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 Section 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."

Considerable attention has been paid to the fairness and transparency of the waiver process. For context, it is relevant to note that Congress has not consistently specified the manner in which information concerning health care waivers is to be released to the public. Indeed, the annual limits provision of PPACA does not even have a specific public reporting requirement. As a result of different legal standards, or in some cases the absence of a congressional directive, no standardized practice for releasing information about health care waivers has ever been developed. With respect to the annual limits waivers, no obvious bias could be found in the publicly available application materials. Moreover, the Government Accountability Office found that the waivers were granted when an application projected a significant increase in premiums or significant reduction in access to health care benefits and not based on organizations factors (e.g., being a union).

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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 (name redacted), (name redac ted), and (name redacted).

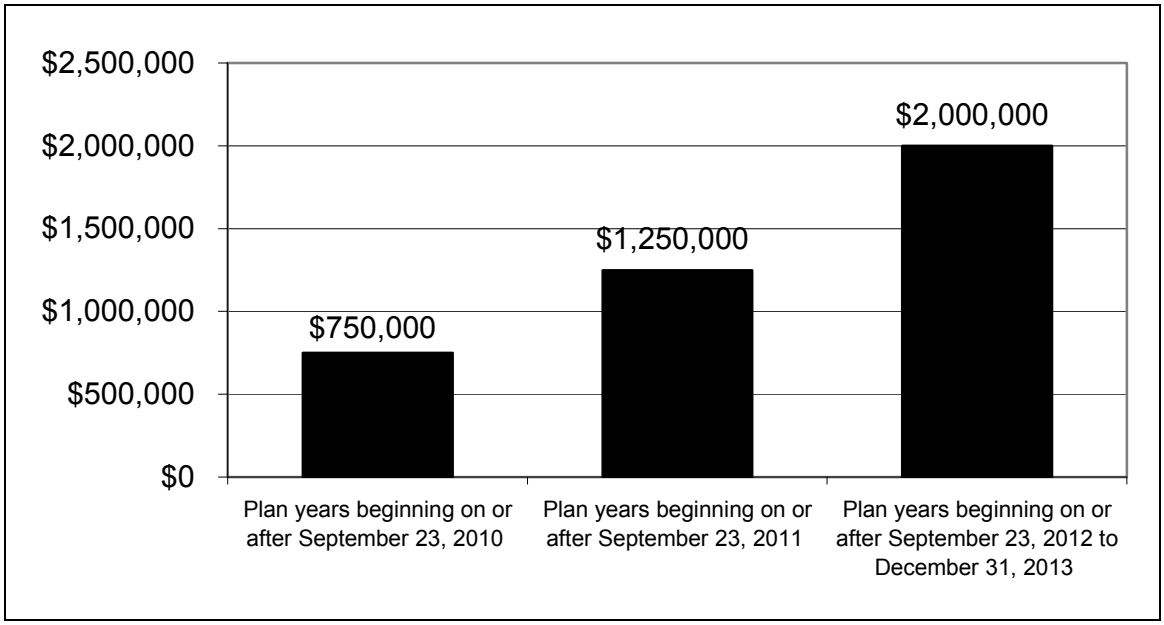
[4] §1004 of PPACA.

[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 due to different consumer demands, but generally, a limited benefit plan offers coverage with restrictive annual limits on total benefits and/or on specific service categories (e.g., surgeries).[9] **Table 1** illustrates an example of grandfathered[10] limited benefits plan called Fundamental Care.[11] In this example, Fundamental Care has a annual deductible of $500 and a policy year maximum or annual limit of $100,000 and service specific benefit maximums. The plan has a drug benefit with a $100 deductible and a $1,000 annual limit. Premiums vary by covered group, but the employer is required to make at least a 50% contribution to the cost of the coverage.

