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 – 1B) -- 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, established transparency and disclosure requirements for group health plans and health insurance issuers that receive a waiver approval. The purpose of this supplemental guidance is to provide model language that group health plans and issuers will be required to use to satisfy the transparency requirements established in the November 5, 2010 supplemental guidance.

II. Requirements for a Group Health Plan or Health Insurance Issuer to Provide Notice of a Waiver from the Annual Limit Requirement

The November 5, 2010 supplemental guidance specified that, as a condition of receiving a waiver from the annual limits requirements under section 2711 of the PHS Act, a group health plan or health insurance issuer must provide a notice informing current and

eligible participants and subscribers that the plan or policy does not meet the minimum annual limits for essential benefits and has received a waiver of the requirement. The Department of Health and Human Services (HHS) believes that the communication of this information is necessary in order for consumers to understand the value and quality of the coverage they have, and to ensure they do not have expectations that the limits in section 2711 apply to their policy. The notice requirement applies to recipients of waivers that have been granted pursuant to the guidance of September 3, 2010 and the supplemental guidance of November 5, 2010, as well as to future applicants that receive a waiver. The notice is required to include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies. In addition, the notice is required to state that the waiver was granted for only one year.

For plans or issuers that have already been approved for a waiver for plan or policy years that begin before February 1, 2011, or that will receive approvals for plan or policy years that begin before February 1, 2011, the notice must be provided to current and eligible participants and subscribers within 60 days from the date of issuance of this guidance. For applicants for waivers covering plan or policy years that begin on or after February 1, 2011, the notice must be provided to eligible participants and subscribers as part of any informational or educational materials, and also in any plan or policy documents evidencing coverage that are sent to enrollees (e.g., summary plan descriptions).

The following model language, which shall be prominently displayed in clear, conspicuous 14 point bold type on the front of the materials, shall be used to satisfy the notice requirement:

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by [name of group health plan or health insurance issuer], does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of:

[dollar amount] on [all covered benefits]
and/or
[dollar amount(s)] on [which covered benefits – notice should describe all annual limits that apply].

In order to apply the lower limits described above, your

health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact [provide contact information for plan administrator or health insurance issuer].

[For plans offered in States with a Consumer Assistance Program] In addition, you can contact [contact information for consumer assistance program].

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).