



ADMINISTRATIVE NOTICE: 2014-03

Date: April 23, 2014

To: Health Insurance Providers / Issuers

From: Insurance Commissioner

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

Subject: Extended Transition to Affordable Care Act-Compliant Policies

On November 27, 2013, The CNMI Office of the Insurance Commissioner, issued a bulletin adopting the transitional policy announced on November 14, 2013 from Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight (“CMS/CCIIO”)¹. This notice is to confirm the CNMI Office of the Insurance Commissioner is adopting² the newly released transition policy from CMS/CCIIO, dated March 5, 2014 – attached for easy reference.

All health insurance issuers may choose to continue coverage eligible for the transitional policy and renew such policies at any time through October 1, 2016, and affected individuals and small businesses³ may choose to re-enroll in such coverage through October 1, 2016. Such policies will not be considered to be out of compliance with certain provisions of the Patient Protection and Affordable Care Act⁴. Please note that coverage which has already been converted to ACA compliance cannot be retroactively made non-ACA compliant.

Health insurance issuers that choose to 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 the November 14, 2013 bulletin from CMS/CCIIO and reiterated in the March 5, 2014 transitional policy extension bulletin⁵. In order to fairly and efficiently regulate health insurance, the Insurance Commissioner must be aware of all plans that are being renewed under the transitional policy.

¹ See CNMI Insurance Commissioner’s Administrative Notice 2013-5 “CMS Transitional Policy for Individual and Small-group Health Plans,” issued on November 27, 2013

² PL 18-34 section § 7638 Extended powers of the CNMI Insurance Commissioner

³ 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.

⁴ See Administrative Notice 2013-5 for a list of these provisions.

⁵ Because these are required standard notices that cannot be modified, the Paperwork Reduction Act does not apply to these notices.

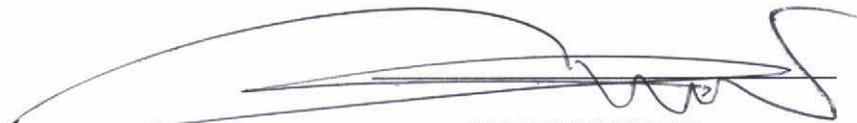
If an issuer choosing to renew coverage for any eligible policies, the following must be submitted to the CNMI Insurance Commissioner's office, either in person or by mail, no later than 10 days from the issuance of this notice and within 1 month of the start date of every applicable policy year subsequent.

- Documentation of the name of the plan, summary of benefits, rates, and the current number of covered lives on the plan
- Proof that the appropriate model notices were issued to affected individuals and small businesses whose plans are reinstated or renewed under the transitional policy (including those who will be considered small businesses in 2016)
- An attestation confirming compliance with this Administrative Notice.

The above documents are notice filings only and are not subject to prior approval. However, if these documents are not submitted by the deadline, the plan will become ineligible for the transitional policy relief.

When reviewing the compliance of plans with local and federal laws, the Commissioner must know which laws a specific plan is subject to in order to make an accurate and fair determination of compliance; therefore, if these documents are not submitted by the deadline, the plan will be ineligible for the transitional policy relief.

This administrative notice is intended only to clarify how the CNMI Insurance Section will adopt the transitional policy extension announced by CCIIO CMS/CCIIO on March 5, 2014. For additional guidance, previous notices and frequently asked questions are attached. This notice has been issued for informational purposes and does not constitute legal advice.

A handwritten signature in black ink, appearing to read 'Sixto K. Igisomar', written over a horizontal line.

SIXTO K. IGISOMAR
CNMI INSURANCE COMMISSIONER



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 2974 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 February 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).⁴

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 about this notice, please contact us.

Or contact the CNMI Consumer Assistance Program for more information on your rights as a health insurance consumer at (670) 664-3005 or advocacyoffice@commerce.gov.mp

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 February 2014, you may keep your existing coverage for the upcoming policy year.

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- 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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[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.]

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