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United States Government Accountability Office
Washington, DC 20548

June 14, 2011

Congressional Committees

Subject: *Private Health Insurance: Waivers of Restrictions on Annual Limits on Health Benefits*

The Patient Protection and Affordable Care Act (PPACA), which became law in March, 2010, generally prohibits health insurance issuers and group health plan sponsors from imposing annual limits on the dollar value of “essential” covered health benefits beginning on January 1, 2014, but allows restricted annual limits, as defined by the Secretary of Health and Human Services (HHS), on the value of those benefits until that time.^{1,2} In setting these annual limits, HHS is statutorily required to ensure that individuals’ access to needed services remains available with a minimal impact on plan premiums. In June 2010, HHS set restrictions on annual limits for each plan year from September 2010 through December 2013.³ To mitigate a potential impact on individuals’ access or premiums for existing plans with benefit limits below these amounts, HHS established a waiver program based on the statutory requirement. Under the program, issuers or other group health plan sponsors could apply for a waiver from the annual limits set by HHS if they attested and presented evidence that meeting the annual limits would result in diminished access to benefits or a significant increase in premiums. To implement various provisions of PPACA, including those related to annual limits, HHS created what is now called the Center for Consumer Information and

¹Effective for plan or policy years beginning on or after September 23, 2010, PPACA also prohibits lifetime limits on the dollar value of essential health benefits. Pub. L. No. 111-148, § 1001, 10101(a), 124 Stat. 119, 130, 883 (adding and amending various sections to part A of title XXVII of the Public Health Service Act (PHSA)) (codified at 42 U.S.C. §§ 300gg-11 et seq.) (requirements for benefit limits imposed by § 2711 of the PHSA, codified at 42 U.S.C. § 300gg-11).

²Health plan coverage may be offered by health insurance issuers, such as a health insurance company or health maintenance organization (HMO), or by sponsors of group health plans, such as employers, unions, or trade associations. Pursuant to § 1302(b) of PPACA, essential health benefits include (1) ambulatory patient services, (2) emergency service, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. Pub. L. No. 111-148, § 1302, 124 Stat. 163. For nonessential health benefits, annual or lifetime limits may be imposed to the extent that such limits are otherwise permitted under federal or state law.

³75 Fed. Reg. 37188, 37236 (June 28, 2010) (to be codified at C.F.R. § 147.126(d)(1)). The minimum annual limit for plan years beginning on or after Sept. 23, 2010, but before Sept. 23, 2011, was \$750,000. The minimum annual limit for plan years beginning on or after Sept. 23, 2011, but before Sept. 23, 2012, will be \$1.25 million. The minimum annual limit for plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014, will be \$2 million.

Insurance Oversight (CCIIO).⁴ CCIIO is now a part of the Centers for Medicare & Medicaid Services (CMS).

The Department of Defense and Full-Year Continuing Appropriations Act for Fiscal Year 2011 directed GAO to report on annual limit waiver requests.⁵ Specifically, we examined (1) the number of applications that CCIIO received for an annual limit waiver and how many of these were approved or denied and (2) the reasons provided by CCIIO for approvals and denials of annual limit waivers.

To determine the number of waiver applications CCIIO received, we reviewed summary data from CCIIO on the applications it received and the approval and denial status of each as of April 25, 2011.⁶ In its summary data, CCIIO categorized applicants by seven types: self-insured employers, health reimbursement arrangements (HRA), multi-employer plans, health insurance issuers, non-Taft Hartley union plans, state-mandated policies, and association health plans. For some applications that requested waivers for multiple plans, CCIIO could separately approve waivers for some plans and deny waivers for other plans included in the same application. To determine the reasons provided by CCIIO for approval or denial, we requested and reviewed original applications and supporting data for a 5 percent random sample of the approved applications, and for all the denied applications. To assure the reliability of the summary data, we reviewed the original applications and supporting data for the 5 percent sample of approved applications as of March 23, 2011, and all of the denied applications as of April 25, 2011, to assure they corroborated the summary data. On the basis of this review, we determined that the summary data we used were sufficiently reliable for purposes of our analyses. We also interviewed officials from CCIIO to learn about the agency's criteria and process for reviewing waiver applications.