Table 1. Benefits Structure of Fundamental Care Plan

Benefit Category	Co-pay or Co-insurance	Visit Limits and Benefit Maximums
Physician Office Visit	$25 co-pay	5 visits per adult/7 per dependent child per year
Preventive Visit	$20 co-pay	$200 per year
Diagnostic, X-Ray, Lab Facility	20% co-insurance	$1,500 per year
Emergency Room/Emergency Care	20% co-insurance	$2,500 per year
Urgent Care Facility/Emergency Care	20% co-insurance	$1,500 per year
Occupational, Physical, Speech Therapy	20% co-insurance	$500 per year
Durable Medical Equipment	20% co-insurance	$750 per year
Chemotherapy & Radiation Therapy	20% co-insurance	$10,000 per year
Ambulance Coverage	20% co-insurance	$250 per trip
All Other Outpatient Covered Expenses	20% co-insurance	$750 per year
Inpatient Care/Surgical Inpatient & Outpatient Care Room and Board	Not applicable	$750 per day
Intensive Care Unit (ICU) or Critical Care Unit (CCU)	Not applicable	$2,000 per day

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

[10] PPACA includes provisions for the grandfathering of existing health insurance plans. Grandfathered plans are exempt from certain PPACA provisions. For more information on the grandfather provision of PPACA, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted).

[11] The Fundamental Care plan is underwritten and administered by Connecticut General Life Insurance Company, a subsidiary of the CIGNA Corporation. Approximately 1,700 employers currently provide health insurance coverage for their part-time, hourly, and seasonal employees through the Connecticut General Life Insurance Company's limited benefit plans.

Benefit Category	Co-pay or Co-insurance	Visit Limits and Benefit Maximums
Inpatient Physician/Ancillary Services,Surgery Facility, Surgical Rooms, Inpatient/Outpatient Surgeon Care, Surgical Facility,Assistant Surgeon Care, Anesthesiologist	20% co-insurance	$20,000 per year
Prescription Coverage/Discount Program	$15 co-pay for a 30-day supply of a generic at retail pharmacy and a $45 co-pay for a 90-day supply of a generic via mail order pharmacy. 50% co-insurance for formulary brand drugs and 75% co-insurance for non-formulary brand drugs.	$1,000 per year

Source: Connecticut General Life Insurance Company, "What you get with the Fundamental Care plan, Enrollment Brochure Excerpt - For Illustration Purposes Only," 2011.

Notes: The Fundamental Care plan is underwritten and administered by Connecticut General Life Insurance Company, a subsidiary of the CIGNA Corporation. Some benefits may vary due to state mandated benefits laws. CIGNA's 24-Hour Employee Assistance Program with unlimited over-the-phone counseling and up to 3 visits per presenting problem is provided to enrollees in this plan.

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.[12] 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.[13] 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.[14] These concerns prompted a December 1, 2010, hearing by the Senate Commerce Committee.[15]

[12] 75 *Federal Register* 37204.

[13] 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.

[14] 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.

[15] 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.

Temporary Waivers

Limited benefit plans do not have a categorical exemption from the reforms of PPACA.[16] However, 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.[17] 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.[18]

Organizations may apply for a waiver on an annual basis until January 1, 2014, when annual limits are prohibited. The standards of the waiver apply equally to all applicants, as there are no differential or preferred paths to a waiver by the category of the applicant, such as unions or small businesses. The operational process for applying for a waiver was published as a memorandum on September 3, 2010.[19] The memorandum, and subsequent guidance, establishes the following reporting requirements:

- the terms of the plan or policy for which a waiver is sought;
- the number of individuals enrolled in the plan or covered by the policy;
- the annual limit(s) and rates applicable to the plan or policy; and
- a brief description of why compliance with the restriction on annual limits standard would result in a significant decrease in access to benefits or a significant increase in premiums paid.

As of April 1, 2011, 1,168 waivers have been approved, representing slightly more that 2.9 million enrollees and policyholders.[20] This means the enrollees and policyholders of the accepted waiver applicants represent around 1.5% of the approximately 194.5 million individuals with private health insurance in the United States.[21] HHS did not provide any data on denied waiver

[16] William G. Schiffbauer, "Regulatory framework for limited medical benefits plans," testimony before the National Association of Insurance Commissioners, August 12, 2010.

[17] 75 *Federal Register* 37187.

[18] 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.

[19] U.S. Department of Health and Human Services, "OCIIO Sub-Regulatory Guidance (OCIIO 2010 - 1): Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711, " September 3, 2010, available at http://cciio.cms.gov/resources/files/ociio_2010-1_20100903_508.pdf.

