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MEMORANDUM
2010-16

Health Care Reform: Saving the Mini-meds

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The Office of Consumer Information and Insurance Oversight (OCIIO) inside the Department of Health and Human Services (HHS) has just expanded the ability of a plan sponsor to address compliance concerns under the Health Care Reform (HCR) with regard to limited benefit plans commonly referred to as mini-meds. On September 3, 2010, OCIIO issued guidance to insurers and to plan sponsors with self-funded limited benefit plans on the methodology for obtaining an HCR-approved waiver of the annual limit requirements set forth in the Interim Final Rule published on June 28, 2010 (please refer to our memorandum 2010-13 for details). The annual limit restriction applies to all group health plans, regardless of grandfathered status. The guidance provides no relief for supplemental medical expense reimbursement plans. The purpose of this Memorandum is to discuss the waiver process.

Basis for the Waiver

Both the HCR law itself and the Interim Final Rule grant HHS the power to waive the law's annual essential health benefit limit restrictions if, in the view of HHS, the enforcement of the annual limit restrictions will result in a "significant decrease in access to benefits" or "would significantly increase premiums." The OCIIO Bulletin will allow group health plans to maintain their existing limits in lieu of terminating the limited benefit coverage or meeting the Interim Final Rule's $750,000 minimum annual limit requirement on the dollar value of essential health benefits for plan years beginning on or after September 23, 2010 but before September 23, 2011.

The Process

1. **Submitting the Application**. For insured plans, the chief executive officer of the issuer (e.g. Aetna or CIGNA) must certify by attestation that:
   - The plan/policy was in force on September 23, 2010; and,
   - The imposition of the $750,000 limit would result in a significant decrease in access to benefits for those currently covered by such plans, or a significant increase in premiums paid by those covered by such plans.

   For self-funded plans, we expect that the plan sponsor must make the same attestations.

2. **The Content of the Application**. In addition to the attestation, the application must include the following content:

- The terms of the plan or policy form(s) for which a waiver is sought;
- The number of individuals covered by the plan or policy form(s) submitted;
- The annual limit(s) and rates applicable to the plan or policy form(s) submitted; and,
- A brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or significant increase in premiums paid by those individuals covered by such plans or policies, along with any supporting documentation.

It would appear that the insured plan issuer would file on behalf of all its "limited benefit" policyholders of record on September 23, 2010 or later and that the waiver would apply to policies issued prior to September 23, 2011. Multiple employer trust managers would obtain waivers for its participating employers and single employer plan sponsors would obtain relief only for its own "limited benefit" plans.

3. **Submission Dates**. The Bulletin requires the applicant to submit the application not less than 30 days before the beginning of the plan year between September 23, 2010 and September 23, 2011. For plan years beginning prior to November 2, 2010, applicants must submit applications not less than ten (10) days before the beginning of the plan year.

   The Bulletin also refers to policy years in its submission date requirements. We do not know whether the policy year reference is restricted to individual policies, but we suspect so. The HCR reforms, as applicable to employer-sponsored group health plans, typically reference the plan year and not the policy year. However, we expect that insurers will submit applications for policies issued before September 23, 2010 and prior to September 23, 2011. For purposes of plan year compliance, the policy renewal date must precede or be the same as the plan year to comply with the Employee Retirement Income Security Act (ERISA), thus alleviating concern over the timing of the insured plan application.

4. **Approval Dates.** HHS will process all completed waiver applications within 30 days of receipt, except that completed applications submitted for plan or policy years beginning before November 2, 2010 will be processed no later than 5 days in advance of such plan or policy year. By "completed application," OCIIO means the application contains all the required information.

5. **Duration of the Waiver.** The waiver will apply only for plan years beginning on or after September 23, 2010 and before September 23, 2011. We expect that HHS may require a separate application for the next plan year ($1.25 million limit). HCR eliminates the waiver capability as of January 1, 2014.

6. **How and Where to Submit the Application**. Issuers and plan sponsors must submit applications for the waiver to:

   Department of Health and Human Services
   Office of Consumer Information and Insurance Oversight
   Office of Oversight
   Attention: James Mayhew, Room 737-F-04

200 Independence Ave. SW
Washington, DC 20201

Or by emailing the items to:
healthinsurance@hhs.gov (use "waiver" as the subject of the email).

OCIIO also suggests that if you need further information, contact the Office of Consumer Information and Insurance Oversight at (301) 492-4100 or by email at healthinsurance@hhs.gov (use "waiver" as the subject of the email).

Commentary

It is our understanding that insured mini-med plans are fairly common in certain industries with a small number of insurers offering such products (e.g. Starbridge *inter alia*). This waiver process should provide much needed relief for these types of policies, at least for 2011. Most insured mini-meds cover a significant number of hourly employees who may end up losing coverage absent the waiver. Most assuredly, the increased premium requirements associated with an increased annual maximum to $750,000 would discourage most employers from offering these policies upon renewal.

Employers who offer freestanding self-funded, limited-benefit plans covering a small number of employees may or may not obtain a waiver, especially if the plan covers full-time employees. For renewal purposes, it will be important to assess the probability of obtaining a waiver under these circumstances.

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