MARSH & McLENNAN AGENCY

COMPLIANCE UPDATE, APRIL 12, 2018

CMS EXTENDS TRANSITION RELIEF FOR NON-COMPLIANT PLANS THROUGH 2019

On April 9, 2018, the Centers for Medicare & Medicaid Services (CMS) announced a one-year extension to the transition policy (originally announced November 14, 2013 and extended several times since) for individual and small group health plans that allows issuers to continue policies that do not meet ACA standards. The transition policy has been extended to policy years beginning on or before October 1, 2019, provided that all policies end by December 31, 2019. This means individuals and small businesses may be able to keep their non-ACA compliant coverage through the end of 2019, depending on the policy year. Carriers may have the option to implement policy years that are shorter than 12 months or allow early renewals with a January 1, 2019 start date in order to take full advantage of the extension.

BACKGROUND

The Affordable Care Act (ACA) includes key reforms that create new coverage standards for health insurance policies. For example, the ACA imposes modified community rating standards and requires individual and small group policies to cover a comprehensive set of benefits. Millions of Americans received notices in late 2013 informing them that their health insurance plans were being canceled because they did not comply with the ACA's reforms. Responding to pressure from consumers and Congress, on Nov. 14, 2013, President Obama announced a transition relief policy for 2014 for non-grandfathered coverage in the small group and individual health insurance markets. If permitted by their states, the transition policy gives health insurance issuers the option of renewing current policies for current enrollees without adopting all of the ACA's market reforms.

TRANSITION RELIEF POLICY

Under the original transitional policy, health insurance coverage in the individual or small group market that was renewed for a policy year starting between Jan. 1, 2014, and Oct. 1, 2014 (and associated group health plans of small businesses), will not be out of compliance with specified ACA reforms. These plans are referred to as "grandmothered" plans.

To qualify for the transition relief, issuers must send a notice to all individuals and small businesses that received a cancellation or termination notice with respect to the coverage (or to all individuals and small businesses that would otherwise receive a cancellation or termination notice with respect to the coverage).

The transition relief only applies with respect to individuals and small businesses with coverage that was in effect since 2014. It does not apply with respect to individuals and small businesses that obtain new coverage after 2014. All new plans must comply with the full set of ACA reforms.

ONE-YEAR EXTENSION

According to CMS, the extension will ensure that consumers have multiple health insurance coverage options and states continue to have flexibility in their markets. Also, like the original transition relief, issuers that renew coverage under the extended transition relief must, for each policy year, provide a notice to affected individuals and small businesses.

Under the transition relief extension, at the option of the states, issuers that have issued policies under the transitional relief in 2014 may renew these policies at any time through October 1, 2019 and affected individuals and small businesses may choose to re-enroll in the coverage through October 1, 2019. Policies that are renewed under the extended transition relief are not considered to be out of compliance with the following ACA reforms:

- community premium rating standards, so consumers might be charged more based on factors such as gender or a pre-existing medical condition, and it might not comply with rules limiting age banding (PHS Act section 2701);
- guaranteed availability and renewability (PHS Act sections 2702 & 2703);
- if the coverage is an individual market policy, the ban on preexisting 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, discrimination based on health status, so consumers may have premium increases based on claims experience or receipt of health care (PHS Act section 2705);
- coverage of essential health benefits or limit on 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); and
- standards for participation in clinical trials, so consumers 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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