legislativeUPDATE

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New Healthcare Waiver Guidance and List of Granted Waivers

The Department of Health and Human Services (HHS) created a process to review and approve waivers from the restrictions related to annual limits on health benefits under the health care reform law. The waivers are for so-called "mini-med plans" that offer annual coverage limits on benefits. These plans are scheduled to be completely regulated out of existence in 2014. However, in the meantime, these plans are often the only form of health insurance available to workers and without the waivers most would no longer be available. The goal of the waiver program was to establish annual limits that would have a minimal effect on premiums and access to health care benefits under these plans.

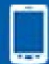
A recently released General Accountability Office (GAO) report: *Private Health Insurance: Waivers of Restrictions on Annual Limits on Health Benefits*, has found that as of April 25, 2011, HHS received a total of 1,415 applications for a waiver of restrictions related to annual limits on health benefits, and approved most of these applications. For 1,347 of the applications, (or over 95 percent), waivers were approved covering all plans in the applications. For another 25 applications, waivers were approved for some plans and waivers were denied for others within the same application. Most applications projecting a premium increase of 10% or more were approved. Applications projecting 6% or less were usually denied and projections between 7% and 9% were usually reviewed. Approximately 3 million people were covered in approved plans and approximately 153,000 people were covered in denied plans. The total number of people covered in the approved plans represents about 2% of people covered by private health insurance plans in 2009.

According to the report, HHS approved requests it received for waivers based on whether or not premiums would rise significantly or access to care would be harmed. The process and criteria developed to approve waivers for these plans were outlined in guidance, and applicants were required to complete a brief application for the waiver. Plans with low annual limits (e.g., $10,000) are most likely to need these waivers to prevent a significant increase in premiums or decrease in access to coverage to comply with the current limit of $750,000. Many of these plans have already received a waiver. Plans with higher annual limits are less likely to qualify for a waiver because complying with the new rules is unlikely to lead to a significant increase in premiums or decrease in access to care. HHS periodically posts the list of the plans that have been granted waivers to ensure the public is aware of the waiver process and stakeholders understand how they are affected.

On June 17, 2011, the Centers for Medicare & Medicaid Services (CMS) introduced a process for plans that have already received waivers and want to renew those waivers for plan years beginning before January 1, 2014. The new guidance extends the duration of waivers that have been granted through 2013, if applicants submit annual information about their plan and comply with requirements to ensure that their enrollees understand the limits of their coverage. Existing waiver recipients must apply to extend their current waiver and all applications must be submitted by September 22, 2011; after that date applications for an extension will no longer be considered. Any plans that have not yet applied for a waiver also must apply by September 22, 2011.

On December 9, 2010 HHS issued rules requiring that health insurers offering mini-med plans must notify consumers in plain language that their plan offers extremely limited benefits and direct them to www.HealthCare.gov where they can get more information about other coverage options. The new guidance issued on June 17, 2011 imposes more stringent disclosure requirements and requires a new version of this consumer notice that will make the information easier for families to understand. Health plans with waivers must tell consumers if their health care coverage is subject to an annual dollar limit lower than what is required under the law. This way, enrollees know when their coverage is limited.

Employers are advised to continue to monitor health reform developments. Should you have questions about this or any aspect of federal health insurance reform, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

connerstrong.com  877-861-3220 news@connerstrong.com Change My Preferences

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