



**The State of New Hampshire
Insurance Department**
21 South Fruit Street, Suite 14
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Roger A. Seigny
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

BULLETIN
Docket No.: INS 13-037-AB

TO: All New Hampshire Licensed Health Carriers and Producers
FROM: Roger A. Seigny 
DATE: November 25, 2013
RE: Renewals of non-ACA compliant policies in 2014

On November 14, 2013, the federal Centers for Medicare and Medicaid Services (“CMS”) issued a letter to state Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. (Attached as Appendix A) Under this policy, non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2014, will not be considered to be out of compliance with certain listed market reforms if certain specific conditions are met.¹ Health insurance issuers may choose to continue coverage that would otherwise be discontinued, and affected individuals and small businesses may choose to renew such coverage.

The New Hampshire Insurance Department will adopt the same transitional policy set out in the attached November 14th CMS letter. An issuer’s fourth quarter 2013 approved rates will be considered de facto approved for 2014 renewals. Issuers may file rates for this coverage. The Department will review these requests on an expedited basis.

Issuers intending to utilize this option must notify the Department of their intention. The notice to the Department shall include copies of all associated consumer notices, which must comply with the standards in the CMS guidance.

For questions regarding this bulletin, contact David Sky at 603-271-2261 or email at david.sky@ins.nh.gov.

¹ In a second guidance document issued November 21, 2013, CMS provided standards for consumer notices required in connection with the exercise of this new carrier option. (Attached as Appendix B)



November 14, 2013

Dear Insurance Commissioners,

Some individuals and small businesses with health insurance coverage have been notified by their health insurance issuers that their coverage will soon be terminated. We understand that, in some cases, the health insurance issuer is terminating or cancelling such coverage because it would not comply with certain market reforms that are scheduled to take effect for plan or policy years starting on or after January 1, 2014, such as the new modified community rating and essential health benefits package standards.¹ Although affected individuals and small businesses may access quality health insurance coverage through the new Health Insurance Marketplaces, in many cases with federal subsidies, some of them are finding that such coverage would be more expensive than their current coverage, and thus they may be dissuaded from immediately transitioning to such coverage.

In light of this circumstance, under the following transitional policy, health insurance issuers may choose to continue coverage that would otherwise be terminated or cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. Under this transitional policy, health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2014, and associated group health plans of small businesses, will not be considered to be out of compliance with the market reforms specified below under the conditions specified below.² We will consider the impact of this transitional policy in assessing whether to extend it beyond the specified timeframe.

The specified market reforms are the portions of the following provisions of the Public Health Service Act that are scheduled to take effect for plan or policy years starting on or after

¹ Health plans that are grandfathered pursuant to section 1251 of the Affordable Care Act and its implementing regulations are not subject to most market reforms. Because there is no need for transitional relief for such plans, the transitional relief afforded in this document is not applicable to grandfathered health plans.

² The Department of Health and Human Services has conferred with the Departments of Labor and the Treasury with respect to those market reforms with respect to which there is shared jurisdiction. With respect to those market reforms, the Departments of Labor and the Treasury concur with the transitional relief afforded in this document.

January 1, 2014, and any corresponding portions of the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (Code):

- Section 2701 (relating to fair health insurance premiums);
- Section 2702 (relating to guaranteed availability of coverage);
- Section 2703 (relating to guaranteed renewability of coverage);
- Section 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage;
- Section 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage;³
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage);
- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials).

The specified conditions are the following:

- The coverage was in effect on October 1, 2013;⁴
- The health insurance issuer sends a notice to all individuals and small businesses that received a cancellation or termination notice with respect to the coverage, or sends a notice to all individuals and small businesses that would otherwise receive a cancellation or termination notice with respect to the coverage, that informs them of (1) any changes in the options that are available to them; (2) which of the specified market reforms would not be reflected in any coverage that continues; (3) their potential right to enroll in a qualified health plan offered through a Health Insurance Marketplace and possibly qualify for financial assistance; (4) how to access such coverage through a Marketplace; and (5) their right to enroll in health insurance coverage outside of a Marketplace that complies with the specified market reforms. Where individuals or small businesses have already received a cancellation or termination notice, the issuer must send this notice as soon as reasonably possible. Where individuals or small business would otherwise receive a cancellation or termination notice, the issuer must send this

³ We note that sections 702 of ERISA and 9802 of the Code remain applicable to group health plans.

