



# South Carolina Department of Insurance

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## BULLETIN NUMBER 2014-05 *Addendum B to Bulletin 2013-12*

TO: All Insurers Licensed to Transact Accident and Health Insurance Business within the State of South Carolina and All South Carolina Licensed Health Maintenance Organizations (collectively "Health Insurance Issuers")

FROM: Raymond G. Farmer  
Director of Insurance 

SUBJECT: Addendum B to Bulletin 2013-12 to Address the Federal Extension of the Transitional Policy for Health Insurance Issuers with Non-Grandfathered Health Insurance Coverage in the Individual Market and/or the Small Group Market, Application of the Transitional Policy to Current Large Groups with 51 to 100 Employees, and Special Request for Data from Health Insurance Issuers in the Individual, Small Group, and Large Group Markets

DATE: April 14, 2014

### I. PURPOSE

On November 14, 2013, the Center for Consumer Information and Insurance Oversight (CCIIO) issued a letter to state Insurance Commissioners outlining a temporary reprieve for non-grandfathered coverage in the small group and individual health insurance markets that would otherwise be modified, canceled, terminated, or non-renewed as a result of the 2014 market reforms provided for in the Patient Protection and Affordable Care Act (transitional policy). The transitional policy, as originally announced, applied to non-grandfathered health insurance coverage in the individual or small group market that was in force on October 1, 2013 and permitted such coverage to be renewed between January 1, 2014 and October 1, 2014 without complying with certain market reforms. In response, the South Carolina Department of Insurance (Department) issued Bulletin 2013-12 on November 19, 2013 to set forth the requirements for issuers wishing to extend coverage pursuant to the initial transitional policy. Following CCIIO's issuance of mandatory notice requirements on November 21, 2013, the Department issued Addendum A to Bulletin 2013-12 on November 25, 2013.

On March 5, 2014, CCIIO issued a bulletin extending the temporary reprieve for an additional two years – to plan or policy years beginning on or before October 1, 2016 (transitional policy extension). The transitional policy extension applies to any non-grandfathered health insurance coverage in the individual or small group market that was in effect prior to January 1, 2014. Additionally, the March 5, 2014 bulletin provided a temporary reprieve for groups with 51-100 employees that are scheduled to be re-classified from the large group market to the small group market as of the first plan year beginning on or after January 1, 2016.

The purpose of this bulletin is to set forth requirements for issuers wishing to extend existing coverage under impacted health plans. Further, the bulletin will describe procedures for filing any necessary amendments to existing policy forms, rates and consumer disclosures. Finally, the bulletin includes a special call for data relating to non-grandfathered health insurance coverage that is currently in existence in the individual, small group, and large group markets in South Carolina.

Given that the transitional policy and transitional policy extension provide that the federal government will not enforce certain requirements on these policies for a period of time, South Carolina declines to enforce the 2014 market reforms that the federal government will not enforce for these specific policies. South Carolina will instead enforce its own laws during this transitional period extension.

## **II. APPLICABILITY AND SCOPE**

For purposes of this bulletin, the terms “health insurance issuer” or “issuer,” “health insurance coverage,” “small group market,” and “individual market” shall have the meaning set forth in South Carolina Code of Laws §38-71-670 and §38-71-840. The definition of individual market and small group market are as amended on October 18, 2011 (*see* Bulletin 2011-11).

This bulletin applies to health insurance issuers offering health insurance coverage in the individual and small group markets with coverage in effect on or before December 31, 2013. It, further, applies to health insurance issuers offering health insurance coverage in the large group market as it relates to groups that are subject to the expansion of the small group market effective January 1, 2016.

This bulletin is not applicable to grandfathered health insurance plans or excepted benefit plans. It also does not apply to plans that are compliant with the 2014 market reforms (i.e. 2014-compliant plans).

Unless superseded by this bulletin, the standards set forth in Bulletin 2013-12 (November 19, 2013) and Addendum A to Bulletin 2013-12 (November 25, 2013) continue to remain in effect as applicable.

