

# HEALTH REFORM IMPACT

## What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### Opt-Out Opportunities for States: Available Waivers of Health Reform's Insurance Coverage Provisions

April 14, 2011

While recent health reform headlines have focused on multiple states' legal challenges to the constitutionality of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act"), a lesser-publicized way in which states have been seeking relief from certain provisions of the Act is already underway. The Act allows states to seek certain formal waivers as provided for within the Act. These provisions include the short-term ability of a state to opt-out of the medical loss ratio requirements for the purpose of individual markets, as well as broader, long-term waivers allowing states to develop programs that satisfy the Act's core goals of increased health insurance coverage and affordability using means that differ from those set forth in the Act.

#### **States seek waiver of medical loss ratio requirements**

Under the Act, health plans offering coverage in the group or individual markets, including grandfathered plans (but excluding self-insured plans), must report to the Department of Health and Human Services ("HHS") the proportion of premium dollars spent on clinical services as compared to the percentage spent on administrative services (medical loss ratio, or "MLR"). Each health plan must keep its annual medical costs at or above 85% of premium revenue for the group market and at or above 80% in the small group and individual market.<sup>1</sup> Under the Act, insurers that fail to meet the MLR are required to rebate to insureds the amount spent in excess of the threshold.

In an attempt to recognize the variation that exists in different state markets, the Act allows states to request a waiver of the MLR requirement for the individual market if HHS determines that applying the MLR requirement "may destabilize the existing individual market in such State."<sup>2</sup> In its interim final rule regarding MLR requirements, HHS provided guidelines for states to use in applying for this waiver, including requiring the state insurance commissioner or other applicable official to file the application and setting forth that the waiver may be granted for up to three years.<sup>3</sup> To apply, a state must demonstrate to HHS that requiring insurers to meet the 80% medical cost threshold may cause one of more insurers

<sup>1</sup> For additional information, please access our prior issue of *Health Reform IMPACT* entitled ["The Devil is in the Details: Interim Final Rules Provide Medical Loss Ratio Definitions and Process" \(January 7, 2011\)](#).

<sup>2</sup> The Patient Protection and Affordable Care Act at 10101.

<sup>3</sup> 75 Fed. Reg. 74863, 74887 (December 1, 2010).

to leave the market, reducing access for individuals. In addition, states must show HHS the number of individuals likely to be affected, as well as the potential change in premiums charged, benefits provided and cost sharing required. The interim final rule set the threshold for when a state waiver would be granted as “when there is a reasonable likelihood that market destabilization and thus harm to consumers, will occur.”<sup>4</sup>

On March 8, 2011, Maine became the first state to be granted an adjustment to the MLR requirement by HHS, after being the first state to apply on July 1, 2010. In making its case, the Maine Superintendent of Insurance stated that one insurer, whose products covered approximately one-third of the state’s individual market enrollees, had indicated that it would pull out of the individual market in Maine should the MLR be implemented.<sup>5</sup> This insurer specializes in catastrophic products, offering lower cost policies than other products in the individual market.<sup>6</sup> Using the Act’s MLR standard, the Maine Bureau of Insurance calculated the insurer to have a 68% MLR in 2009, while the other two insurers in Maine’s individual market had MLRs greater than 80%. Agreeing that the loss of this insurer might limit consumers’ ability to purchase new policies of comparable price and benefits and, therefore, might represent a reasonable likelihood of market destabilization, HHS granted Maine a waiver of the Act’s MLR requirement, setting the MLR requirement for the state at Maine’s current statutory standard of 65% for three years (2011-2013), although HHS will require Maine to provide additional data at the end of 2012 to support the third year of the waiver.

In addition to Maine, a number of states have either applied or are in the process of applying for a similar adjustment. These states include New Hampshire, Nevada, Kentucky, Iowa, North Dakota, Georgia and, most recently, Florida. While Maine expressly included language supporting the Act, some states such as Georgia and Florida have included in their request letters the possibility and/or belief that the Act itself is unconstitutional.

### **CMS Issues Proposed Regulations for State Innovation Waivers**

In Section 1332 of the Act, states may receive a waiver of some of the health insurance coverage requirements in the Act if the state has a plan for satisfying the goals of those provisions through different means than provided for in the Act. Known as a state innovation waiver or a 1332 waiver, those sections of the Act eligible for waiver include health insurance exchanges, individual mandates, tax credits and employer responsibility provisions. To receive a 1332 waiver, a state must show that its plan satisfies all of the following requirements (the “Requirements”):

1) Comprehensive Coverage Requirement - the state plan will provide insurance coverage that is at least as comprehensive as required by the Act;

2) Affordability Requirement - the state plan will provide coverage and cost sharing protections against out-of-pocket spending that are at least as affordable as those created by the Act;

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<sup>4</sup> *Id.* at 74886. The regulation states “This interim final regulation does not require the Secretary to find that adherence to the 80 percent MLR standard is certain to result in market destabilization in order to grant an adjustment from it. Nor does it allow the Secretary to grant an adjustment in the case where market destabilization is a remote possibility. Rather, this interim final regulation both allows and requires an adjustment to the state’s MLR to be granted when there is a reasonable likelihood that market destabilization and thus harm to consumers, will occur.”

