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Roger A. Seigny
Commissioner

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Deputy Commissioner

**BULLETIN
Docket No.: INS-15-014-AB**

TO: All New Hampshire Licensed Health Carriers and Producers



FROM: Roger A. Seigny
Insurance Commissioner

DATE: April 20, 2015

RE: Guidance on Application of Extended Transition to Individual and Group Policies
and Employee Counting

I. Introduction

On March 5, 2014, the federal Centers for Medicare and Medicaid Services (“CMS”) issued an Insurance Standards Bulletin (attached as Appendix A) providing for an extension of the transition period for non-grandfathered coverage in the small group and individual health insurance markets. Under the transition guidance, certain non-grandfathered health insurance coverage is not considered to be out of compliance with some market reforms under the Affordable Care Act (ACA) if specific conditions are met. Health insurance issuers may choose to continue such coverage, and affected individuals and businesses may choose to renew such coverage.

On March 11, 2014, the New Hampshire Insurance Department (NHID) adopted this extended transitional guidance via the [New Hampshire Insurance Department March 11, 2014 Bulletin INS 14-009-AB](#).¹

¹ http://www.nh.gov/insurance/media/bulletins/2014/documents/ins_14_009_ab.pdf

In its [2016 Letter to Issuers](#),² CMS offered additional guidance regarding the application of the federal extended transition period to groups that currently purchase insurance on the large group market, but will be considered small groups pursuant to 42 USC 18024(b)(3) starting on January 1, 2016. Specifically, CMS stated that:

Under guidance CMS issued on March 5, 2014, CMS announced an exercise of enforcement discretion under which transition relief would apply to employers with between 51 and 100 employees that purchased large employer coverage while still defined as large employers in the State, under which these employers could renew such policies for plan years beginning before October 1, 2016 and be subject to Federal enforcement only of large employer requirements. As of January 1, 2016, however, employers with from 51 to 100 employees purchasing new coverage must comply with small employer requirements, including the rating restrictions and the single risk pool requirement.

This bulletin clarifies the approach that the NHID will take to renewal of large-group coverage for plan years beginning before October 1, 2016 by employers that are defined as large group in 2015, but will be defined as small group beginning January 1, 2016. The NHID reserves the right to review and revisit this guidance annually.

II. Legal Authority

The New Hampshire Insurance Commissioner “is charged with the rights, powers, and duties pertaining to the enforcement and execution of the insurance laws” of New Hampshire. NH RSA 400-A:3. The Commissioner has general rulemaking and enforcement authority with respect to regulation of the business of insurance in New Hampshire.

In its March 5, 2014 Insurance Standards Bulletin, CMS granted authority to states to allow health insurance issuers that have sold a policy that meets the extended transitional standards it set forth to renew such policies through October 1, 2016. States were given the option to adopt the transitional policy through October 1, 2016 or for a shorter amount of time and were given the following additional options in adopting the extended transitional policy:

- Adopt for both the individual and small group markets;
- Adopt for the individual market only; or
- Adopt for the small group market only.
- States were also given the option to adopt the transitional relief policy only for large businesses that purchase insurance in the large group currently but will be considered small groups starting on January 1, 2016.

III. Extended Transition for Large Group Plans

Via the [New Hampshire Insurance Department March 11, 2014 Bulletin INS 14-009-AB](#),³ the NHID stated that it would “follow the same transitional policy set out in the [March 5, 2014]

² <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>

³ http://www.nh.gov/insurance/media/bulletins/2014/documents/ins_14_009_ab.pdf

CMS bulletin,” which includes transitional relief for large businesses that, pursuant to 42 USC 18024(b)(3), will be considered small groups as of January 1, 2016. As such, issuers that have sold large group coverage to groups with between 51 and 100 members prior to January 1, 2016 and have continued to renew that coverage, may choose to continue to do so through policy years starting on or before October 1, 2016. Those groups will not be required to transition to small group plans when the definition of small group changes on January 1, 2016⁴ if applicable conditions are met. Nor will they be considered to be out of compliance with certain listed market reforms that apply to the small group market if those conditions are met.

