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CONGRESSIONAL TESTIMONY

HHS Waivers of Regulations on Health Plan Annual Benefit Limits

Testimony before
Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census and the National Archives

United States House of Representative

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Mr. Chairman and members of the Committee, thank you for inviting me to testify before you today.

My name is Edmund F. Haislmaier. I am Senior Research Fellow in Health Policy at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

I have over twenty years experience as an analyst specializing in health care policy and markets. Relevant to the topic of today's hearing I would note that my career experience includes numerous instances in which I have assisted, at their request, lawmakers in Congress and various states with designing and drafting health care legislation, particularly with respect to insurance market regulation.

I will begin my testimony with an overview of the relevant law, follow that with a discussion of the underlying health policy issues, and finally proceed to the principal focus of this hearing -- namely, the appropriateness of the waiver process HHS has promulgated and applied in implementing a new statutory provision that regulates annual benefit limits set by health plans.

Background

Section 1001 of the Patient Protection and Affordable Care Act (Public Law 111-148) made a number of amendments to Title 27 of the Public Health Service Act (42 U.S.C. 300gg et seq.). One of those amendment was the addition of a new Section 2711 prohibiting "a group health plan and a health insurance issuer offering group or individual health insurance coverage" from imposing any lifetime or annual "limits on the dollar value of benefits for any participant or beneficiary," effective for plan years beginning on or after January 1, 2014.[1]

The statutory language of Section 2711 further stipulates in subsection (a)(2) that:

> With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term ‘restricted annual limit’ for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

Thus, prior to 2014 the statute permits plans to impose annual coverage limits that are equal to or higher than a minimum dollar amount, grants the Secretary of HHS the discretion to define that minimum dollar amount, and further instructs the

[1] PL 111-148 § 1001.

Secretary to define the minimum dollar amount in a manner that ensures that "access to needed services is made available with a minimal impact on premiums."

Last summer, HHS published interim final regulations implementing this provision of PPACA.[2] In those regulations, HHS set the "restricted annual limit" as follows:[3]

For a plan or policy year	Minimum annual limit
Beginning on or after September 23, 2010, but before September 23, 2011	$750,000
Beginning on or after September 23, 2011, but before September 23, 2012	$1,250,000
Beginning on or after September 23, 2012, but before January 1, 2014	$2,000,000

Thus, HHS has implemented this provision by defining the 'restricted annual limit' as three separate limits for each of the three years prior to 2014. However, in the regulations HHS further provided that:

> For plan years (in the individual market, policy years) beginning before January 1, 2014, the Secretary may establish a program under which the requirements of paragraph (d)(1) of this section relating to annual limits may be waived (for such period as is specified by the Secretary) for a group health plan or health insurance coverage that has an annual dollar limit on benefits below the restricted annual limits provided under paragraph (d)(1) of this section if compliance with paragraph (d)(1) of this section would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage.[4]

HHS justified its addition of this waiver process as follows:

> The restricted annual limits provided in these interim final regulations are designed to ensure, in the vast majority of cases, that individuals would have access to needed services with a minimal impact on premiums. So that individuals with certain coverage, including coverage under a limited benefit plan or so-called ‘‘mini-med’’ plans, would not be denied access to needed services or experience more than a minimal impact on premiums, these interim final regulations provide for the Secretary of Health and Human Services to establish a program under which the requirements

[2] "Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections," *Federal Register*, Vol. 75, No. 123, pp. 37188-37241, Monday, June 28, 2010.
[3] 45 CFR § 147.126(d)(1).
[4] 45 CFR § 147.126(d)(3).

> relating to restricted annual limits may be waived if compliance with these interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums.[5]

As of the end of February 2011, HHS has so far granted one-year waivers to 1,040 health plans with a total of 2.62 million enrollees.[6]

The underlying health policy issue

As data cited by HHS shows, only a relatively small portion of health plans currently have annual benefit limits.[7] Furthermore, the practice of setting annual benefit limits in health plans has steadily declined over time. The reason is that insurers and employee benefit managers have come to view better "case management" of high-cost cases as a more effective cost-control strategy than simply setting a fixed annual dollar limit on plan benefits.

The principal exception to that general trend is a subset of plans that are commonly called "mini-med" plans. Indeed, as noted in the quote above, HHS cites as justification for its waiver process the adverse effects that imposing higher annual coverage limits will have on mini-med plans.

A mini-med plan has a benefit design that is essentially the mirror image of that of a high-deductible plan. Under a high-deductible plan the enrollee is responsible for paying routine medical expense, with the plan only paying benefits when medical expenses exceed the deductible. In contrast, the design of a mini-med plan reverses this arrangement. A mini-med plan typically pays for routine medical care with little or no patient co-pays, but does not cover major medical expenses.

Employers typically offered mini-med plans in settings characterized by low-wage workers, high employee turnover, and part-time or seasonal employment. In such circumstances it is uneconomical or impractical to offer those workers traditional, full-benefit plans. What mini-med plans provide is an employee benefit that is at least of some immediate, practical value to workers -- even if doesn't offer adequate protection against major medical expenses. In some ways, the situation is analogous to that of a of car owner who purchases auto insurance that only covers the cost of damage or injury to others, but doesn't pay to repair or replace his own car.

No one would contend that mini-med plans are ideal, or are even an adequate alternative to full-benefit medical coverage. Rather, they exist as a kind of "better than nothing" solution for certain, limited circumstances.

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[5] *Federal Register*, page 37191.
[6] "Helping Americans Keep the Coverage They Have and Promoting Transparency," The Center for Consumer Information & Insurance Oversight, U.S. Department of Health and Human Services, at: http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html
[7] *Federal Register*., tables 3.2 and 3.3 on page 37204.