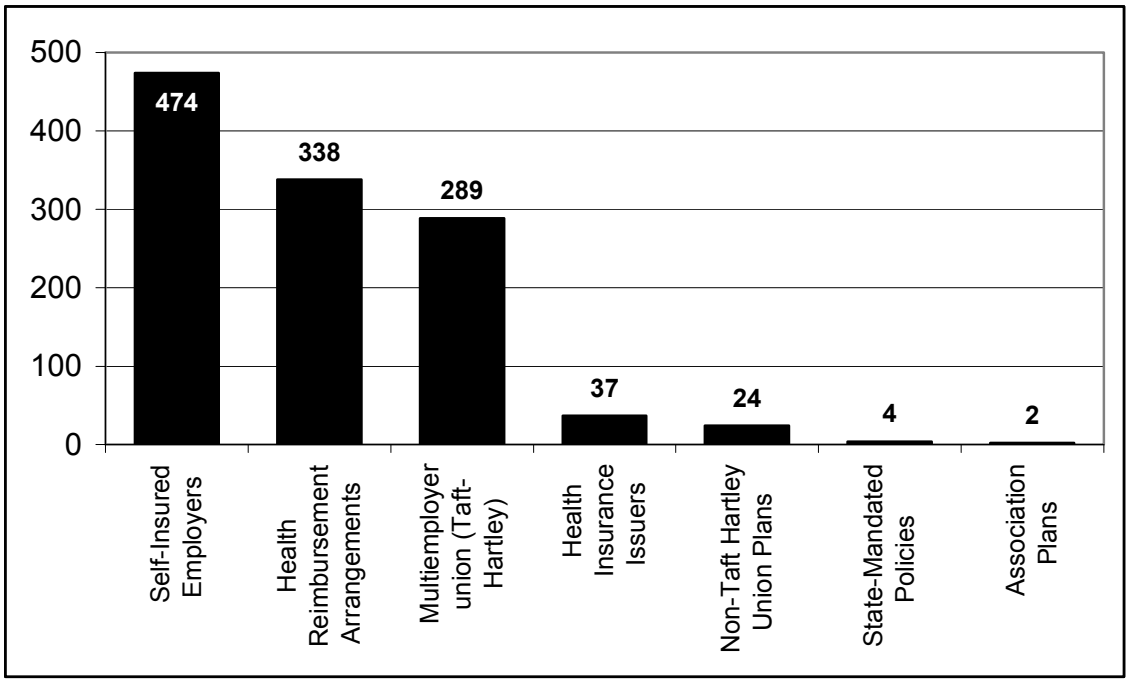
[20] U.S. Department of Health and Human Services, "Helping Americans Keep the Coverage They Have and Promoting Transparency," April 1, 2011, available at http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

[21] For estimates of private health insurance coverage, see Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2009," U.S. Department of Commerce, Economics and Statistics Administration, Census Bureau, September 2010.

applicants, but has reported that 94% of the applicants were granted waivers.[22] As illustrated by **Figure 2**, most (94.3%) of the waivers were approved for either self-insured employers (40.6%), health reimbursement arrangements (HRAs, 28.9%), or multiemployer union plans (24.7%).[23] As illustrated by **Figure 3**, most (92.5%) of enrollment for the approved waivers was for either health insurance issuers (29.7%), multiemployer union plans (29.4%), non-Taft Hartley union plans (19.1%), or self-insured employers (14.3%).[24]

Figure 2. Approved Restricted Annual Limits Waivers, by Organization Type

April 1, 2011



Source: CRS chart created from U.S. Department of Health and Human Services data available at http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

Notes: Self-insured employers refers to employers that choose to accept the insurance risk for covering their own employees' health benefits. In some cases these self-insured employers will contract with a health insurance

[22] Testimony of Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight Steven B. Larsen, in U.S. Congress, House Committee on Oversight and Government Reform, Subcommittee on Health Care, District of Columbia, Census, and the National Archives, 112th Congress, 1st Session, March 15, 2011, available at http://oversight.house.gov/images/stories/Testimony/CMS_CCIIO_Larsen_Testimony_FINAL_3.15.11.pdf.

