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The Honorable Kathleen Sebelius
Department of Health and Human Services
Hubert H. Humphrey Building,
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: HHS Waiver Process for Restricted Annual Limits and Limited Health Benefit Plans

Dear Secretary Sebelius:

The Department of Health and Human Services ("HHS"), Department of Treasury and Department of Labor (the "Agencies") recently issued an interim final regulation implementing various patient protection provisions of the Patient Protection and Affordable Care Act ("PPACA"). 75 Fed. Reg. 37188 (June 28, 2010) (the "IFR"). The IFR establishes rules permitting restricted annual limits on essential health benefits for plan years beginning prior to January 1, 2014. In connection with the IFR, the Agencies did not provide any specific relief that would allow limited benefit plans (also sometimes known as "mini-med plans") to maintain lower annual dollar limits prior to January 1, 2014. However, the preamble to the IFR indicates that HHS will establish a program under which the requirements relating to restricted annual limits may be waived for limited benefit plans and that HHS expects to issue guidance on the scope and process for applying for a waiver in the near future. 75 Fed. Reg. at 37191.

Aetna is one of the nation's leading diversified health care benefits companies, providing members with information and resources to help them make better informed decisions about their health care. Our programs and services strive to improve the quality of health care while controlling rising health benefit costs. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and medical management capabilities. Aetna's affiliate, SRC, is a leading provider of limited benefit policies. The SRC policies are exclusively group health insurance policies (rather than individual health) and they have been issued to more than 1350 employers covering over 430,000 employees and dependents in a given year.

As a key stakeholder affected by PPACA and by the IFR, Aetna is committed to working with HHS and the other Agencies in developing reasonable administrative standards in its implementation. Aetna has a substantial interest in the waiver process that HHS is adopting and is therefore providing comments on the scope and process that HHS might employ in developing

the waiver program. It is particularly important that the waiver program be established promptly so that applications can be made and decisions rendered in the near term.

Background

Approximately 1.4 million workers nationwide have group healthcare coverage under limited health benefit plans that cover accident- and sickness- related medical expenses. These plans typically have an annual dollar cap on overall benefits and/or an annual dollar cap on specific services. The individuals covered by such plans typically work for employers on a part-time, seasonal, or temporary basis and are ineligible for coverage under the employer's regular group health plan, or are in an eligibility waiting period for an employer's regular health plan. SRC's experience is that over 40% of employers make contributions to fund the limited benefit plans. Generally, employee premiums are paid pre-tax via a payroll reduction.

Public Health Service Act ("PHSA") § 2711 provides that effective for plan years beginning on or after September 23, 2010, a group health plan and a health insurance issuer offering group or individual coverage may not impose annual limits on the dollar value of essential benefits, *except* as permitted by the Secretary of HHS for plan years beginning prior to January 1, 2014. In defining the term "restricted annual limit," PPACA specifies that the Secretary of "shall ensure that access to needed services is made available with a minimum impact on premiums." *Id.* Annual dollar limits are prohibited altogether beginning in 2014. The restriction on annual limits applies to both new plans and grandfathered group health plans. *See* PPACA § 1251(a)(4)(B)(i).

Pursuant to the authority granted to the Secretary of HHS, the IFR implements PHSA § 2711 and permits group health plans, group health insurance coverage and individual insurance to maintain annual limits on essential health benefits as follows:

- $750,000 for plan and policy years beginning on or after September 23, 2010 but before September 23, 2011;
- $1.25 million for plan and policy years beginning on or after September 23, 2011 but before September 23, 2012;
- $2 million for plan and policy years beginning on or after September 23, 2012 but before January 1, 2014.

45 C.F.R. § 147.126(d). These limits are substantially higher than the typical annual limits established under Aetna's SRC limited benefit plans. Unless HHS issues timely waivers allowing limited health benefit plans to establish lower annual dollar limits, these plans, as currently designed, could be prohibited for plan years beginning on or after September 23, 2010, resulting in the loss of coverage for 1.4 million workers.

Aetna modeled how much more part-time, hourly and seasonal workers would have to pay if their current plan limits had to be raised to comply with the new limits. The study included all net claims incurred in 2009 eligible for payment on a net basis (i.e., charges minus the applicable provider contractual discounts). The results indicate that claims costs would increase by at least 514% and that premium costs increase by at least 383%. Such increases will be unaffordable for

many of the typical lower wage workers that enroll in these policies. The typical enrollee in a limited benefit plan has an annual before-tax income of between $10,000 and $30,000. If forced to comply with the new annual limit requirements, we project that the premiums would increase from an average of 10% of annual after-tax net income to an average of almost 50% of annual after-tax net income, which is an effective five-fold increase in healthcare premium cost.

Importantly, these workers will not be eligible for guaranteed issue coverage in the individual market, or federal subsidies available through Exchanges, until 2014.

Recommendations on Scope and Process for Waiver Program

The preamble to the IFR indicates that the waiver process is being established "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 . . . ." 75 Fed. Reg. at 37191. The preamble indicates that the restricted annual limits rule 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." *Id.* (Emphasis added).

