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BULLETIN NO. 2022-03

TO: All Health Insurance Issuers, Health Care Service Plans and Health Maintenance Organizations

FROM: Jim L. Ridling
Commissioner of Insurance

DATE: March 30, 2022

RE: Extension of Transitional Relief

EFFECTIVE: Immediately

REPLACES: Bulletin 2021-01 (February 3, 2021)

Consistent with federal guidance issued on March 23, 2022, and attached hereto, transitional relief in both the individual market and small group market in Alabama may be continued to the extent consistent with the attached guidance at the option of each issuer. Issuer may use either early renewal or short policy years to implement the extension.

This Bulletin replaces the federal guidance provided in ALDOI Bulletin No. 2021-01.

JLR/WR/bc

attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: March 23, 2022

From: Dr. Ellen Montz, Director, Center for Consumer Information and Insurance Oversight

Title:

Insurance Standards Bulletin Series – INFORMATION – Extension of Limited Non-Enforcement Policy through 2023 and Later Benefit Years

Subject:

Extended Non-Enforcement of Affordable Care Act-Compliance with Respect to Certain Policies

I. Purpose

This bulletin extends the Centers for Medicare & Medicaid Services' (CMS) policy under which CMS will not take enforcement action against certain non-grandfathered health insurance coverage in the individual and small group market that is out of compliance with certain specified market reforms. The extended non-enforcement policy[1] in this bulletin applies for policy years beginning after October 1, 2022, and will remain in effect until CMS announces that all such coverage must come into compliance with the specified requirements.

II. Background

On November 14, 2013, CMS issued a letter to the State Insurance Commissioners outlining a transitional policy for certain non-grandfathered coverage in the small group and individual health insurance markets.[2] CMS announced in its November 14, 2013 letter that, if allowed by applicable State authorities, health insurance issuers would be able to choose to continue certain coverage that could not otherwise remain in place without significant changes to comply with Affordable Care Act requirements, and individuals and small businesses with such coverage could, as a result, choose to re-enroll in such coverage. CMS further stated that, under the non-enforcement 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 would not be treated as being out of compliance with certain market reforms set forth below if certain specific conditions are met.

[1] While this bulletin refers to a "non-enforcement policy" and some of the previous bulletins on this topic referred to a "transitional policy," the substance of the policy remains unchanged.
[2] Centers for Medicare & Medicaid Services, "Letter to State Insurance Commissioners" (Nov. 14, 2013), available at https://www.cms.gov/cciio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf

CMS has continuously extended this non-enforcement policy, with the most recent extension in effect until policy years beginning on or before October 1, 2022, provided that all such coverage comes into compliance by January 1, 2023.[3]

As provided in previously issued guidance, health insurance coverage subject to the non-enforcement policy is not treated as 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;[4]
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage); and
- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials).

Additionally, health insurance coverage subject to the non-enforcement policy is not treated as 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 comply with some or all of these provisions in their renewed policies.

III. Guidance

CMS is committed to bringing all non-grandfathered coverage in the individual and small group markets into compliance with all applicable Affordable Care Act requirements. However, we are extending our non-enforcement policy to policy years beginning after October 1, 2022. Specifically, states may allow issuers that have renewed coverage under the non-enforcement policy continually since 2014[5] to renew such coverage for a policy year starting after October 1, 2022. This extended non-enforcement policy will remain in effect until CMS announces that coverage renewed under this non-enforcement policy must come into compliance with the relevant requirements.

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[3] Centers for Medicare & Medicaid Services, "Insurance Standards Bulletin Series –INFORMATION—Extension of Limited Non-Enforcement Policy through 2022" (Jan. 19, 2021), available at: https://www.cms.gov/files/document/extension-limited-non-enforcement-policy-through-calendar-year-2022.pdf

[4] We note that section 702 of the Employee Retirement Income Security Act and section 9802 of the Internal Revenue Code remain applicable to group health plan coverage

[5] For purposes of determining whether coverage has been renewed continually, see the definition of when a product will be considered the same "product" under 45 CFR 144.103.

States can elect to extend the non-enforcement policy for shorter periods than outlined above.[6] States may also apply the non-enforcement policy to fewer market reform provisions than outlined above but may not extend it to additional provisions. Furthermore, states may choose to adopt the extended non-enforcement policy 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.

Under the extended non-enforcement policy, health insurance coverage in the individual or small group market that meets the criteria of the extended non-enforcement policy and associated group health plans of small businesses, as applicable, will not be treated by CMS as out of compliance with the market reforms as specified above. Health insurance issuers that renew coverage under this extended non-enforcement policy, must, for each policy year, provide the relevant attached notice to affected individuals and small businesses as specified in previously issued guidance.[7]

All health insurance coverage subject to this non-enforcement policy that has rate increases subject to review under PHS Act section 2794 should use the rules and processes for submission to states and CMS that were updated April 9, 2018,[8] to ensure compliance with PHS Act section 2794 requirements.

IV. Where to get more information

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

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[6] Following enactment of the Protecting Affordable Coverage for Employees Act (Pub. L. 114-60), the non-enforcement policy in the March 5, 2014 guidance for certain eligible large employers no longer applies. However, states that elect to expand the definition of small employer to 1-100 employees may, under State law authority, choose to provide transition relief to those employers, as appropriate.

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

[8] Centers for Medicare & Medicaid Services, "Rate Review Justification (RRJ) Reporting Requirements for Transitional Plans" (April 9, 2018), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-RRJ-Instructions.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, 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.][9]

[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.

[9] The bracketed 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, you may keep your existing coverage for the upcoming policy year.

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- 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).
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