehensive health plan so that they can have some medical coverage. With the requirements of health reform, it would seem these mini-med plans would no longer be permitted because their annual dollar benefit limits are significantly below the $750,000 minimum. However, when it issued regulations earlier in the year, the government indicated it would allow these plans to apply for a waiver of the annual restricted dollar limits until 2014. Plans would need to apply for a waiver in this situation, using the process released in early September 2010.

Another problem for these mini-med plans is a requirement that becomes effective on January 1, 2011: the medical loss ratio requirements. Carriers must spend a certain percentage of premiums on claims. Mini-med plans don't often achieve the loss ratios health reform requires, so that requirement makes it more difficult for companies to maintain mini-med plans. McDonald's, for example, found meeting the medical loss ratio requirements was a problem and decided to discontinue the plan. Because of the ensuing negative publicity, the government decided to waive the requirements for McDonald's and is considering alternatives for these plans.

The latest *Insurance Standards Bulletin*:

- Establishes transparency and disclosure requirements for plans that receive waivers.
- Clarifies that a state can apply for a waiver for health insurance issuers in the state under certain circumstances, and it establishes a process for a state waiver request.
- Describes the factors DHHS will consider in analyzing a waiver application.
- Discusses applying the medical loss ratio provisions of health reform.

This *Reform Update* reviews the key aspects of this *Standards Bulletin*.

Transparency and Disclosure Requirements for Plans That Receive Waiver Approvals

The Department of Health and Human Services (DHHS) realized that its September guidance did not require companies to inform enrollees that the DHHS had approved a waiver of the annual dollar limit requirements. DHHS believes informing enrollees is necessary. Enrollees need to know the value and quality of their coverage and whether the minimum annual dollar benefit limitations will apply to their plan.

As a condition of receiving a waiver allowing restricted annual dollar limits, a group health plan or health insurance issuer must notify each participant or subscriber that the plan has received a waiver allowing it to set annual dollar limits on the amount it will cover for essential benefits. The notice must include the dollar amount of the annual limit, list the benefits involved, and state the waiver was granted for only one year. It must be prominently displayed in a clear, conspicuous 14-point bold type font. DHHS will soon post model notice wording on this website, http://www.hhs.gov/ociio/regulations/index.html.

This notice requirement applies to current and future waivers. No specific delivery or timing requirements for these notices have been issued.

Process to Follow When a State Requests Waivers for its Health Insurance Issuers

Some state laws require insurance carriers to offer policies with restricted annual limits below the minimum health reform requirements. This *Bulletin* clarifies that a state may apply for a waiver of the restricted annual limits for its state-mandated insurance policies if the state law required the carrier to offer the policies before September 23, 2010. Even if the state requests the waiver, the carrier must demonstrate that lifting annual limits would result in a significant decrease in access to benefits or a significant increase in premiums.

States will need to follow a specific process to request a waiver for insurance carriers in the state. They must submit the following materials electronically to OCIIOOversight@hhs.gov:

1. State laws specifying the annual limits of less than the restricted annual limit for essential benefits of the state-mandated policy for which a waiver is sought.
2. The names of the insurers required to offer the state-mandated policy.
3. For each insurer, the number of people the state-mandated policy covers.
4. The state's estimate or analysis explaining that increasing the annual limits would cause a significant decrease in access to benefits or significant increase in premiums.

Because this *Bulletin* was issued after September 23, 2010, approval for these waivers will be retroactive to September 23, 2010. The state must reapply for the waiver each plan year until January 1, 2014.

Insurance carriers must provide the notice described in the previous section when the state applies for a waiver.

Factors Considered in Analyzing a Waiver Application

Following are factors used to determine whether the restricted annual limits would cause a decrease in access to benefits or significant increase in premiums:

- **The applicant's explanation of how complying with the restriction on annual limits would cause a significant decrease in access to benefits.** Decreases may include dropped coverage or plan insolvency.
- **The policy's current annual limits.** If a plan has higher limits, it would have less cost impact to comply with annual restricted limits.
- **Change in premium in percentage terms.** The higher the percentage increase in premiums in order to comply, the more likely the increase will be considered significant.
- **The number and type of benefits the annual limit affects.** Some policies have limits only on some essential benefits such as prescription drugs. For example, while increasing the limit on prescription drugs to $750,000 may increase the portion of the premium related to prescription drug coverage significantly, it may not significantly increase the overall cost of health insurance for enrollees.
- **The number of enrollees on the plan seeking a waiver.**

DHHS requests all this information as part of the waiver application process and will use these criteria to determine whether it can grant the waiver.

Application of Medical Loss Ratio Provisions of Health Reform to Limited Benefit Plans

Carriers of mini-medical plans have asked to be exempt from the medical loss ratio requirements. These plans argue that the administrative cost associated with mini-medical plans is similar to the administrative cost of comprehensive health plans. Mini-med plans, however, collect far less in premiums than a more comprehensive medical plan. The resulting low medical loss ratio could not meet the limits required. Applying medical loss ratios standards to mini-med plans without taking into account the special circumstances of those plans could cause some carriers to discontinue coverage before 2014. As a result, some enrollees would lose the minimal coverage they have.

The DHHS intends to issue regulations on medical loss ratios and that guidance will take into account the special circumstances of mini-med plans when it determines how to calculate the medical loss ratio.

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