As noted at the end of this bulletin, issuers intending to renew coverage under the transition policy must first notify the NHID of their intention.

IV. Definition of Coverage Change

For groups that were already in the small group market and for individual market coverage, only coverage that was in effect as of October 1, 2013 may qualify for the extended transitional relief. In defining whether a current policy was in effect on October 1, 2013 or, for large group coverage, was in effect as of December 31, 2015, the NHID will look to the following relevant legal standards:

- **Standards for Grandfathered Plans.** 45 CFR 147.140 states that to maintain grandfathered status, the health plan coverage cannot:
 - o eliminate all or substantially all benefits to diagnose or treat a particular condition;
 - o increase a percentage cost-sharing requirement (such as an individual's coinsurance requirement);
 - o increase a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), by an amount that exceeds the maximum percentage increase as defined by 45 CFR 147.140 (g)(3)(ii);
 - o increase a fixed-amount copayment by the greater of:
 - An amount equal to \$5 increased by medical inflation, as defined in paragraph 45 CFR 147.140(g)(3)(i) (that is, \$5 times medical inflation, plus \$5), or
 - An amount that exceeds the maximum percentage increase as defined by 45 CFR 147.140 (g)(3)(ii);
 - o Experience for any tier of coverage for any class of similarly situated individuals (as described in 45 CFR 146.121(d)) a decrease in the contribution rate by the employer or employer organization calculated by either the cost of coverage as defined by 45 CFR 147.140(g)(3)(iii)(A) or a formula by more than 5 percentage points;
 - o Add an annual or lifetime limit on the dollar value of benefits; or
 - o Decrease an annual limit on the dollar value of all benefits.

⁴ 42 USC 18024(b)(3)

In this case, relative increases or decreases are measured against the amounts in place on October 1, 2013. Carriers should consult 45 CFR 147.140 for the detailed standards.

- **Regulatory Parameters for Uniform Modifications of Coverage** – Under the standards for recertification for plan years beginning in 2016, a plan will be considered the same plan under 45 CFR 147.106 only if:
 - o Changes made are solely pursuant to applicable Federal or State requirements;
 - o The product is offered by the same health insurance issuer;
 - o The product is offered as the same product network type;
 - o The plan covers a majority of the same counties in its service area;
 - o Changes in cost-sharing are solely related to changes in cost and utilization of medical care or to maintain the same metal tier level or coverage;
 - o The plan provides the same covered benefits except for changes in benefits that cumulatively impact the A/V by no more than 2 percent.

Carriers should consult 45 CFR 147.106 for the detailed standards.

The NHID will review these standards cumulatively, meaning that a plan will be considered to no longer qualify for transitional status if it violates any requirement in either of the standards noted above. In addition, the NHID interprets the above standards to prohibit the following types of changes by transitional plans:

- The addition of pediatric dental coverage; and
- Changing the product line under which the coverage is offered.

V. Cancellation of Transitional Plans

In compliance with applicable state and federal standards, an issuer may terminate a transitional plan prior to coverage years beginning October 1, 2016.

VI. Employee Counting

The ACA's method of counting employees for the purposes of determining whether a purchaser falls in the individual, small group or large group market is different from the method traditionally used in New Hampshire. During the initial implementation period, the NHID issued [Bulletin INS 13-017-AB](#)⁵ on August 16, 2013 stating that New Hampshire rules for the counting of employees would continue to be used in certain circumstances. However, in view of federal preemption and in the interest of clarity and uniformity, federal counting rules should be used in all cases starting with policies that are issued or renewed on or after July 1, 2015.

VII. Notification

Issuers intending to renew coverage under the transition policy must notify the NHID of their intention. The notice to the NHID shall include copies of all associated consumer notices, which

⁵ http://www.nh.gov/insurance/media/bulletins/2013/documents/ins_13-017-ab-mktrules.pdf

must comply with the standards in CMS guidance. Send the notice to Marlene Sawicki at marlene.sawicki@ins.nh.gov with the subject line of “Transition Policies.”