⁴ In light of this condition, the transitional relief afforded in this document is not applicable to newly obtained health insurance coverage. It applies only with respect to individuals and small businesses with coverage that was in effect on October 1, 2013; it does not apply with respect to individuals and small businesses that obtain new coverage after October 1, 2013.

notice by the time that it would otherwise send the cancellation or termination notice.

State agencies responsible for enforcing the specified market reforms are encouraged to adopt the same transitional policy with respect to this coverage.

Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance.

Sincerely,

/Signed, GC, November 14, 2013/

Gary Cohen
Director
Center for Consumer Information and Insurance Oversight



Date: November 21, 2013
From: Gary Cohen, Director, Center for Consumer Information and Insurance Oversight
Title: Insurance Standards Bulletin Series -- INFORMATION
Subject: Standard Notices for Transition to ACA Compliant Policies

On November 14, 2014, CMS issued a letter to State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. If permitted by applicable State authorities, health insurance issuers may choose to continue coverage that would otherwise be terminated or cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. Under this transitional policy, non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2014, will not be considered to be out of compliance with certain market reforms if certain specific conditions are met.

One of the conditions for the transitional policy is that the health insurance issuer must send a notice to all individuals and small businesses that received a cancellation or termination notice with respect to the coverage, or send a notice to all individuals and small businesses that would otherwise receive a cancellation or termination notice with respect to the coverage, that informs them of (1) any changes in the options that are available to them; (2) which of the specified market reforms would not be reflected in any coverage that continues; (3) their potential right to enroll in a qualified health plan offered through a Health Insurance Marketplace and possibly qualify for financial assistance; (4) how to access such coverage through a Marketplace; and (5) their right to enroll in health insurance coverage outside of a Marketplace that complies with the specified market reforms.

Included with this guidance are standard notices that are required to be used in order to satisfy the requirement outlined above. Attachment 1 is the notice that must be sent to policyholders that have already been sent a cancellation notice for the existing coverage. Attachment 2 is the notice that must be sent to policyholders that have not previously been sent a cancellation notice for the existing coverage. The appropriate notice must be delivered to the policyholder separately from any other plan materials or correspondence.

Also included as Attachment 3 is standard language that satisfies the requirement when health insurance issuers proceed with the cancellation of the coverage in either the small group or individual health insurance markets. The use of this language will be considered to satisfy the requirement to notify policyholders of the discontinuation of their policies if it is prominently displayed in all cancellation notices sent between the issuance of this guidance and December 31, 2014. CMS will be working closely with states as the primary enforcers of these notice requirements.

Where to get more information:

If you have any questions regarding this guidance, please e-mail CCIIO at marketreform@cms.hhs.gov.

Attachment 1

This notice must be used when a prior cancellation notice was sent and the issuer is providing an option to the policyholder to continue the existing coverage:

Dear Policyholder,

We previously notified you that your current policy is being cancelled because it doesn't meet the minimum standards required by the health care law. We are now writing to inform you that, under federal guidance announced in November 2013, you may keep this coverage for the upcoming plan year beginning in 2014.

How Do I Keep My Current Plan?

To keep your current plan, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it will NOT provide all of the rights and protections of the health care law. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and that take effect for coverage beginning in 2014. As a result, your coverage:

- May not meet standards for fair health insurance premiums, so it can charge more based on factors such as gender or a pre-existing condition, and it doesn't have to comply with rules limiting the ability to charge older people more than younger people (section 2701).
- May not meet standards for guaranteed availability, so it can exclude customers based on factors such as a pre-existing condition (section 2702).
- May not meet standards for guaranteed renewability (section 2703).
- May not meet standards related to pre-existing conditions for adults, so it can exclude coverage for treatment of an adult's pre-existing condition (section 2704).
- May not meet standards related to discrimination based on health status (section 2705).
- May not meet standards for non-discrimination in providers (section 2706).
- May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs and might have unlimited cost-sharing (section 2707).
- May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a serious or life-threatening disease (section 2709).