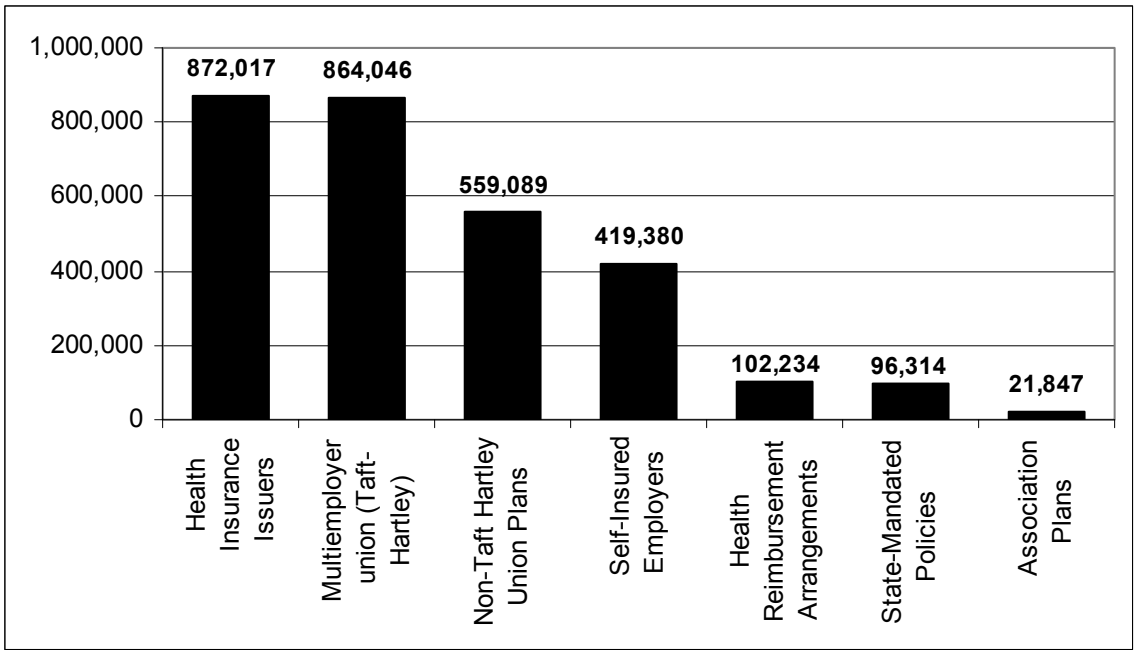
[23] Some employers choose to self-insure, thus accept the insurance risk for covering their own employees' health benefits. In some cases these self-insured employers will contract with a health insurance company to perform administrative functions such as claims processing. Health reimbursement arrangements are employer-funded group health plans where employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Multi-employer group health plans are created by a collective bargaining agreement between a union and multiple employers, under the Taft- Hartley Act. Both the union and the employer are trustees or managers of the fund.

[24] Health insurance issuers refers to health insurance companies that received waivers for their limited benefit plans sold in either the employer group or individual markets. Non-Taft Hartley union health plans that are typically the result of a collectively bargained agreement between a union and an employer not under the rules of the Taft- Hartley Act. In some cases, these plans provide supplemental coverage to employer-based health plans.

company to perform administrative functions such as claims processing. Health reimbursement arrangements are employer-funded group health plans where employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year, and unused amounts may be rolled over to be used in subsequent years. Multi-employer group health plans are created by a collective bargaining agreement between a union and multiple employers, under the Taft- Hartley Act. Both the union and the employer are trustees or managers of the fund. Non-Taft Hartley union health plans that are typically the result of a collectively bargained agreement between a union and an employer not under the rules of the Taft- Hartley Act. In some cases, these plans provide supplemental coverage to employer-based health plans. State-mandated policies refers to the laws in some states 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. Association health plans refers to an association that is any entity through which health insurance is offered to a collection of member employers and/or individuals.

Figure 3. Enrollment in Restricted Annual Limits Waiver Plans, by Organization Type

April 1, 2011



Source: CRS chart created from U.S. Department of Health and Human Services data available at http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html.

Notes: See **Figure 2** notes.