The problem

The problem is that in drafting this particular provision of PPACA, Congress did not account for its effects on mini-med plans. However, Congress could have instead opted for any one of three alternative approaches that would have avoided creating the problem.

One option would have been to simply delay the effective date of the provision until after 2014, when the legislation's new subsidies for more comprehensive coverage would become available to workers losing their current mini-med coverage. Congress did, in fact, delay the effective dates of a number of other provisions in PPACA until 2014 to avoid similar disruptions.

A second option would have been to exempt mini-meds plans from the new coverage requirement by defining them in the statute as a form of "supplemental coverage." This second approach even has statutory precedent. Specifically, this provision of PPACA is an amendment to the section of the Public Health Service Act that was created by the 1996 Health Insurance Portability and Accountability Act (HIPAA) and which includes a list of "supplemental" coverages that are exempted from the requirements imposed on comprehensive medical insurance.[8] Such exempted insurance products include; dental-only, vision-only, workman's compensation, long-term care, etc. PPACA did nothing to alter those existing statutory exemptions, but Congress could easily have avoided this issue by adding mini-med plans to that list.

Yet a third option would have been for Congress to provide transitional assistance for individuals losing mini-med coverage until the new subsidies become available in 2014. For example, Congress established in Section 1102 of PPACA a transitional reinsurance program for early retirees, which terminates on January 1, 2014.[9]

In fact, however, Congress did none of the above.

HHS' response in its regulation was to impose on plans a set of increasing mandatory minimum annual coverage limits between now and 2014, but then attempt to preserve existing coverage by selectively waiving those requirements for certain plans.

What is wrong with HHS' waiver "solution"

The first problem is that it appears HHS has exceeded its statutory authority in creating this waiver process.

The statute does not explicitly grant HHS authority to waive the application of this provision. In contrast, I count twenty-one other sections of PPACA in which Congress

[8] 42 U.S.C. 300gg-91(c).
[9] PL 111-148 § 1102.

did grant HHS explicit, *new* waiver authority with respect to specific provisions.[10] Thus, it is reasonable to presume that if Congress had intended the Department to institute a waiver process as part of its implementation of this particular provision, Congress would have said so in the statute.

Furthermore, this provision does not present HHS with inherently conflicting instructions from Congress that can only be resolved through the creation of a waiver process. The waiver process established by HHS is not the only way that the Department could have fulfilled Congress' requirement that, "In defining the term 'restricted annual limit' for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums." Indeed as the forgoing sentence in the statute indicates, HHS could have "defined" the "restricted annual limit" as an amount sufficiently low enough that "access to needed services is made available with a minimal impact on premiums," even in the case of mini-med plans.

In other words, the Department could have avoided adversely effecting mini-med plans by simply setting a lower amount for the transitional limit. The wording of the statute certainly seems to indicate that Congress' intent was to forego writing a figure into the statute, and instead delegate to HHS the task of determining an appropriate amount -- nothing more.

Beyond the question of whether the establishment of this waiver program exceeds the discretionary authority granted by Congress to the Department in the statute, there is also the larger question of whether this action by the Department constitutes appropriate or desirable public policy.

I believe that the waiver process established by HHS in this instance is inappropriate and undesirable on three public policy grounds:

First, it results in unequal application of the law to affected parties and creates unequal burdens. Some applicants may get waivers while others may not. Furthermore, affected employers that are larger, and thus have more resources for responding to regulatory interventions, are more likely to be aware of, and apply for, the waivers than smaller firms with fewer resources.

Second, it creates at least the perception -- and possibly the fact -- that regulatory enforcement is being subordinated to Administration political priorities or concerns. The combination of HHS establishing interim dollar limits in the regulation, but then also instituting a process for waiving those limits on a case-by-case basis, appears deliberately designed to convey the perception that the new law is having a positive effect, while selectively avoiding any enforcement actions that might create the opposite public perception that the law is resulting in adverse, unintended consequences.

[10] Instances of Congress granting HHS new, explicit waiver authority in PL 111-148 can be found in § 1332, 2704, 2707, 3001, 3021, 3022, 3023, 3024, 3026, 3110, 3303, 4101, 4108, 5311, 5403, 5509, 6112, 6401, 6402, 10323, and 10326.

Third, it creates the opportunity, and the temptation, for Administration officials to apply the law corruptly or to engage in political favoritism when making enforcement decisions. Even if actual enforcement is not in fact tainted, the existence of a regulatory process that appears to invite such a possibility needlessly raises suspicions and undermines public confidence in the rule of law.

What Congress should do now

Based on the foregoing I recommend that Congress now take two actions.

First, Congress should instruct HHS to rewrite the regulation so as to eliminate this waiver program and limit its exercise of discretionary authority to only those matters in this provision over which Congress explicitly granted the Department discretionary authority. In particular, HHS should confine itself to the statutory requirement that the Department define the "restricted annual limit" to be applied prior to 2014. HHS could either retain the limits it has already defined in regulation, or replace them with a new, lower limit.

Second, Congress should consider whether or not it will change or further clarify the statutory language of this provision of PPACA, in the context of its broader debates over the future of this legislation in general and its numerous specific provisions.

Mr. Chairman, this concludes my prepared testimony. I thank you and the rest of the Committee for inviting me to testify before you on this issue. I will be happy to answer any questions that you or members of the Committee may have.

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None.

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I certify that the above information is true and correct.

Signature: s/Edmund F. Haislmaier Date: March 14, 2011