## **III. TRANSITIONAL POLICY EXTENSION**

The transitional policy has been extended to permit issuers in the individual and small group markets to renew non-grandfathered policies that had plan or policy years beginning on or before December 31, 2013. The transitional policy extension does not impose the original requirement that coverage had to be in effect on October 1, 2013, meaning that individual and small group policies issued or renewed with coverage effective dates between October 2, 2013 and December 31, 2013 are now included in the transitional policy. Such coverage may now be renewed for a plan or policy year starting between January 1, 2014 and October 1, 2016, meaning that it could stay in effect until October 1, 2017 (depending upon the renewal date) without being considered noncompliant with certain federal requirements. The details of the policy are set forth in Bulletin 2013-12 and Addendum A to Bulletin 2013-12. A copy of the March 5, 2014 CCIIO notice extending the period is attached to this guidance and labeled as Appendix E.

The March 5, 2014 notice also applies to businesses with 51 to 100 employees that are currently defined as part of the large group market. Effective January 1, 2016, Section 1304(b) of the Patient Protection and Affordable Care Act defines “small employer” as “...an employer who employed... at least 1 but not more than 100 employees...,” effectively expanding the small group health insurance market from the current size (2-50) to 2-100 employees. Health insurance issuers providing coverage for these businesses will now have the option of renewing these businesses in their current, large group, policies for policy years beginning on or before October 1, 2016, meaning that it could stay in effect until October 1, 2017 (depending upon the renewal date) without

these policies being considered noncompliant with the provisions of the ACA that apply to the small group market but not the large group market.

It is important to note that the above provisions only apply to non-grandfathered policies in the individual, small group, and large group (51-100 employees) market that were purchased and for which coverage became effective prior to January 1, 2014. This policy is not applicable to any policy that has been converted to be compliant with the 2014 market reforms or to any newly issued coverage under a 2014-compliant plan. This transitional policy extension is, further, only applicable to renewals of non-grandfathered policies on a prospective basis.

#### **IV. SOUTH CAROLINA DEPARTMENT OF INSURANCE REQUIREMENTS**

This most recent announcement could cause some market confusion. The Department plans to take the action necessary to prevent any further market disruption in accordance with the requirements set forth below.

##### *Individual and Small Group Markets*

The Department is amending Bulletin 2013-12 to permit issuers to offer consumers the option to renew non-grandfathered coverage under the extended transitional policy through October 1, 2016 for both the individual and small group markets. This applies to any policy in the individual or small group market that had an effective date on or before December 31, 2013 and remains in effect until its renewal date. It does not apply to any policy that has been canceled, terminated, amended, converted, or otherwise superseded by a 2014-compliant plan as it is strictly an offer to renew existing coverage on a prospective basis through October 1, 2016.

Issuers that elected to offer renewals of non-grandfathered coverage pursuant to Bulletin 2013-12 may continue to offer such renewal on or before October 1, 2016 for their affected insureds by notifying the Department of their intention to participate in the transitional policy extension and complying with the notice and special reporting requirements below. To fall within this category, the health insurance issuer must be one of the eleven issuers identified on the list of Companies Participating in Transitional Relief, which was posted to the Department's website in January 2014 and is attached as Appendix F.

Some issuers decided not to offer renewal of non-grandfathered coverage under the initial transitional policy. These issuers may have had non-grandfathered policyholders that were not given the option to renew their existing coverage between January 1, 2014 and today. The Department is concerned about the impact upon consumers of their participation going forward under this extension of the transitional policy. It is the Department's intent, however, to permit as many consumers as possible to have the option to keep their existing coverage should they wish to do so. As such, these issuers will not automatically be permitted to adopt the transitional policy but, instead, may apply to the Department for approval to participate under the extension. However, issuers must be able to clearly demonstrate that their participation under the extension would not result in any unfairly discriminatory treatment of their policyholders. The application should include any information that would assist the Department in making such a determination.

##### *Groups of 51-100 Employees*

The Department will permit issuers to offer renewals of large group coverage to businesses that currently purchase insurance in the large group market but that, for plan or policy years beginning on or after January 1, 2016, will be redefined for purposes of purchasing insurance such that they would otherwise be required to purchase health insurance coverage meeting the 2014 market reforms applicable to the small group market. These businesses may be offered the opportunity to renew their existing, large group-compliant coverage for plan or policy years between January 1, 2016 and October 1, 2016.