Legislative Activity in the 112th Congress

The Health Care Waiver Transparency Act (H.R. 1184/S. 650)

On March 17, 2011, the Health Care Waiver Transparency Act was introduced by Representative Darrell Issa (H.R. 1184) and Senator John Ensign (S. 650). H.R. 1184/S. 650 would require the Secretary of HHS to publish, on the HHS website, detailed criteria used to determine approval of an application submitted for a waiver, adjustment, or other compliance relief provided for under the authority of PPACA or title I or subtitle B of title II of the Health Care and Education Reconciliation Act (P.L. 111-152). The Secretary of HHS would be further required to publish each application for a waiver, the determination of the Secretary of HHS whether to approve or

reject the application, and the reason for such approval or rejection. H.R. 1184/S. 650 would also expressly prohibit preferential treatment being given to any waiver applicant based on political contributions or association with a labor union, a health plan provided for under a collective bargaining agreement, or another organized labor group.

Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10)

Section 1856(b) of P.L. 112-10 requires the Government Accountability Office (GAO) to submit to Congress a report that includes the results of an audit of requests for waiver of the restricted annual limit not later than June 14, 2011. The report must include an analysis of the number of approvals and denials of such requests and the reasons for such approval or denial.

Oversight

Concern regarding the favoritism toward unions in granting waivers, the frequency of the waivers, and the transparency of the waiver process has prompted oversight and legislative activity. On January 20, 2011, the House Energy and Commerce Committee sent a letter to the director of the Center for Consumer Information and Insurance Oversight (CCIIO)[25] asking for, among other things, documents and information regarding the submission and approval of the waivers for restricted annual limits.[26] Similar letters requesting additional details on the waivers and waiver applicants have been sent by Senator Hatch and by Senator Ensign.[27] On March 22, 2011, the House Committee on Small Business sent a letter to the Secretary of HHS asking a series of questions and for documentation concerning the specific impact of the waivers on small businesses.[28] The waivers have also been a topic of discussion in several hearings on PPACA.[29]

For context, it is relevant to note that Congress has not consistently specified the manner in which information concerning health care waivers is to be released to the public. Indeed, the annual

[25] The Center for Consumer Information and Insurance Oversight (CCIIO) is a component of the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services. CCIIO has been tasked by the Secretary of Health and Human Services with implementing HHS's responsibilities for the private health insurance provisions of PPACA.

[26] Letter from Committee Chairman Fred Upton and Subcommittee Chairman Cliff Stearns to Jay Angoff, Director of the Center for Consumer Information and Insurance Oversight, January 20, 2011, available at http://republicans.energycommerce.house.gov/Media/file/Letters/012011hhs.PDF.

[27] 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; and letter from Senator John Ensign to Secretary of Health and Human Services Kathleen Sebelius, March 30, 2011, available at http://ensign.senate.gov/public/index.cfm?FuseAction=Media.PressReleases&ContentRecord_id=07ce46d4-c491-8a07-d402-2af81a4b8e6e&Region_id=&Issue_id.

[28] Letter from Committee Chairman Sam Graves and Subcommittee Chairwoman Renee Ellmers to Secretary of Health and Human Services Kathleen Sebelius, March 22, 2011, available at http://smallbusiness.house.gov/UploadedFiles/Sebelius_Letter_3_22_11.pdf.

[29] House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations Health Care, *Issues Involving the Center for Consumer Information and Insurance Oversight,* 112th Congress, 1st Session, February 16, 2011; House Committee on Oversight and Government Reform, Subcommittee on Health Care, District of Columbia, Census, and the National Archives, *Obamacare: Why the need for waivers?*, 112th Congress, 1st Session, March 15, 2011. Senate Committee on Finance, *Health Reform: Lessons Learned During the First Year*, 112th Congress, 1st Session, March 16, 2011.

limits provision of PPACA does not even have a specific public reporting requirement.[30] As a result of different legal standards, or in some cases the absence of a congressional directive, no standardized practice for releasing information about health care waivers has ever been developed. As illustrated in **Table 2**, there is substantial variation in the release of information between different health care waiver types.

