Waiving the Restriction of Annual Limits in Private Health Insurance

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Summary

Considerable congressional attention has been placed on the dollar value of health insurance coverage in terms of out-of-pocket (OOP) costs placed on policyholders. One method that lowers the dollar value of coverage is the use of annual limits on the dollar amount of coverage. Private health insurers use annual limits to require the consumer to assume 100% of the cost of coverage after a certain amount of spending for the year has been reached. While annual limits may be a benefit design feature in any type of health insurance, they are used as the primary method of cost control for limited benefit plans, which provide low premium coverage typically to low-income part-time or seasonal workers. Limited benefit plans generally have annual limits on both the total dollar coverage and on specific coverage categories (e.g., hospitalizations and outpatient surgeries). Without the limited benefit plan option, many of these low-income workers would likely be uninsured. On the other hand, these plans have been criticized as providing little value and giving a false sense of security to policyholders.

The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) prohibits the use of annual limits effective 2014 and places certain restrictions on their use effective for plan years starting on or after September 23, 2010. These restrictions would effectively eliminate limited benefit plans. Accordingly, the Secretary of Health and Human Services has implemented a waiver process for limited benefit plans under the authority provided by §1001 of PPACA to define restricted annual limits in such a way as to “ensure that access to needed services is made available with a minimal impact on premiums.”

As of January 26, 2011, 729 organizations, representing approximately 2.2 million enrollees and policyholders, have been approved by HHS for waivers of the restriction on annual limits. Some states have laws that require health insurance issuers to market a standardized policy that includes annual limits that are below the federal restricted annual limits. In these limited situations, states may apply for a waiver of the restricted annual limits on behalf of issuers of state-mandated policies. As of January 26, 2011, Massachusetts, New Jersey, Ohio, and Tennessee have obtained waivers for issuers with 93,470 enrollees or policyholders. Concern regarding the frequency of the waivers and the transparency of the waiver process has prompted oversight letters from the House Energy and Commerce Committee and the Ranking Member of the Senate Finance Committee.

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Introduction

Considerable congressional attention has been placed on the treatment of consumers within the private health insurance marketplace.[1] Among the many concerns, particular attention has been paid to the value of coverage in terms of out-of-pocket (OOP) costs relative to premiums. One method that lowers the value of coverage is the use of annual limits on the dollar amount of coverage. Private health insurers use annual limits to require the consumer to assume 100% of the cost of coverage after a certain amount of spending for the year has been reached. The spending can be for the total health benefits covered or targeted to specific services, such as hospitalizations. Policyholders and plan members that exceed these coverage caps end up with very high OOP costs. However, market demand for low-premium coverage has led to the proliferation of limited benefit plans ("mini-med plans") that rely on annual limits to keep premiums down. According to the Department of Health and Human Services (HHS) approximately 18 million Americans are subject to annual limits in their health coverage.[2]

The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was enacted on March 23, 2010, and amended by the Health Care and Education Reconciliation Act (P.L. 111-152, HCERA), enacted on March 30, 2010 (hereafter collectively referred to as PPACA). PPACA, among other provisions, reorganizes and amends title XXVII of the Public Health Service Act (PHSA) to reform the private health insurance marketplace. [3] The "immediate" reforms in sections 2711 through 2719 of the PHSA become effective for plan years beginning on or after September 23, 2010.[4] The plan year refers to the 12-month period during which a policy or plan benefit is effective.[5] Among the immediate reforms are consumer protections from high OOP costs by placing restrictions on and eventually prohibiting the use of annual limits.

This report provides an overview of the waiver available for the restriction on annual limits and will be periodically updated to reflect any legislative or regulatory changes.

Restriction on Annual Limits

For plan years beginning on or after six months after enactment, group health plans, grandfathered group health plans, and health insurance issuers offering group or individual plans are restricted, as determined by the Secretary of HHS (hereafter the Secretary), from establishing

[1] For example, see U.S. Congress, House Committee on Ways and Means, Health Reform in the 21st Century: Insurance Market Reforms, 111th Cong., 1st sess., April 22, 2009 (Washington: GPO, 2009); U.S. Congress, House Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions, Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families, 111th Cong., 1st sess., April 23, 2009 (Washington: GPO, 2009); U.S. Congress, Senate Committee on Commerce, Science, and Transportation, Consumer Choices and Transparency in the Health Insurance Industry, 111th Cong., 1st sess., June 24, 2009 (Washington: GPO, 2009); and U.S. Congress, Senate Committee on Health Education Labor and Pensions, Protection from Unjustified Premiums, 111th Cong., 1st sess., April 20, 2010, available at http://help.senate.gov/hearings/.