The Department has received inquiries regarding the application of the transitional policy extension to large groups with 51 to 100 employees prior to January 1, 2016. These inquiries have centered around whether the transition policy extension permits current, non-grandfathered plans in the large group market with 51 to 100 employees to be renewed without coming in to compliance with the Public Health Service (PHS) Act sections that are listed in the transitional policy extension. Many of these provisions do not apply to the large group market, but there may be a small subset of these sections that do apply, such as Sections 2706 (non-discrimination in health care), 2707 (annual limitation on cost sharing), and 2709 (coverage for individuals participating in approved clinical trials). We have sought clarification from CCIIO and have been advised that the transitional policy extension does not exempt groups with 51 to 100 employees from the 2014 market reforms that already apply to the large group market. As such, these groups must comply with the 2014 market reforms that otherwise apply to the large group market for any plan or policy year beginning on or after January 1, 2014. However, these groups may renew their coverage between January 1, 2016 and October 1, 2016 without coming into compliance with certain federal requirements that apply to the small group market but not to the large group market.

Large group issuers seeking to offer such renewals must notify the Department of their intention to participate in the transitional policy extension and comply with the notice and special reporting requirements below.

#### Issuer's Decision Must Be Applied in a Uniform, Non-discriminatory Manner

Issuers wishing to continue coverage pursuant to the extension of the transitional policy shall make the election to follow the transitional policy on a market-wide basis, offering renewal coverage to all impacted policyholders in the individual market, small group market, and/or large group market as it applies to such groups with 51-100 employees. This offer must be made in a uniform and non-discriminatory manner. The issuer should document their actions in this regard so as to ensure compliance with South Carolina law.

#### Notice to Impacted Individuals and Related Requirements

Under the extended transitional policy, health insurance coverage in the above specified markets that meet the criteria specified in this bulletin series will not be considered to be out of compliance with the market reforms identified in Bulletin 2013-12 (*see* Section III, Page 2). Issuers that offer to renew coverage under this policy must, for each plan or policy year beginning on or before October 1, 2016, provide notice to impacted individuals that informs them of (1) the opportunity to renew their existing coverage; (2) major provisions in the 2014 market reforms that will not be reflected in their existing coverage should it be renewed; (3) their potential right to enroll in 2014-compliant coverage on or off the Federally-facilitated Marketplace or Federally-facilitated SHOP and the possibility to qualify for federal subsidies; and (4) how to access coverage on and off the FFM or FF-SHOP.

The Department set forth a sample notice as Appendix C to Bulletin 2013-12 to assist issuers in developing a notice that meets federal requirements but is issuer-specific in an effort to limit consumer confusion. Addendum A to Bulletin 2013-12 advised participating insurers that the federal, standardized notices detailed in the November 21, 2013 CCIIO notice would not be required for South Carolina issuers. Following the March 5, 2014 CCIIO guidance that would again require these standardized notices of issuers participating in the transitional policy extension, the Department again advised CCIIO leadership of its objections to utilizing standardized notices and, further, the potential to cause even greater uncertainty for consumers and participating issuers. As such, issuers are advised that neither South Carolina nor CCIIO will be requiring or enforcing the federal notice(s) required under the March 5, 2014 guidance. Carriers should proceed under the guidance issued by this Department via this bulletin series.

Carriers that previously elected to participate in the transitional policy have already gone through the process to get their notices approved. These notices may require some updating in order to continue to be relevant under this transitional policy extension. The Department will work each carrier directly to address any changes that need to be approved for said notices.

Carriers that did not initially participate in the transitional policy will be required to submit notices for approval as a part of the application process to participate in this extension of the transitional policy.

Carriers that elect to participate in the transitional policy as it relates to groups of 50 – 100 employees will be required to draft notices for these groups and submit these to the Department for approval during the 2015 calendar year.

As opposed to the “opt-in” method utilized in the federal, standardized notices whereby policyholders are directed to contact the issuer in order to continue their existing coverage, carriers are encouraged to develop a process through which consumers may elect to keep their current policy simply by continuing to pay their premium (i.e., an “opt-out” approach). The Department further suggests that carriers consider developing a hot line for consumers with questions regarding the transitional policy. Irrespective of the implementation of a dedicated hot line, a phone number, preferably a toll-free number, must be identified in any notice to consumers along with additional contact information (e.g., email address) for consumer questions. Finally, carriers are encouraged to educate their agents on the details regarding this transitional policy so that they may also be of assistance to impacted consumers.