VIII. Contact Information

Questions related to this bulletin should be directed to Jennifer Patterson, Health Policy Legal Counsel, at 603-271-2261 or email at jennifer.patterson@ins.nh.gov; or Michael Wilkey, Director of Compliance and Consumer Services at the New Hampshire Insurance Department, at <mailto:michael.wilkey@ins.nh.gov> or by phone at (603)-271-2261 ext. 330.



Date: March 5, 2014

From: Gary Cohen, Director, Center for Consumer Information and Insurance Oversight

Title: Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016

Subject: Extended Transition to Affordable Care Act-Compliant Policies

On November 14, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a letter to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. CMS announced in its November 14, 2013 letter that, if permitted by applicable State authorities, health insurance issuers may choose to continue certain coverage that would otherwise be cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. CMS further stated that, under the 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.

As provided in the November 14, 2013 letter, policies subject to the transitional relief are not considered to be out of compliance with the following provisions of the Public Health Service Act (PHS Act):

- 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;¹
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage);

¹ We note that sections 702 of ERISA and 9802 of the Code remain applicable to group health plan coverage.

- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials);

Additionally, policies subject to the transitional relief are not considered to be out of compliance with section 1312(c) of the Affordable Care Act (relating to the single risk pool requirement). As a reminder, issuers can choose to adopt one or all of these provisions in their renewed policies.

CMS indicated in its November 14, 2013 letter that it would consider the impact of this transitional policy in assessing whether to extend it beyond the specified timeframe. We have considered the impact of the transitional policy and will extend our transitional policy for two years – to policy years beginning on or before October 1, 2016, in the small group and individual markets. We will consider the impact of the two-year extension of the transitional policy in assessing whether an additional one-year extension is appropriate.

This policy also applies to large businesses that currently purchase insurance in the large group market but that, as of January 1, 2016, will be redefined by section 1304(b) of the Affordable Care Act as small businesses purchasing insurance in the small group market. At the option of the States and health insurance issuers, they, too, will have the option of renewing their current policies through policy years beginning on or before October 1, 2016, without their policies being considered to be out of compliance with the provisions specified above that apply to the small group market but not to the large group market.

At the option of the States, health insurance issuers that have issued or will issue a policy under the transitional policy anytime in 2014 may renew such policies at any time through October 1, 2016, and affected individuals and small businesses may choose to re-enroll in such coverage through October 1, 2016.

States that did not adopt the November 14, 2013 transitional policy, and that regulate issuers whose 2013 policies renew anytime between the date of issuance of this bulletin and December 31, 2014, including any policies that they allowed to be renewed early in late 2013, may choose to implement the transitional policy for any remaining portion of the 2014 policy year (i.e., this policy could apply to “early renewals” from late 2013). Moreover, States can elect to extend the transitional policy for a shorter period than through October 1, 2016 (but may not extend it to policy years beginning after October 1, 2016).

Furthermore, States may choose to adopt both the November 14, 2013 transitional policy as well as the extended transitional policy through October 1, 2016, or adopt one but not the other, in the following manner:

- For both the individual and the small group markets;
- For the individual market only; or
- For the small group market only.
- A State may also choose to adopt the transitional relief policy only for large businesses that currently purchase insurance in the large group market but that, for policy years beginning on or after January 1, 2016, will be redefined as small businesses purchasing insurance in the small group market.

Under the extended transitional policy, health insurance coverage in the individual or small group market that meets the criteria of the extended transitional policy through October 1, 2016, and associated group health plans of small businesses, as applicable, will not be considered to be out of compliance with the market reforms as specified above. Health insurance issuers that renew coverage under this extended transitional policy through October 1, 2016, must, for each policy year, provide the relevant attached notice to affected individuals and small businesses as specified in our November 14, 2013 guidance.²

All transitional policies that have rate increases subject to review under PHS Act section 2794 should utilize the rules and processes for submission to States and CMS that were in place prior to April 1, 2013, to assure compliance with PHS Act section 2794 requirements.