We conducted our work from April 2011 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

We found that as of April 25, 2011, CCIIO received a total of 1,415 applications for a waiver of restrictions related to annual limits on health benefits, and approved most of these applications. For 1,347 of the applications, or over 95 percent, CCIIO approved waivers covering all plans in the applications. For another 25 applications, CCIIO approved waivers for some plans and denied waivers for others within the same application. CCIIO denied waivers covering all plans in 40 applications. Three applications were pending at the time of our review. Approximately 3 million people were covered in approved plans and approximately 153,000 people were covered in denied plans. The total number of people

⁴CCIIO was originally known as the Office for Consumer Information and Insurance Oversight (OCIIIO).

⁵Pub. L. No. 112-10, § 1856(b), 125 Stat. 38, 167.

⁶We downloaded summary data on approved applications posted May 13, 2011 on the CCIIO Web site at http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html. The list included applications approved as of April 25, 2011. We received summary data from CCIIO on denied applications also as of April 25, 2011, which were the most currently available at the time of our review.

covered in the approved plans represents about 2 percent of people covered by private health insurance plans in 2009.

CCIIO granted waivers on the basis of an application's projected significant increase in premiums or significant reduction in access to health care benefits. According to CCIIO officials, applications with a projected premium increase of 10 percent or more tended to be approved while applications with a projected premium increase of 6 percent or less tended to be denied. Applications with a premium increase between 7 and 9 percent warranted additional staff reviews to determine if the application met the agency's criteria. In corroboration, among our 5 percent sample of approved applications, we found that CCIIO granted waivers mostly for applications that projected the annual limit restriction would result in a significant premium increase of more than 10 percent, in addition to a significant decrease in access to benefits. Conversely, most of the denied applications projected a premium increase of 6 percent or less.

In reviewing a draft of this report, HHS provided technical comments, which we incorporated as appropriate.

Background

CCIIO created a process to review and approve waivers from the restrictions related to annual limits on health benefits. According to officials, CCIIO's goal was to establish annual limits that would have minimal effect on premiums and access to health care benefits. The process and criteria CCIIO developed to approve waivers were outlined in guidance issued in September, November, and December 2010. Applicants were required to complete a brief application form for the waiver. The form had to include (1) the terms of the plan or policy for which the waiver was sought; (2) the number of individuals covered by the plan or policy; (3) the current annual limits on, and premium rates for, essential benefits; (4) a brief description of why compliance with the annual limit restriction would result in a significant decrease in access to benefits or a significant increase in premiums for those currently covered by such plans or policies; and (5) an attestation, signed by the plan administrator or Chief Executive Officer of the issuer of the benefits certifying that the plan was in force prior to September 23, 2010, and that the documentation provided was accurate.

Each application underwent more than one level of review by CCIIO, according to agency officials. CCIIO staff first reviewed the application to ensure it was complete, and followed up with applicants to obtain any missing data. Program staff made an initial approval or denial recommendation based on the extent of the projected significant premium increases or projected significant decreases in access to benefits. The CCIIO Director or other senior management then met with program staff to review each recommendation to ensure that the criteria were consistently applied, and made the final decision. Applications that requested waivers for multiple plans could receive approval for some plans and denial for others based on the attestations and the supporting documentation for each. CCIIO notified applicants about the decisions, and offered denied applicants the opportunity to apply for reconsideration if they provided additional facts to support their request.

CCIIO Approved Most Applications for Waivers of Restrictions on Annual Benefits

CCIIO received a total of 1,415 applications for waivers as of April 25, 2011, and approved most of them. CCIIO approved waivers covering all plans in 1,347 applications, or over 95 percent of applications. For another 25 applications, CCIIO approved waivers for some plans and denied waivers for others within the same application. CCIIO denied waivers

covering all plans in 40 applications. Three applications were pending at the time of our review. Approximately 3.1 million people were covered in plans included in the approved applications, and approximately 153,000 people were covered in plans included in the denied applications (see table 1).⁷ The total number of people covered in these approved plans represents about 17 percent of people covered by all private health insurance plans with annual limits and about 2 percent of people covered by private health insurance plans overall in 2009.⁸

Table 1: Applications Approved and Denied by Applicant Type and People Covered, as of April 25, 2011

Type of applicant ^a	Approved applications	People covered in approved plans	Denied applications	People covered in denied plans
Self-insured employers ^b	528	445,527	14	4,988
HRAs ^c	457	116,379	0	0
Multi-employer group plans ^d	315	969,789	41	88,750
Health insurance issuers ^e	39	873,326	7	55,718
Non-Taft-Hartley union plans ^f	27	582,582	2	2,959
State-mandated policies ^g	4	96,314	0	0
Association health plans ^h	2	11,776	1	362
Total	1,372	3,095,693	65	152,777

Source: GAO analysis of CCIIO data.