[2] See regulatory impact analysis at 75 FR 37187.

[3] For more information on the private health insurance provisions of PPACA, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, Bernadette Fernandez, and Mark Newsom.

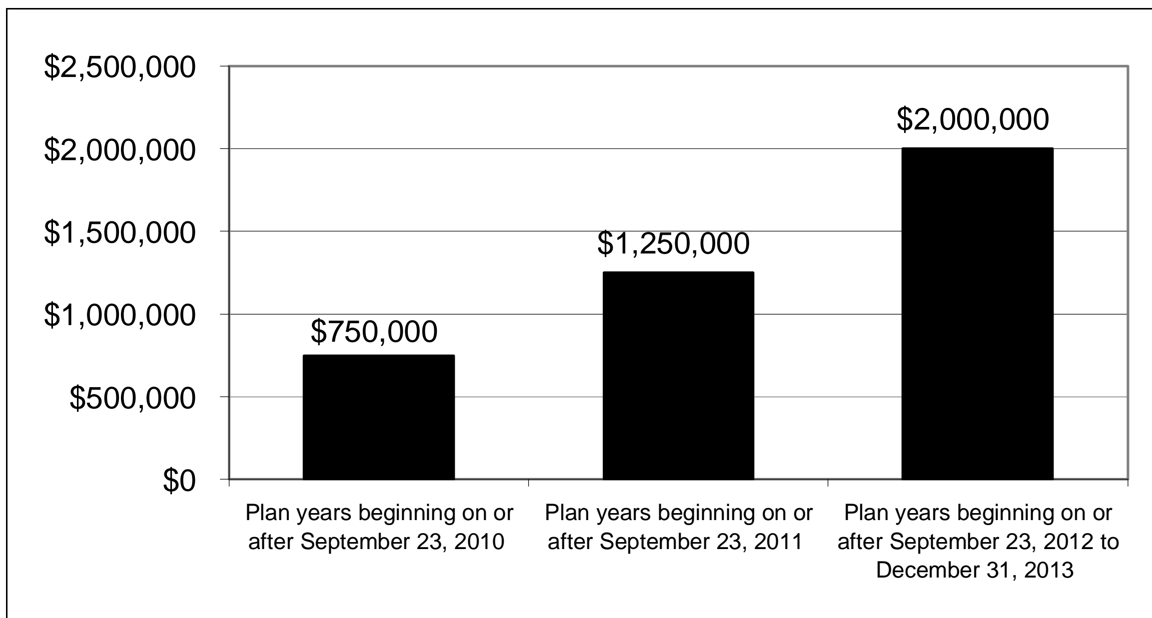
[4] §1004 of PPACA.

[5] See regulation preamble discussion at 75 *Federal Register* 74864.

annual limits on the dollar value of essential health benefits for any participant or beneficiary.[6] Essential health benefits may be further defined by the Secretary, but they must include at least the following types of care: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, and preventive and wellness and chronic disease management and pediatric services, including oral and vision care.[7] Annual limits are permissible for health care expenses that are not considered part of the essential health benefits. PPACA also requires the Secretary to ensure that there is access to needed services with a minimal impact on premiums in the context of defining the restriction on annual limits. This provision is the basis for the Secretary's waiver authority.

On June 28, 2010, the Secretary promulgated regulations, with the Secretaries of Labor and the Treasury, defining the restrictions on annual limits.[8] In order to limit the magnitude of the likely premium increases for coverage that previously used annual limits, the regulations have a three-year phase-in period allowing insurers to implement annual limits of $750,000 in the first year culminating in a $2 million allowable annual limit in the final year, as illustrated in **Figure 1**. On January 1, 2014, annual limits will be prohibited altogether.

Figure 1. Phase-In of Restricted Annual Limits for Essential Health Benefits



Source: 75 *Federal Register* 37187.

