DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

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From: Steven Larsen, Director, Office of Oversight

Title: Insurance Standards Guidance Series—INFORMATION

Subject: OCIIO Guidance (OCIIO 2010 – 1C) -- SUPPLEMENTAL GUIDANCE.

Markets: Group and Individual

I. Purpose

On September 3, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) published guidance setting out the process that a group health plan or health insurance issuer should follow to apply for a waiver for a limited benefit plan or "mini-med" plan of 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 established 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 (PHS Act), as amended by the Affordable Care Act. The September 3, 2010 guidance established the waiver program for plan or policy years beginning on or after September 23, 2010 and before September 23, 2011; waivers are granted for a single year. The waiver authority does not extend beyond plan or policy years beginning on or after January 1, 2014, when no annual limits on essential health benefits are permitted, except in the case of grandfathered individual market policies.

On November 5, 2010, OCIIO published supplemental guidance that, among other things, created a process for States with laws in effect before September 23, 2010 requiring issuers to offer low annual limits policies to apply for an annual limits waiver on behalf of health insurance issuers. The purpose of this supplemental guidance is to: (1) clarify that waivers of annual limit restrictions pursuant to the waiver authority in the June 28, 2010 IFR generally apply only to policies already in place before September 23, 2010; and (2) specify two limited circumstances under which issuers in the group and individual markets that have obtained a waiver of the annual limit requirement for certain policies may sell new policies that do not comply with annual limit restrictions under the IFR waiver authority.

II. Sale of New Business by Issuers Receiving Waivers

Since issuing the September 3rd and November 5th guidance documents, the Department

of Health and Human Services (HHS) has received reports that some health insurance issuers who have received or expect to receive a waiver of the annual limits intend to issue new non-conforming policies after September 23, 2010. The effect of this would be an increase in the number of policies that are not compliant with the annual limits requirement of section 2711 of the PHS Act. The purpose of the IFR authority to waive annual limit requirements was not to permit new non-compliant insurance policies to be sold, but, for the period prior to 2014, to minimize disruption of existing coverage, or in some cases State-established markets, where the application of restrictions on annual limits would significantly decrease access to, or the costs of, existing coverage. Accordingly, HHS generally will grant waivers of the annual limit requirements solely for the purpose of maintaining coverage sold before September 23, 2010. Except as provided in A and B below (and except as to new participants or beneficiaries in an existing group health plan), health insurance issuers may not provide new policies to group health plans or sell new policies in the individual market after September 23, 2010 that do not meet the requirements of section 2711 of the PHS Act.

This bulletin provides for two limited exceptions to this restriction, in the case of States with mandated low annual limits policies, and to permit existing group health plans with waivers to change issuers as permitted under a recent change to the IFR relating to status as a grandfathered health plan.

A. State-Mandated Policies

The November 5, 2010 guidance discussed that, in some States, issuers offer policies with annual limits below the minimum requirements established in the June 28, 2010 IFR, in compliance with State laws that would mandate that such coverage be offered in the absence of the new Federal annual limit restrictions. The guidance established a process by which States with such laws in effect before September 23, 2010 could submit a waiver application on behalf of issuers offering coverage under such laws. In the case of States with such laws in effect, the State had made a determination that availability of such policies was in the interests of its citizens. To accommodate existing State efforts to maintain access to coverage that were in place prior to the new annual waiver limits taking effect, HHS has determined that issuers offering coverage under these State laws under a waiver of annual limit requirements may continue to sell those policies to individuals and groups through September 23, 2011. These policies may not be sold after September 23, 2011 unless the State, or issuers in the State, obtains a new waiver. In this case, while HHS is accommodating existing state efforts to maintain access to these products in order not to disrupt an existing marketplace established under State law, this policy would not apply to laws enacted subsequent to September 23, 2010 intended to create a new similar marketplace.

B. Group Policies

In light of the recently published amendment to the IFR relating to status as a grandfathered health plan (75 Fed.Reg. 70114), which provides that changing of issuers in and of itself will not cause loss of grandfather status, HHS has determined that it is

also appropriate, in certain circumstances, to clarify the September 3, 2010 guidance to permit group health plan sponsors that had a policy with a waiver of the annual limit requirements to purchase a new policy after the date of issuance of this guidance from a different issuer that has also obtained a waiver of annual limit restrictions. We note, however, that as stated in the amendment to the IFR regarding grandfather status, if the new policy includes changes described in paragraph (g)(1) of the grandfather interim final regulations, the plan ceases to be a grandfathered health plan. The circumstances under which a plan sponsor may purchase a new policy with annual limits below the level specified in the June 28, 2010 IFR after the date of issuance of this guidance but before September 23, 2011 are as follows:

1. In all cases, the plan sponsor must have been offering group health insurance coverage to its employees before September 23, 2010, for which the issuer had obtained from HHS a waiver of the annual limits requirement;
2. The new issuer from which the group health plan is obtaining the new policy must have obtained a waiver from HHS for the new policy;
3. Except in the situation outlined in #4, the annual limits of the new policy may not be lower than the annual limits of the previous policy;
4. In the situation where an issuer is no longer offering the coverage the plan sponsor had before September 23, 2010, the plan sponsor may obtain a replacement policy with a lower annual limit only if other comparable coverage with the same level of annual limits as the prior policy is not available.[1]

Any health insurance issuer of new waivered coverage to a group plan sponsor must obtain from the plan sponsor an attestation that the criteria outlined above are satisfied, and the attestation must be accompanied by a copy of the prior policy outlining the terms of the prior coverage. Issuers shall retain this information in accordance with the data retention requirements of the September 3, 2010 and November 5, 2010 guidance documents.

Where to get more information:

If you have any questions regarding this supplemental guidance, please e-mail the OCIIO mailbox at OCIIOOversight@hhs.gov (use "supplemental guidance" in the subject line).

[1] While this guidance allows a plan sponsor to be eligible for a waiver from the annual limit requirements if the plan sponsor obtains a replacement policy with a lower annual limit, as noted earlier the change to a lower annual limit would cause a loss of grandfather status under paragraph (g)(1)(vi)(C) of the interim final regulations relating to status as a grandfathered health plan.