Notes: Twenty-five applications that included waiver approvals and denials for plans within the same application are counted in both the approved and denied categories. Three applications were pending approval or denial at the time of our review.

^aBased on categories established by CCIIO.

^bA self-insured employer is one that funds health coverage for its employees and assumes the financial risk rather than purchases coverage from a health insurance issuer.

^cA Health Reimbursement Account (HRA), for purposes of the annual limit waiver program, is defined as an account that an employer funds for use by employees to reimburse for qualified health care expenses up to a fixed dollar amount per year.

^dA multi-employer group health plan is created by a collective bargaining agreement between a union and employers, under the Taft-Hartley Act.

^eA health insurance issuer is typically a health insurance company or an HMO.

^fNon-Taft-Hartley union plans are plans that are collectively bargained agreements between a union and employers and are not subject to the Taft-Hartley Act.

^gState-mandated policies refer to standardized policies with annual dollar limits specified by state law that insurers are required to offer in some states.

^hAn association health plan is offered by an entity that provides health insurance to a collection of member employers or individuals.

⁷Though not separately identified and categorized by CCIIO, we found that about 29 of the 58 plans in our 5 percent sample of approved applications and 21 of the 65 denied applications included plans that could be categorized as limited benefit or “mini-med” plans, with an annual limit on essential health benefits of \$250,000 or less. Mini-med plans provide limited basic medical coverage combined with lower premium costs and a lower coverage cap than a comprehensive or major medical plan. Mini-med plans vary widely in the range of services covered as well as the annual and lifetime limits, and there is no standard industry definition for these plans.

⁸See 75 Fed. Reg. 37204 and Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey,” EBRI Issue Brief, no. 347 (September 2010).

CCIIO Granted or Denied Waivers Based on Projected Significant Increases in Premiums or Significant Decreases in Access to Benefits

CCIIO granted waivers on the basis of applications' projected significant increases in premiums or significant decreases in access to health care benefits. Officials told us that they could not exclusively rely on specific numerical criteria to define a significant increase in premiums or a significant decrease in access to benefits, because applicant characteristics and circumstances varied widely. For example, for a plan with high premiums, a relatively small percentage increase could result in a large dollar increase. Conversely, for a plan with low premiums, a large percentage increase could result in a relatively small dollar increase. In addition to reviewing the projected premium increases, officials told us that they examined other factors including the number and type of benefits affected by the annual limit; the plan's enrollment; and the plan's current annual limits as compared to the permissible limit to determine if the projected premium increases were credible. The expectation was that large differences between the plan's current limit and the permissible annual limit would be expected to yield large premium increases, whereas small differences would be expected to yield smaller premium increases. Nevertheless, officials said that applications with a projected premium increase of 10 percent or more tended to be approved while applications with a projected premium increase of 6 percent or less tended to be denied. Applications with a premium increase between 7 and 9 percent were subjected to a closer review.⁹

Among our 5 percent sample of approved applications, most were granted on the basis of a projected premium increase of 10 percent or more in addition to a significant decrease in access to benefits needed to meet the annual limit requirement. Specifically, among the 58 approved applications we reviewed, 39 applications included a projected premium increase of 10 percent or more, 2 applications an increase between 7 and 9 percent, and 1 application an increase of less than 6 percent (see table 2). Nearly all applications had an attestation that meeting the restrictions on annual limits would also result in a significant decrease in access to benefits, including the remaining 16 applications that did not have a projected premium increase. The current plan annual limits for approved applications in our sample ranged from a low of \$444 to a high of \$2 million with a median limit of \$45,000.¹⁰

⁹Officials told us that in establishing these thresholds, CCIIO examined studies that showed that as premium increases approach the 7 to 9 percent range, enrollees are more likely to drop coverage.

¹⁰Some applications included varying annual limits for different plans or types of benefits; these applications are not included in our calculation of the median annual limit.

