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

Updated February 2020

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 Bulletin in which it re-extended its transitional policy to permit renewals with a termination date no later than December 31, 2020.

On January 31, 2020, HHS released another Bulletin in which it re-extended its transitional policy to permit renewals with a termination date no later than December 31, 2021, provided that all such coverage comes into compliance with the specified requirements by January 1, 2022.

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 January 2020 is available at 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 (indexed)	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 (except for QSEHRAs and ICHRAs)	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

Requirement	Applies to Non-grandfathered Renewed Non-compliant Plans	Applies to Grandfathered Plans	Applies to Fully ACA-Compliant Plans
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
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
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 250 or more W-2s in prior calendar year	Not unless employer issued 250 or more W-2s in prior calendar year	Not unless employer issued 250 or more 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 was suspended for 2017 and 2019. The tax is repealed effective January 1, 2021.
** Transitional reinsurance fee only applied for the 2014, 2015, and 2016 benefit years.
† PCORI fee does not apply for plan/policy years ending after September 30, 2029.

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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