Given the significant extension of the transitional policy period and the impact of such renewal offers on the ability of consumers to select a 2014-compliant plan, notices should be issued well in advance of the renewal date in order to allow consumers greater time to make a decision to renew their existing coverage or move to a 2014-compliant plan. As such, the Department encourages issuers to send notices up to 90 days in advance of the renewal date.

Carriers must maintain documentation that notice required under this provision is provided to all impacted individuals as a part of its documentation that such renewals are being offered in a uniform, non-discriminatory fashion.

## **V. NOTICE TO DOI OF ISSUER’S DECISION REGARDING THE TRANSITIONAL POLICY EXTENSION AND SPECIAL REPORT OF RELATED DATA**

All issuers in the individual, small group, and large group markets must inform the Department of whether or not they intend to extend coverage pursuant to the extension of the transitional policy described in Sections III and IV of this bulletin.

In order for the Department to gauge the impact of the transitional policy extension on the market, this notice should detail the information set forth below.

- Name of Underwriting Issuer;
- Transitional Policy Participation by Market Segment:
  - Individual Market (Yes, the issuer will participate/ No, the issuer will not participate);
  - Small Group Market (Yes, the issuer will participate/ No, the issuer will not participate); and
  - Large Group Market (As it relates to those groups with 51-100 employees: Yes, the issuer will participate / No, the issuer will not participate);
- Number of Lives by Market Segment Covered Under Policies Subject to the Transitional Policy Extension:
  - Individual Market;
  - Small Group Market; and
  - Large Group Market (51-100 Employees);
- Name and Contact Information for Primary Point of Contact; and
- *If carrier did not participate in the initial transitional policy*, Information Necessary to Grant Participation (as outlined under the Individual and Small Group Markets subheading of Section III on page 3).

The Department may, further, require carriers to submit periodic reports relating to their non-grandfathered population throughout the period covered under the transitional policy extension.

The above information is requested under the Department's authority to require special reports pursuant to S.C. Code of Laws §38-13-160. In order to effectively assist consumers that will undoubtedly have an interest as to whether or not they may continue their existing coverage, the Department does plan to release information relating to carrier participation that, at a minimum, will include the names of the carriers that will be offering policyholders the option to renew their non-grandfathered coverage through the extension period. However, the data requested relating to the number of covered lives will not be released at a carrier-specific level as §38-13-160 requires the Department to keep replies strictly confidential. If any data is released, it will only be on an aggregate level by market segment. Any additional information provided by the issuer that the issuer believes to be proprietary, trade secret, or otherwise not releasable pursuant to the South Carolina Freedom of Information Act must clearly be marked as such.

These responses, and any questions related to this special reporting requirement, should be submitted via email to [healthdata@doi.sc.gov](mailto:healthdata@doi.sc.gov) with the subject matter: "Non-grandfathered Health Plans." ***The Department requests that this information be submitted no later than Monday, April 28, 2014 regardless of whether or not the issuer intends to extend coverage pursuant to this transitional policy.*** If the issuer is unable to make a final determination or produce the required information by that date, the issuer should notify the Department as such and the Department will work with the issuer on an individual basis as necessary. Please note that this reporting deadline does not apply to the submission of the necessary form and/or rate filings associated with this determination.

## **VI. FILING REQUIREMENTS AND EXPEDITED FILING REVIEW PROCESS**

The Department appreciates that issuers may not have filed forms and/or rates to continue non-grandfathered health insurance plans through the extended transition period. As such, the Department will make every effort to expedite the filing review process for any filings needed in order to extend coverage to impacted consumers that have coverage that would otherwise be modified, terminated or canceled after the expiration of the initial transitional period. What follows are the guidelines for such filings.

### *Policy Form Changes and Notices to Policyholders*

The Department does not anticipate the need for substantial changes to policy forms pursuant to this transitional policy as the majority of these health plans should be non-grandfathered health plans that already comply with the ACA Immediate Market Reforms (as detailed in Bulletin 2013-04, available online at <http://doi.sc.gov/DocumentCenter/View/3040>). The Department recognizes that changes may need to be made to policy forms to address certain items such as annual limits on EHBs, waiting periods of greater than 90 days, or federal mental health parity requirements pursuant to final rules that are effective for plan or policy years beginning on or after July 1, 2014.