6 §1001, as amended by §10101 of PPACA: §2711 PHSA. Grandfathered individual market policies are exempted from this provision. The restrictions on annual limits also do not apply to Medical Savings Accounts (MSAs) under section 220 of the Internal Revenue Code (IRC) and Health Savings Accounts (HSAs) under section 223 of the IRC.

7 §1302(b) of PPACA.

8 75 *Federal Register* 37187.

Impact on Limited Benefit ("Mini-Med") Plans

There is substantial variability in the marketplace, but generally, a limited benefit plan offers less coverage than a typical employer group plan by placing more restrictive annual limits on total coverage and on specific service categories (e.g., surgeries).[9] **Table 1** illustrates typical limited benefit plan options that focus on coverage limits rather than high deductibles as a method of holding down costs. In these examples, provided by Cigna under the marketing name Starbridge, all three levels have total benefit annual limits options of between $25,000 and $100,000. All three levels also have service specific annual limits (e.g., for inpatient care).

Table 1. Starbridge Standard Limited Benefit Plans from Cigna, 2010

Benefits	Level 1	Level 2	Level 3
Doctor Office Visits	$15 Copay per visit	$15 Copay per visit	$15 Copay per visit
Outpatient Care	$100 deductible, 20% coinsurance, $1,000 annual limit	$100 deductible, 20% coinsurance, $1,000 annual limit	$100 deductible, 20% coinsurance, $1,000 annual limit
Inpatient Care	$2,000 annual limit	$3,000 annual limit	$5,000 annual limit
In-Hospital Surgery	Included in inpatient care	$1,500 limit per surgery	$2,500 limit per surgery
Maternity	Included in inpatient care	$1,500 limit per hospital stay	$2,500 limit per hospital stay
Wellness	Discount only	$20 co-pay and $100 maximum benefit per visit	$20 co-pay and $100 maximum benefit per visit
Pharmacy	Discount only	$15 co-pay for generics and $30 co-pay for brand. $300 annual limit	$15 co-pay for generics and $30 co-pay for brand. $600 annual limit
Accident Coverage	$50 deductible per occurrence, 20% co-insurance, $1,000 maximum coverage per occurrence, $2,000 annual limit	$50 deductible per occurrence, 20% co-insurance, $2,500 maximum coverage per occurrence, $5,000 annual limit	$50 deductible per occurrence, 20% co-insurance, $5,000 maximum coverage per occurrence, $10,000 annual limit
Death Benefit	$10,000	$15,000	$25,000
Total annual limits	Varies by contract between $25,000-$100,000 per year	Varies by contract between $25,000-$100,000 per year	Varies by contract between $25,000-$100,000 per year

Source: CIGNA Health Care, "Starbridge Limited Benefit Plans," 2010, available at http://www.cignavoluntary.com/docs/StandardPlans.pdf.

Notes: The plans are offered only to groups with 51 or more eligible employees. "Discount only" means that Cigna negotiates a discounted price from the provider.

[9] John Welch and Karen Bender, *Limited Benefit Plan Options in the Small Group Market*, Mercer and Oliver Wyman, December 17, 2009.

HHS estimates that about 17.9 million persons have plans or policies that are subject to annual limits, primarily in the individual (65% of total) and small group (31% of total) markets.[10] Industry groups have argued that limited benefit plans are necessary because more comprehensive coverage would be too costly without the federal subsidies for qualified health plans in the exchanges that are not available until 2014.[11] They say that without the option of limited benefit plans, these workers would likely become uninsured. This assertion has been the basis for requesting and granting waivers from the restriction on annual limits. On the other hand, some consumer groups have argued that limited benefit plans are not deserving of any regulatory leniency. They assert that many consumers enroll in these plans without understanding how little protection they provide against large health expenses, resulting in a lack of access to care and substantive medical debt when they experience a major illness or accident.[12] These concerns prompted a December 1, 2010, hearing by the Senate Commerce Committee.[13]

