



## Option for Some to Renew Policies That Do Not Fully Meet ACA Standards

Updated March 2019

In the fall of 2013, the Department of Health and Human Services (HHS) announced a [transitional relief program](#) that allowed state insurance departments to permit early renewal at the end of 2013 of individual and small group policies that do not meet the “market reform” requirements of the Patient Protection and Affordable Care Act (ACA) and for the policies to remain in force until their new renewal date in late 2014.

On March 5, 2014, HHS released a [Bulletin](#) that extended transitional relief to permit renewals as late as October 1, 2016, allowing plans to remain in force until as late as September 30, 2017. On February 29, 2016, HHS released another [Bulletin](#) to permit renewals until October 1, 2017, with a termination date no later than December 31, 2017. On February 23, 2017, HHS released another [Bulletin](#) in which it re-extended its transitional policy to permit renewals with a termination date no later than December 31, 2018. On April 9, 2018, HHS released another [Bulletin](#) in which it re-extended its transitional policy to permit renewals with a termination date no later than December 31, 2019. On March 25, 2019, HHS released another [Bulletin](#) in which it re-extended its transitional policy to permit renewals with a termination date no later than December 31, 2019, provided that all such coverage comes into compliance with the specified requirements by January 1, 2021.

The primary market reforms are the requirements that policies include the 10 essential health benefits, be valued at the “metal levels” (platinum 90%, gold 80%, silver 70%, or bronze 60%), and be community rated (which means that rates may only be based on age with a 3:1 limit, smoking status with a 1.5:1 limit, rating area and whether dependents are covered). Under the ACA, all non-grandfathered group health plans must ensure that annual out-of-pocket cost sharing (for example, deductibles, coinsurance and copayments) for in-network essential health benefits does not exceed certain limits; in February 2015, HHS clarified that the out-of-pocket limits apply to each individual, even those enrolled in family coverage.

Not all existing policies automatically may or will be renewed. In addition to permission from the federal government, both the state insurance department and the insurance company must agree to renew these non-compliant policies. A list of state decisions as of September 2018 is available at [healthinsurance.org](http://healthinsurance.org).

States and insurers have the option to include some of the market reform requirements that the federal government says may be disregarded. States had the option to allow renewals of individual policies only, small group policies only, or both types of policies, and to allow this for 2015 only or for both 2015 and

2016. In 2016, these market reforms started to apply to mid-size employers (those with 50 to 100 employees) so states had the option to allow renewal of existing policies to those employers as well.

### Requirements that Apply to Plans Renewed Under This Exception

Requirement	Applies to Non-grandfathered Renewed Non-compliant Plans	Applies to Grandfathered Plans	Applies to Fully ACA-Compliant Plans
Essential health benefits (EHBs) must be offered	No	No	Yes
Must meet metal levels (60%, 70%, 80%, 90%) except for catastrophic plans	No	No	Yes
Modified community rating	No	No	Yes
Out-of-pocket may not exceed \$7,900/\$15,800	Yes	No	Yes
Nondiscrimination in health care providers	No	No	Yes
Guaranteed issue and renewal	Pre-2014 rules apply (participation and contribution requirements allowed)	Pre-2014 rules apply (participation and contribution requirements allowed)	Yes
Single risk pool	No	No	Yes
Annual and lifetime dollar limits prohibited on essential health benefits	Yes	Yes	Yes
Protections for those in clinical trials	No	No	Yes
Dependent to age 26 coverage	Yes	Yes	Yes
Nondiscrimination based on health status	Pre-2014 rules apply	Pre-2014 rules apply	Yes
Small business tax credit	Not available	Not available	Yes (in SHOP)
HRAs must integrate with a group medical plan	Yes	Yes	Yes
Health insurer provider tax (indirect obligation) *	Yes (insurer will report and pay)	Yes (insurer will report and pay)	Yes (insurer will report and pay)
Transitional reinsurance fee **	Yes (insurer will report and pay)	Yes (insurer will report and pay)	Yes (insurer will report and pay)
Penalties apply if employer doesn't offer coverage to employees who average 30 or more hours/week	Not unless employer has 50 or more employees within the controlled group	Not unless employer has 50 or more employees within the controlled group	Not unless employer has 50 or more employees within the controlled group
Penalties apply if employer doesn't offer affordable, minimum value (60%) coverage to employees	Not unless employer has 50 or more employees within the controlled group	Not unless employer has 50 or more employees within the controlled group	Not unless employer has 50 or more employees within the controlled group

<b>Requirement</b>	<b>Applies to Non-grandfathered Renewed Non-compliant Plans</b>	<b>Applies to Grandfathered Plans</b>	<b>Applies to Fully ACA-Compliant Plans</b>
Report to IRS regarding affordable, minimum value coverage	Not unless employer has 50 or more employees	Not unless employer has 50 or more employees	Not unless employer has 50 or more employees
Cadillac tax ***	Yes	Yes	Yes
Nondiscrimination (highly compensated)	Yes (once rules are issued)	No	Yes (once rules are issued)
First dollar coverage for preventive care	Yes	No	Yes
Patient protections on choice of provider and emergency room	Yes	No	Yes
Claims and appeals requirements	Yes	No	Yes
MLR rebates must be distributed	Yes	Yes	Yes
Summaries of Benefits and Coverage (SBCs) required	Yes	Yes	Yes
W-2s must include the cost of health coverage	Not unless employer issued more than 250 W-2s in prior calendar year	Not unless employer issued more than 250 W-2s in prior calendar year	Not unless employer issued more than 250 W-2s in prior calendar year
Patient-Centered Outcomes Research Institute (PCORI) fee due †	Yes (insurer will report and pay on medical; employer will report and pay on any HRA)	Yes (insurer will report and pay on medical; employer will report and pay on any HRA)	Yes (insurer will report and pay on medical; employer will report and pay on any HRA)

\* Health insurer provider tax is suspended for the 2019 fee year (2018 data year).

\*\* Transitional reinsurance fee only applies for the 2014, 2015, and 2016 benefit years.

\*\*\* Cadillac tax effective date is delayed until January 1, 2022.

† PCORI fee does not apply for plan years ending after September 30, 2019.

All newly-issued policies must meet all of the ACA requirements.

Insurers that choose to renew existing policies must send a notice to all individuals and small businesses each year that explains:

- Any changes in the options that are available to them
- Which of the market reforms would not be included in the renewed policy
- The person's potential right to enroll in a qualified health plan offered through a health insurance Marketplace and possibly qualify for financial assistance
- How to access coverage through a Marketplace
- The person's right to enroll in health insurance coverage outside of a Marketplace that complies with the market reforms

Renewed policies will satisfy the individual's requirement to have "minimum essential" coverage. It appears that each renewed policy will need to be evaluated to determine whether it meets minimum value (60%). Access to affordable, minimum value coverage through an employer will make the individual ineligible for a premium tax credit/subsidy. Rate increases will need to be reported, and in some cases reviewed.

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