Should such changes need to be made, the issuer should submit a form filing to amend the underlying policy form(s) via endorsement and include the following in the filing cover letter:

1. a list of the underlying form(s) to be amended and the state tracking number(s) for the underlying form(s);
2. an explanatory memorandum that details the changes to the underlying form(s);
3. provide a copy of the underlying policy form(s) for reference purposes; and
4. details of any variability in the form(s) being submitted for approval.

According to the CCIIO letter, there is the possibility that the transitional policy may be extended beyond the January 1, 2014 – October 1, 2016 time period. That, coupled with the limited duration of this transitional relief, does not necessitate the amendment of the renewability or termination provisions in the underlying contract. In

lieu of amending these provisions, the issuer can provide notice of the temporary nature of this renewal of coverage via the notice to impacted individuals provided for above.

Issuers are required to provide notice to impacted individuals of the opportunity to renew their coverage under this transitional policy. Issuers should follow the guidance under the “Notice to Impacted Individuals and Related Requirements” subheading of Section IV in this guidance. A final copy of the notice(s) with issuer-specific changes should be provided to the Department as a part of any form and/or rate filing for review and/or approval.

### Rate Changes

Any rate requests shall be made pursuant to Bulletin 2011-03 (<http://doi.sc.gov/DocumentCenter/View/2765>) or Bulletin 2011-11 (<http://doi.sc.gov/DocumentCenter/View/2773>), as applicable. Policies subject to the transitional relief are not considered to be out of compliance with Section 1312(c) of the Patient Protection and Affordable Care Act (relating to the single risk pool requirement).

Rate filing requests below the “unreasonable” threshold established by the U.S. Department of Health and Human Services need not be submitted in HIOS, but may be submitted via SERFF only. A supporting actuarial memorandum must be provided as a part of any rate filing.

### General Requirements Applicable to Form and/or Rate Filings under this Bulletin

All filings must be made via SERFF. In addition to the specified items above, the following information must be included with the filing:

1. Filing Description – The filing description must clearly state that the filing has been made to enable the continuation of coverage pursuant to the transitional policy. In addition, the filing description must clearly state whether or not any changes have been made to the form and whether or not rates are impacted by the filing;
2. Cover Letter – The Cover Letter should detail the items noted above as well as any supporting documentation provided for in the filing (e.g., copies of underlying policy form(s));
3. Sample Policyholder Notice(s);
4. Completed Form Schedule Tab (if applicable);
5. Completed Rate/ Rule Schedule Tab (if applicable); and
6. Retaliatory Filing Fees (if applicable).

Issuers are encouraged to submit filings as quickly as possible in order to provide consumers with options as soon as possible. Filings following the requirements of this bulletin and containing the information outlined above will be subject to an expedited review process and will be processed as quickly as practical. Upon submission of a filing pursuant to this bulletin, issuers should submit an email to [healthdata@doi.sc.gov](mailto:healthdata@doi.sc.gov) with the subject matter: “Filing # [INSERT STATE FILING # HERE]” to advise of the submission of the filing in order to be identified quickly as being subject to expedited review.

***By submission of a filing pursuant to this bulletin, the issuer acknowledges that it will comply with the requirements of this bulletin series, including the provisions applicable to providing notice to all impacted parties and to act in a uniform, non-discriminatory manner by offering renewal to all impacted policyholders in a market.***

## **VII. EFFECTIVE DATE**

This bulletin is effective immediately.

## VIII. QUESTIONS

Questions regarding this bulletin should be submitted via email to [healthdata@doi.sc.gov](mailto:healthdata@doi.sc.gov) and include the company name and primary point of contact (with phone number and email address) for follow up.

## IX. LINKS TO REFERENCE MATERIALS

1. [SCDOI Bulletin 2013-12](#): Transitional Policy for Health Insurance Issuers with Health Insurance Coverage in Effect in the Individual Market and/or the Small Group Market on October 1, 2013 and Special Request for Data from Health Insurance Issuers in the Individual, Small Group, and Large Group Markets (November 19, 2013)  
*Web Address: <http://doi.sc.gov/DocumentCenter/View/7287>*
2. [Addendum A](#) to SCDOI Bulletin 2013-12: Addendum to Bulletin 2013-12 to Address the Federal Guidance Specific to Required Notices to Impacted Policyholders (November 25, 2013)  
*Web Address: <http://doi.sc.gov/DocumentCenter/View/7306>*

*Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are Departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.*

***CCIO BULLETIN  
DATED MARCH 5, 2014***

***(SEE THE FOLLOWING SEVEN PAGES)***

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**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;<sup>1</sup>
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage);

<sup>1</sup> 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.<sup>2</sup>

All transitional policies that have rate increases subject to review under PHS Act section 2794 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.<sup>3</sup> 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](mailto:marketreform@cms.hhs.gov).