On December 19, 2013, CMS issued guidance indicating that individuals whose policies are cancelled because the coverage is not compliant with the Affordable Care Act qualify for a hardship exemption if they find other options to be more expensive, and are able to purchase catastrophic coverage.³ This hardship exemption will continue to be available until October 1, 2016, for those individuals whose non-compliant coverage is cancelled and who meet the requirements specified in the guidance.

Where to get more information:

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

² Because these are required standard notices that cannot be modified, the Paperwork Reduction Act does not apply to these notices.

³ The December 19, 2013 guidance can be found here: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf>.

Attachment 1

This notice must be used when a cancellation notice has already been 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 does not meet the minimum standards required by the Affordable Care Act. We are now writing to inform you that, consistent with federal guidance initially announced in November 2013, and extended in March 2014, you may keep this coverage for the upcoming policy year.

How Do I Keep My Current Policy?

To keep your current policy, 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 may NOT provide all of the protections of the Affordable Care Act. 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 took effect for coverage beginning in 2014. If you choose to renew your current policy, your coverage:

- May not meet standards for fair health insurance premiums, so you might be charged more based on factors such as gender or a pre-existing medical condition, and it might not comply with rules limiting the ability to charge older people more than younger people (PHS Act section 2701).
- May not meet standards for guaranteed availability, so it might exclude consumers based on factors such as a pre-existing medical condition (PHS Act section 2702).
- May not meet standards for guaranteed renewability (PHS Act section 2703).
- If the coverage is an individual market policy, may not meet standards related to pre-existing medical conditions for adults, so it might exclude coverage for treatment of an adult's pre-existing medical condition such as diabetes or cancer (PHS Act section 2704).
- If the coverage is an individual market policy, may not meet standards related to discrimination based on health status (PHS Act section 2705).
- May not meet standards for non-discrimination with respect to health care providers (PHS Act 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 or maternity care, or might have unlimited cost-sharing (PHS Act 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 life-threatening or other serious disease (PHS Act section 2709).

How Do I Choose A Different Policy?

You have options for getting quality health insurance. [You may shop in the Health Insurance Marketplace, where all policies meet certain standards to help 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 medical condition. The Marketplace allows you to choose a private policy that fits your budget and health care needs. You may qualify for tax credits or other federal financial assistance to help you afford health insurance coverage purchased through the Marketplace.]⁴

[You can also get new health insurance outside the Marketplace.] All new policies guarantee certain protections, such as your ability to buy a policy even if you have a pre-existing medical condition. [However, federal financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, because you may have to buy your coverage within a limited time period.

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 or **TTY: 1-855-889-4325**.

If you have questions, please contact us.

⁴ 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 cancellation notice has not yet 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, consistent with federal guidance initially announced in November 2013 and extended in March 2014, you may keep your existing coverage for the upcoming policy year.

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As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it may NOT provide all of the protections of the Affordable Care Act. 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 took effect for coverage beginning in 2014. If you choose to renew your current policy, your coverage:

- May not meet standards for fair health insurance premiums, so you might be charged more based on factors such as gender or a pre-existing medical condition, and it might not comply with rules limiting the ability to charge older people more than younger people (PHS Act section 2701).
- May not meet standards for guaranteed availability, so it might exclude consumers based on factors such as a pre-existing medical condition (PHS Act section 2702).
- May not meet standards for guaranteed renewability (PHS Act section 2703).
- If the coverage is an individual market policy, may not meet standards related to pre-existing medical conditions for adults, so it might exclude coverage for treatment of an adult's pre-existing medical condition such as diabetes or cancer (PHS Act section 2704).
- If the coverage is an individual market policy, may not meet standards related to discrimination based on health status (PHS Act section 2705).
- May not meet standards for non-discrimination with respect to health care providers (PHS Act 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 or maternity care, or might have unlimited cost sharing (PHS Act 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 life-threatening or other serious disease (PHS Act section 2709).

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