Aetna strongly supports the creation of a waiver program by HHS for limited benefit plans and commends the Agency for doing so. It is critical that the waiver program be structured in an effective and efficient manner in order to allow workers who have elected limited benefit plan coverage to keep the coverage they have, at least until 2014. In addition, consistent with the preamble to the IFR, clear standards should be set for determining whether compliance with the IFR will result in either (1) a significant decrease in access to benefits, or (2) a significant increase in premiums. Aetna makes the following recommendations with respect to the scope and process for the waiver program:

1. Insurers as applicants: Insurers that issue limited benefit policies with respect to group health plans or as non-grandfathered individual policies should be permitted to apply for the HHS waiver. The insurer should be able to seek waivers on a product by product basis. As such, waivers could be granted for an entire book of similar policies or certificates issued by the insurer. Employers and individuals that have elected limited benefit plans would not have to apply for waiver, unless the employer sponsors a self-funded limited benefit plan, in which case the employer could apply for the waiver directly. Under this structure, the insurer would do the work for its employer and individual policyholders. HHS would have far fewer waivers to process and it will be more likely that timely waivers will be issued.

2. New products and material modifications: Insurers would be required to seek new waivers for new limited benefit plan products developed prior to 2014, or for material changes to existing products that are subject to a waiver. A material modification would be defined as any modification that would require a summary of material modifications under DOL regulations. *See* 29 CFR § 2510.104.

3. Coverage until 2014: Waivers should extend until the later of the last date of the plan year beginning prior to January 1, 2014, or the date when an Exchange is operational in a given state, unless a material change to the product subject to waiver occurs. Insurers should not

be required to apply for waivers annually. An annual program will burden both the waiver applicant and HHS, and will create uncertainty for employers and individuals that purchase such policies.

4. New policies: Waivers should cover new policies and certificates issued by the insurer, provided that the new policies and certificates are issued pursuant to a product that is subject to a valid HHS waiver. Limited benefit plans play an important place in the pre-2014 marketplace and such affordable coverage should be available to fill the gaps of employer coverage until 2014.

5. New enrollees: Waivers should permit new enrollees into existing coverage. An employer that sponsors a limited benefit plan should be able to treat all part-time, seasonal, temporary or other similarly situated employees the same with respect to eligibility for the plan.

6. Demonstrating significant decrease in access to benefits or significant increase in premiums: Consistent with the text of PHSA § 2711 and the preamble to the IFR, an applicant should be able to obtain a waiver if it demonstrates either a significant decrease in access to benefits or a significant increase in premiums (i.e., these are independent ways for an applicant to demonstrate that a waiver should be granted). Objective standards should be established for this determination to expedite the waiver process and ensure fairness among applicants.

    a. Demonstrating a significant decrease in access to benefits: The applicant should be able to meet this requirement by showing that in order to comply with the $750,000 restricted annual limit for plan years beginning on or after September 23, 2010 and before September 23, 2011, and assuming no other policy changes are made with respect to the scope of benefits, the resulting premiums will cost more than 9.5% of the average enrollee's weekly wage. It is expected that this standard would likely be demonstrated in the event an employer applies for a waiver since the employer would have access to such information. Employers could provide other information to demonstrate the likelihood that the application of the annual limits rule will impact their ability to offer benefits. The applicant should be required to attest to any cost estimates or data supplied in support of the application.

    b. Demonstrating a significant increase in premiums: The applicant should be able to meet this requirement by showing that in order to comply with the $750,000 restricted annual limit for plan years beginning on or after September 23, 2010 and before September 23, 2011, and assuming no other policy changes are made with respect to the scope of benefits, premiums will increase by greater than medical inflation plus 15% above the current premium rate. Alternatively, a premium increase of 50% or more shall be deemed to result in a "significant increase in premiums." The applicant should be required to provide an actuarial certification for this cost estimate.

The waiver process should specify that the Secretary has discretion to consider other indicia of a significant decrease in access to benefits, and/or a significant increase in premiums.

7. Notice: In the event a waiver is granted, the applicant (e.g., insurer) should be required to provide notice to its policyholders that their limited benefit plan is subject to a waiver (similar to the requirement under the grandfathered health plan IFR). Waiver applicants could be required to notify HHS when they are no longer relying on a waiver (e.g., they withdraw a policy from the market prior to 2014).

8. Applicant information: Relevant information of the applicant should be required. Such information should include the name of the company, individual contact, address, EIN, affiliates, description of the insurer's lines of business, scope of products subject to the waiver, representative samples of product documentation (e.g., approved policy forms) for which the waiver is sought, and the number of policyholders and individuals covered by the plans that are subject to the waiver application.

9. Certification: Applicants for waivers should be required to certify the accuracy of the waiver application.

10. Timing: HHS should process applications within 30 days of a complete submission. In the event the application raises issues that require a supplemental filing, HHS should be required to ask for supplemental information within the 30 day period.

11. Delayed application date: The filing of a timely application should delay the application of the September 23, 2010 compliance deadline such that applicants are not deemed out of compliance with PPACA in the event that HHS does not act on the waiver application in sufficient time for the applicant to comply with PPACA in the event the waiver application is denied.

12. Right to a conference: HHS should notify applicants in advance if it has tentatively determined to deny a waiver. Applicants should have a right to a conference with HHS in connection with an application that HHS intends to deny, so that the applicant can clarify issues and modify its application as appropriate. Applicants must request a conference within 15 days of notice by HHS.

13. Publication: HHS should publish its waiver decisions.

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Aetna believes that the forgoing recommendations will result in an effective and administrable waiver program that will allow workers who have elected limited benefit plan coverage to keep the coverage they have until 2014. It establishes clear standards for determining that there is a significant decrease in access to benefits, or significant increase in premiums. And it ensures that HHS has access to sufficient information on which to grant a waiver, while protecting the rights of applicants. We would be pleased to respond to any further questions you may have.

Sincerely,

Steven B. Kelmar

CC: Jay Angoff
Steve Larsen