<sup>2</sup> Because these are required standard notices that cannot be modified, the Paperwork Reduction Act does not apply to these notices.

<sup>3</sup> 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 March 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).

### **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.]<sup>4</sup>

[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](http://HealthCare.gov) or call 1-800-318-2596 or **TTY: 1-855-889-4325**.

If you have questions, please contact us.

<sup>4</sup> 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 March 2014, you may keep your existing 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.]<sup>5</sup>

[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](http://HealthCare.gov) or call 1-800-318-2596 **or TTY: 1-855-889-4325**.

If you have questions, please contact us.

<sup>5</sup> The bracket language does not apply to the U.S. territories that do not have a Marketplace.

***SCDOI'S LIST OF COMPANIES  
PARTICIPATING IN TRANSITIONAL RELIEF  
ISSUED JANUARY 2014***

*(SEE THE FOLLOWING PAGE)*

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## COMPANIES PARTICIPATING IN TRANSITIONAL RELIEF

*In November 2013, a temporary reprieve was announced to permit the renewal of non-grandfathered health insurance plans that would otherwise be modified or terminated as a result of the 2014 market reforms provided for in the Patient Protection and Affordable Care Act. The South Carolina Department of Insurance worked with carriers to prevent further market disruption and provide guidance to issuers interested in participating in this transitional relief policy. As a result of this action, 11 carriers with non-grandfathered policies covering 143,000 individuals in South Carolina elected to participate in transitional relief. Below is a listing of companies (including phone numbers for consumer inquiries) that have elected to participate in the transitional relief plan and, thus, will offer individual and/or small group policyholders the opportunity to renew their non-grandfathered health plan for an additional year. Pursuant to federal requirements, this offer is only applicable to non-grandfathered health plans that were in effect as of October 1, 2013 and that are renewed between January 1 and October 1, 2014.*

*Tips for Consumers: Participating carriers are required to provide notice to policyholders of the opportunity to renew their coverage under this transitional policy, so consumers should expect to hear directly from their carrier if they are offering renewal of non-grandfathered plans. Consumers are encouraged to contact their carrier with questions regarding whether they may continue their existing coverage. The Department's Office of Consumer Services may be reached at 1 (800) 768-3467 for assistance.*

<b>COMPANY NAME, CONTACT INFORMATION</b>	<b>MARKET SEGMENT(S)</b>
<b>BlueCross BlueShield of South Carolina</b> For Individuals: 1 (800) 868-2500 ext. 46401 For Small Groups: 1 (800) 868-2500 ext. 41010	<b>Individual &amp; Small Group</b>
<b>BlueChoice Health Plan of South Carolina</b> 1 (866) 280-0766	<b>Individual &amp; Small Group</b>
<b>Connecticut General Life Insurance Company*</b> 1 (877) 345-6756	<b>Individual</b>
<b>Golden Rule Insurance Company*</b> 1 (800) 657-8205	<b>Individual</b>
<b>Humana Insurance Company*</b> 1 (877) 222-0650	<b>Individual</b>
<b>John Alden Life Insurance Company</b> 1 (800) 328-4316	<b>Small Group</b>
<b>Mid-West National Life Insurance Company</b> 1 (800) 527-5504	<b>Individual</b>
<b>The MEGA Life and Health Insurance Company</b> 1 (800) 527-5504	<b>Individual</b>
<b>Time Insurance Company</b> 1 (800) 328-4316	<b>Small Group</b>
<b>UnitedHealthcare Insurance Company</b> 1 (888) 842-4571	<b>Small Group</b>
<b>UnitedHealthcare Insurance Company of the River Valley</b> 1 (877) 369-1202	<b>Small Group</b>

*\*The companies marked with an asterisk (\*) have amended their policy forms to set a standardized policy year that begins sometime in December 2013. Policyholders should receive notice of the amendment directly from the company.*