Table 2. Examples of Public Information Released by CMS on Waivers

Waiver	Description of Public Release
Medical Loss Ratio: Section 2718 of the PHSA, as added by PPACA requires health insurance issuers in the individual market to have a MLR of 80% or issue premium rebates to their policyholders. The law provides states the opportunity to apply for a waiver of the requirement under certain circumstances.	Section 2718 of the PHSA does not have a specific public reporting requirement with respect to the waivers of the MLR provision for the individual market. Nevertheless, CMS has released detailed information from each applicant. This includes supporting information and answers to follow-up questions from CMS that go beyond the initial application submission. CMS also has published a decision letter for each completed application detailing why a waiver was granted or not.
Medicare Payment Demonstrations: the Secretary has the authority to conduct Medicare demonstrations that waive requirements in Title XVIII of the Social Security Act (SSA) that relate to reimbursement and payment (42 U.S.C. § 1395b–1).	The SSA requires the Secretary to obtain "the advice and recommendations of specialists who are competent to evaluate the proposed experiment or demonstration project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct the proposed experiment or demonstration project, and its relationship to other similar experiments and projects already completed or in process." However, the law does not specify the manner in which the evaluation shall be publicly released. Generally, CMS has released application materials and research reports examining the impact of a payment demonstration. For example, CMS released detailed instructions for applying for the Medicare Part D Payment Demonstration in 2005 and subsequently released a study in October 2007 examining the impact of the demonstration. Unlike the MLR or restricted annual limits waivers, CMS generally does not release on-going information concerning waiver applications and enrollment in waiver programs.
Medicaid Waivers: The Social Security Act (SSA) authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Section 1115 of the SSA provides the Secretary broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program. Section 1915(b) of the SSA provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid. Section 1915(c) of the SSA provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings.	Traditionally, CMS has provided some background information including waiver proposals, approval letters, proposed budgets, and research evaluation reports. Section 10201 of PPACA amended the SSA to enhance transparency in the application and renewal of Medicaid and the Children's Health Insurance Program (CHIP) section 1115 waivers by requiring: (1) a process for public notice and comment at the state level, including public hearings; (2) public release of the goals of the program, the expected state and federal costs and coverage projections of the demonstration project, and the specific plans of the state to ensure that the demonstration project is in compliance with the SSA; (3) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input; (4) a process for the submission to the Secretary of periodic reports by the state concerning the implementation of the demonstration project; and (5) a process for the periodic evaluation by the Secretary of the demonstration project. The Secretary is required to submit an annual report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.

[30] Section 2711 of the PHSA.

Sources: MLR waiver details are available at http://cciio.cms.gov/programs/marketreforms/mlr/index.html; the Medicare Part D Payment Demonstration plan sponsor application instructions are available at https://www.cms.gov/DrugCoverageClaimsData/Downloads/partdpymntdemo.pdf; the Medicare Part D Payment Demonstration impact study by Leslie M. Greenwald and Nathan West, "Medicare Part D Payment Demonstration Focus Group Report," October 2007, is available at https://www.cms.gov/DemoProjectsEvalRpts/downloads/PDP_Focus_Report.pdf; and CMS information on Medicaid waivers is available at http://www.cms.gov/MedicaidStWaivProgDemoPGI/.

Note: This table is intended to illustrate the variation observed in the public release of information for certain example waiver types. This is not a comprehensive list of CMS waivers.

No obvious bias could be found in the publicly available application materials for the annual limits waivers. The available evidence suggests no favoritism for any particular applicant groups (e.g., unions). *The Hill* obtained records of waiver denials and reported that as of mid-February, CMS had denied 79 requests for waivers and that unions accounted for roughly 60% of those denials.[31] Moreover, in completing the work required by P.L. 112-10, the GAO found that CMS granted waivers when an application projected a significant increase in premiums or significant reduction in access to health care benefits rather than organizational factors (e.g., union membership, geographical location, number of employees).[32]

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[31] Sam Baker, "Early waiver denials went mostly to unions," The Hill, May 20, 2011, available at http://thehill.com/blogs/healthwatch/health-reform-implementation/162419-early-waiver-denials-went-mostly-to-unions-.

[32] Government Accountability Office, "Private Health Insurance: Waivers of Restrictions on Annual Limits on Health Benefits," GAO-11-725R, June 14, 2011, available at http://www.gao.gov/new.items/d11725r.pdf.