<sup>5</sup> Letter from Mila Kofman, superintendent of insurance, State of Maine to Kathleen Sebelius, secretary of U.S. Department of Health and Human Services (July 1, 2010), available [here](#).

<sup>6</sup> Maine included in its letter a link to the 10-K securities filing by HealthMarkets, Inc., the parent company of MEGA Life and Health Insurance Company.

3) Scope of Coverage Requirement - the state plan will provide coverage to at least a comparable number of its residents as the Act would provide; and

4) Federal Deficit Requirement - the state plan will not increase the federal deficit.

Under the Act, state innovation waivers are to be available beginning in 2017, but currently bi-partisan legislation, supported by President Obama, is under consideration that would make waivers available starting in 2014.

On March 14, 2011, the Department of the Treasury ("Treasury") and HHS jointly issued proposed regulations (the "Regulations") describing the criteria for receiving a state innovation waiver and the process required for states to apply for a state innovation waiver.<sup>7</sup>

*Criteria.* To demonstrate that a state plan will satisfy the Requirements, the state submission must include the following:

- a comprehensive description of state legislation and programs implementing the state's plan;
- a copy of enacted state legislation authorizing the waiver request;
- a specific list of which provisions of the Act are to be waived and summaries of why; and
- analyses, actuarial certifications, data, key assumptions, current demographics and statistics, targets and other information sufficient for determination by HHS and/or Treasury to determine that the state plan satisfies the Requirements.

This supporting information must include, among other things, a detailed 10-year state budget plan including all costs under the state plan, certifications and analyses showing how the state plan would impact coverage requirements, determinations of how the state plan would work with those parts of the Act not waived under the request, details of how the plan would address access to healthcare services when people leave the state, information regarding how the state plan would prevent fraud, waste and abuse, and any additional information or explanations regarding how the state plan would impact residents, employers and insurers.

*Process.* Under the Regulations, prior to submission of a 1332 waiver application, states must provide a public notice and comment period sufficient to insure meaningful input to the waiver application prior to submission to HHS. This notice and comment process requires the state to provide the public with a comprehensive description of the state's waiver application, notify citizens of where the state's waiver application is available, describe how and where the public can provide comments, and hold public hearings where the state seeks public input into the application and plan. Upon completion of this process, the state may submit a 1332 waiver to HHS for preliminary review.<sup>8</sup> Within 45 days of submission, HHS must complete the preliminary review confirming that the application is complete but making no substantive determinations related to the application. If HHS deems the application complete, a federal notice and comment period automatically will begin, and the final decision by HHS (and Treasury, when appropriate) will be issued on the 1332 waiver no later than 180 days from the start of the federal notice and comment process.

*Monitoring, Compliance and Reporting.* Once a 1332 waiver is approved, states will have ongoing monitoring, compliance and reporting requirements. Under the Regulations, within six months after the implementation date of a section 1332 waiver and annually thereafter, a state must hold an open forum

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<sup>7</sup> 76 Fed. Reg. 13553 (March 14, 2011).

<sup>8</sup> The regulations permit, but do not require, states to submit a single waiver application if they are requesting a waiver under 1332 and a waiver of Medicaid or the Children's Health Insurance Program under the waiver procedures currently in place for these programs.

to gather public input on progress under the waiver. In addition, a state must submit quarterly reports to HHS regarding progress, operational challenges and corrective actions underway regarding the state plan, as well as more thorough annual reports regarding progress, compliance and public feedback. HHS and/or Treasury (as applicable depending on the sections of the Act waived) shall conduct periodic reviews of the state's progress and will review any documented complaints. HHS and Treasury shall have the right to suspend or terminate a waiver at any time should a state fail to comply with the terms of the waiver; should this event occur, federal funds related to the waiver and transition period will be limited.

If you have questions regarding the information in this issue, or with respect to other provisions of the health reform legislation as it relates to your insurance industry and operations, please contact any of the attorneys in our Insurance and Managed Care Practice Group listed below.

Also, please [click here](#) to visit our special Web page for Health Reform IMPACT.

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