How Do I Choose A Different Plan?

You have new options and rights for getting quality, affordable health insurance. [You may shop in the Health Insurance Marketplace, where all plans meet certain standards to guarantee health care security and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing condition. The Marketplace allows you to choose a private plan that fits your budget and health care needs. You may also qualify for tax credits or other financial assistance to help you afford health insurance coverage through the Marketplace.]¹

[You can also get new health insurance outside the Marketplace.] Most new plans guarantee certain protections, such as your ability to buy a plan even if you or your employees have a pre-existing condition. [However, financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, since you have to buy your coverage within a limited time period to preserve your consumer protections.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596.

If you have questions, please contact us.

¹ The bracket language does not apply to the U.S. territories that do not have a Marketplace.

Attachment 2

This notice must be used when a prior cancellation notice has not been sent and the issuer is providing an option to the policyholder to continue the existing coverage:

Dear Policyholder,

We are writing to inform you that, under federal guidance announced in November 2013, you may keep your existing coverage for the upcoming plan year beginning in 2014.

How Do I Keep My Current Plan?

To keep your current plan, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it will NOT provide all of the rights and protections of the health care law. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and that take effect for coverage beginning in 2014. As a result, your coverage:

- May not meet standards for fair health insurance premiums, so it can charge more based on factors such as gender or a pre-existing condition, and it doesn't have to comply with rules limiting the ability to charge older people more than younger people (section 2701).
- May not meet standards for guaranteed availability, so it can exclude customers based on factors such as a pre-existing condition (section 2702).
- May not meet standards for guaranteed renewability (section 2703).
- May not meet standards related to pre-existing conditions for adults, so it can exclude coverage for treatment of an adult's pre-existing condition (section 2704).
- May not meet standards related to discrimination based on health status (section 2705).
- May not meet standards for non-discrimination in providers (section 2706).
- May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs and might have unlimited cost-sharing (section 2707).
- May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a serious or life-threatening disease (section 2709).

How Do I Choose A Different Plan?

You have new options and rights for getting quality, affordable health insurance. [You may shop in the Health Insurance Marketplace, where all plans meet certain standards to guarantee health care security and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing condition. The Marketplace allows you to choose a private plan that fits your budget and health care needs. You may also qualify for tax credits or other financial assistance to help you afford health insurance coverage through the Marketplace.]²

[You can also get new health insurance outside the Marketplace.] Most new plans guarantee certain protections, such as your ability to buy a plan even if you or your employees have a pre-existing condition. [However, financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, since you have to buy your coverage within a limited time period to preserve your consumer protections.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596.

If you have questions, please contact us.

² The bracket language does not apply to the U.S. territories that do not have a Marketplace.

Attachment 3

The following language may be used to satisfy the requirement to notify policyholders (and participants and beneficiaries covered under such coverage) of the discontinuation of their policies. This language should be prominently displayed and placed before language, if any, about auto-enrolling an individual in a specific product:

How Do I Choose A Different Plan?

Even though this plan will no longer be offered, you have new options and rights for getting quality, affordable health insurance. [You may shop in the Health Insurance Marketplace, where all plans meet certain standards to guarantee health care security and no one who is qualified to purchase through the Marketplace can be turned away or charged more because of a pre-existing condition. The Marketplace allows you to choose a private plan that fits your budget and health care needs. You may also qualify for tax credits or other financial assistance to help you afford health insurance coverage.]³

[You can also get new health insurance outside the Marketplace.] Most new plans guarantee certain protections, such as your ability to buy a plan even if you or your employees have a pre-existing condition. [However, financial assistance is not available outside the marketplace.]

You should review your options as soon as possible, since you have to buy your coverage within a limited time period to preserve your consumer protections. You have 60 days from the time your current plan ends to select a new plan that meets your needs.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596.

³ The bracket language does not apply to the U.S. territories that do not have a Marketplace.