Table 2: Reasons for Waiver Approval among Random Sample of 58 Approved Applications, as of March 23, 2011

Reason for approval	Number of applications	Share of sampled approved applications
Significant premium increase and significant decrease in access to benefits	41	71%
10 percent or more	38	66
Between 7 to 9 percent	2	3
6 percent or lower	1	2
Significant premium increase (10 percent or more) only	1	2
Significant decrease in access only	16	28
Total	58	100%^a

Source: GAO analysis of CCIIO data.

Notes: According to CCIIO officials, applications with a projected premium increase of 10 percent or more tended to be approved while applications with a projected premium increase of 6 percent or less tended to be denied. Applications with a premium increase between 7 and 9 percent were subjected to a closer review.

^aPercentages do not total 100 due to rounding.

Among the 65 denied applications we reviewed, most were denied on the basis of a projected premium increase of 6 percent or less. Specifically, 48 of the denied applications included an attestation that meeting the restrictions related to annual limits would result in a 6 percent or lower premium increase and 8 applications an increase between 7 and 9 percent (see table 3). An additional seven applications were denied because they were incomplete. All initially denied applicants were given the opportunity to apply for reconsideration, and 27 applicants did so. Of these, 24 were approved based on additional information provided, and 3 were pending at the time of our review.

Table 3: Reasons for Waiver Denial among All 65 Denied Applications, as of April 25, 2011

Reason for denial	Number of applications	Share of denied applications
Premium increase generally 6 percent or lower ^a	48	74%
Premium increase between 7 and 9 percent	8	12
Other ^b	2	3
Incomplete applications ^c	7	11
Total	65	100%

Source: GAO analysis of CCIIO data.

Notes: According to CCIIO officials, applications with a projected premium increase of 10 percent or more tended to be approved while applications with a projected premium increase of 6 percent or less tended to be denied. Applications with a premium increase between 7 and 9 percent were subjected to a closer review.

^aCCIIO relied on other factors including current annual limits and effect on access for 7 of these applications.

^bBoth of these applications projected a greater than 10 percent premium increase, however one application was for a plan with zero enrollees and the other application included three plans, two of which had premium increases below 6 percent.

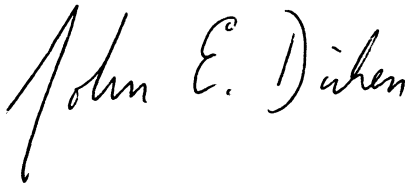
^cApplicants were nonresponsive after repeated attempts by CCIIO to follow up.

Agency Comments

We received written comments on a draft of this report from HHS (see enc. 1). In its comments, HHS highlighted that it has issued temporary waivers from the rules restricting the size of annual limits in order to protect coverage for workers in certain plans and to prevent either a significant increase in premiums or a significant decrease in access to coverage. HHS also highlighted steps it has taken to make the waiver process more transparent, such as posting a list of approved annual limit waivers. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees. We are also sending copies of this report to the Secretary of Health and Human Services. This report is also available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Individuals making key contributions to this report include Randy DiRosa, Assistant Director; Iola D'Souza; Thomas Han; and Laurie Pachter.



John E. Dicken
Director, Health Care Issues

Enclosure

List of Committees

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Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

John Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

JUN 10 2011

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft correspondence entitled, "Private Health Insurance: Waivers of Restrictions on Annual Limits on Health Benefits" (GAO 11-725R).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "PRIVATE HEALTH INSURANCE: WAIVERS OF RESTRICTIONS ON ANNUAL LIMITS ON HEALTH BENEFITS" (GAO-11-725R)

The Department appreciates the opportunity to review and comment on this draft correspondence.

The Affordable Care Act will end limited-benefit plans, sometimes called "mini-med" plans, in 2014 and provide Americans with affordable, high-quality coverage options. Unfortunately, today, mini-med plans are often the only type of private insurance offered to some workers. In order to protect coverage for these workers, HHS has issued temporary waivers from rules restricting the size of annual limits to some group health plans and health insurance issuers. Waivers are only available if the plan certifies that a waiver is necessary to prevent either a significant increase in premiums or a significant decrease in access to coverage.

The annual limit waiver process has been carried out in a way that reflects a commitment to transparency and responsible implementation. HHS regularly posts a list of approved annual limit waivers. The list includes the name of the company, the date their application was received, the plan effective date, the number of enrollees covered, the date the application was completed, and the date the waiver was approved. HHS has also issued guidance that ensures that consumers in plans with low annual limits are notified of the quality of their health plan so that they can make informed decisions about whether mini-med coverage is right for them.

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