Temporary Waivers

Regulators have found the industry argument for waivers compelling while acknowledging the potential risks to consumers. In the interim final regulations on restricted annual limits, the Secretaries of HHS, Labor, and the Treasury announced that HHS would establish a waiver process for limited benefit plans in order to preserve coverage at similar premiums.[14] In other words, it was assumed that applying the restriction on annual limits to limited benefit plans would result in substantive increases in the premiums charged for those insurance products. HHS, however, expressed concern that consumers might be confused about the value of their coverage in relation to the restriction on annual limits. Accordingly, HHS is requiring plans that are approved for the waiver to prominently display in their materials a "black box type" warning in 14-point bold font explaining that their plan does not meet the standards of the law with respect to annual limits.[15]

HHS established that waiver applications may be made for one plan or policy year at a time and must include (1) the terms of the plan or policy form(s) for which a waiver is sought; (2) the number of individuals covered by the plan or policy form(s) submitted; (3) the annual limit(s) and rates applicable to the plan or policy form(s) submitted; (4) 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 covered by such plans or policies, along with any supporting documentation; and (5) an attestation, signed by the plan administrator or Chief Executive Officer of the issuer of the

[10] 75 *Federal Register* 37204.

[11] Letter from the National Business Group on Health, to the Secretaries of Health and Human Services, Labor, and the Treasury, August 27, 2010; Letter from the National Restaurant Association, to the Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, August 27, 2010.

[12] Letter from Families USA, to the Secretaries of Health and Human Services, Labor, and the Treasury, August 27, 2010; Letter from Health Care For All New York, to the Secretaries of Health and Human Services, Labor, and the Treasury, August 27, 2010; Carol Pryor, Andrew Cohen and Jeffrey Prottas, *The Illusion of Coverage: How Health Insurance Fails People When They Get Sick*, The Access Project, 2007.

[13] U.S. Senate Committee on Commerce, Science & Transportation, "Are Mini Med Policies Really Health Insurance?" December 1, 2010, available at http://commerce.senate.gov/public/index.cfm?p=Hearings.

[14] 75 *Federal Register* 37187.

[15] U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, "OCIIO Guidance (OCIIO 2010-1B) Supplemental Guidance," Insurance Standards Bulletin, December 9, 2010.

coverage, certifying that the application of restricted annual limits to such plans or policies would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies.[16] Subsequent concern regarding the frequency of the waivers and the transparency of the waiver process has prompted oversight letters from the House Energy and Commerce Committee and the Ranking Member of the Senate Finance Committee.[17]

As of January 26, 2011, 729 organizations, representing approximately 2.2 million enrollees and policyholders, have been approved by HHS for waivers of the restriction on annual limits.[18] The vast majority (712 plans, or 97% of the total waivers) were granted to employer-sponsored health plans that are employment-related, of which 182 (about 25% of the total) are collectively bargained ("union"). Of the non-union employers, there is a mix of different organizations, including retailers (e.g., American Eagle Outfitters, Meijer, and Mars Super Markets), restaurant chains (e.g., Jack in the Box, Cracker Barrel, and Denny's), and health insurance companies (e.g., Aetna, Cigna, and Highmark Blue Cross Blue Shield of West Virginia).

Some states have laws that require health insurance issuers to market a standardized policy that includes annual limits that are below the federal restricted annual limits. In these limited situations, states may apply for a waiver of the restricted annual limits on behalf of issuers of state-mandated policies. As of January 26, 2011, Massachusetts, New Jersey, Ohio, and Tennessee have obtained waivers for issuers with 93,470 enrollees or policyholders.

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[16] U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, "OCIIO Sub-Regulatory Guidance (OCIIO 2010 - 1): Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711," Insurance Standards Bulletin, September 3, 2010.

[17] Letter from Committee Chairman Fred Upton and Subcommittee Chairman Cliff Stearns, to the Secretary of Health and Human Services, January 20, 2011, available at http://republicans.energycommerce.house.gov/Media/file/Letters/012011hhs.PDF; and Letter from Senator Orrin Hatch, to Donald Berwick, Administrator of the Centers for Medicare and Medicaid Services, February 8, 2011, available at http://finance.senate.gov/newsroom/ranking/release/?id=7c5a7c0f-ba13-44ae-bd1d-43c3a8cf29f9.

[18] U.S. Department of Health and Human Services, "Helping Americans Keep the Coverage They Have and Promoting Transparency," January 26, 2011, available at http://www.hhs.gov/cciio/regulations/approved_applications_for_waiver.html.