STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

Order No. 16-013-M

Affordable Care Act
Transitional Policy Extension
_____/

Issued and entered
this 25th day of March 2016
by Patrick M. McPharlin
Director

ORDER REGARDING FINAL EXTENSION OF AFFORDABLE CARE ACT TRANSITIONAL POLICY

In 2013 and 2014, the Centers for Medicare & Medicaid Services (CMS) issued a series of guidance documents offering a multi-phase "transitional policy" that would allow non-grandfathered individual and small group insurance plans additional time to comply with several Affordable Care Act (ACA) market reforms. The Director of the Department of Insurance and Financial Services (DIFS) has adopted each phase of the transitional policy. See Order No. 13-055-M; Order No. 14-015-M; Order No. 15-012-M (rescinded); and Order No. 15-044-M.

On February 29, 2016, CMS again issued guidance allowing a final extension of the transitional policy (Final Transitional Period). Under the Final Transitional Period, individual and small group[1] plans that have been continuously renewed under the previous transitional periods and have been continuously in effect since January 1, 2014, are permitted to renew such coverage for a policy year starting on or before October 1, 2017, but only if the policy ends on or before December 31, 2017.

[1] The final extension of the transitional policy allowed by this Order applies only to individual and small group market plans. After the enactment of the Protecting Affordable Coverage for Employees Act, the transitional policy that applied to large group plans was no longer in effect. See Order No. 15-044-M, issued on October 9, 2015 (rescinding Order No. 15-012-M).

Issuers are not required to participate in the Final Transitional Period. Issuers that wish to renew their transitional plans under the Final Transitional Period must, for each policy year, provide a standard notice to affected individuals and small businesses. The required notice is appended to the CMS guidance issued on February 29, 2016, which may be found here.

Issuers that participate in the Final Transitional Period should be aware that all plans must still comply with the following four sections of the ACA and applicable federal regulations:

- Section 2711 (relating to the prohibition on annual dollar limits on essential health benefits);
- Section 2726 (relating to mental health parity requirements applicable to individual plans upon renewal on or after July 1, 2014);
- Section 2708 (relating to the prohibition on excessive waiting periods, applicable to small group plans only); and
- Section 2704 (relating to the prohibition on pre-existing conditions).

Unlike previous transitional periods, issuers that opt to implement the Final Transitional Period may allow policy years shorter than 12 months, or early renewals with a January 1, 2017 start date, as long as the policy does not remain in force beyond December 31, 2017, and is not issued for a period longer than 12 months.

THEREFORE, IT IS ORDERED that issuers may continue to renew, through December 31, 2017, individual and small group plans that have been continuously renewed under the previous transitional policies.

FURTHER, IT IS ORDERED that plans that are renewed in accordance with federal guidance and this Order will be exempt from the following ACA market reforms (although issuers are not prohibited from complying with these sections, at the issuer's option):

- 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;
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage);
- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials);
- Section 1312(c) (relating to the single risk pool requirement).

FURTHER, IT IS ORDERED that plans participating in the Final Transitional Period that are renewed in accordance with federal guidance and this Order will be exempt from the following sections of state law:

- MCL 500.2213b(4)-(6) and MCL 550.1401e(4)-(6) (relating to guaranteed renewability)[2];
- MCL 500.3428 and MCL 550.1501c (relating to network adequacy standards)[3];
- MCL 500.3472 and MCL 550.1620(2)-(4) (relating to the prohibition of pre-existing condition exclusions and the establishment of open enrollment periods), except with respect to group coverage;
- MCL 500.3474a and MCL 550.1410b (relating to permissible rating factors);
- MCL 500.3612a (relating to permissible rating factors for conversion policies);
- MCL 500.3705(b) (relating to permissible rating factors for small group policies);
- MCL 500.3712(2) (relating to guaranteed renewability for small group policies).

FURTHER, IT IS ORDERED that issuers renewing plans under the Final Transitional Period, must, for each policy year, provide the relevant CMS notice(s) to affected individuals and small businesses as specified in the February 29, 2016 CMS guidance. In addition, issuers must provide a separate notice of any rate increases to affected policyholders in accordance with state law. Both notices must be filed with DIFS.[4]

FURTHER, IT IS ORDERED that issuers adhere to the following filing requirements:

- Rates and forms must be filed via SERFF at least 60 days prior to the policy's renewal date;

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[2] Renewed plans remain subject to MCL 500.2213b(1)-(3) and MCL 550.1401e(1)-(3).
[3] Renewed plans remain subject to, if applicable, MCL 500.3530 and MCL 550.1504(1)(a).
[4] The notices of reinstatement and rate increases are subject to review, but not prior approval, by DIFS.

- Rate and form filings must be in compliance with all applicable sections of federal law and the Insurance Code of 1956, MCL 500.100 *et seq.*, and PA 350 of 1980, MCL 550.1101 *et seq.*, except as set forth in this Order;
- Form filings must include, under Forms, a copy of the applicable CMS notice(s);
- Any separate notice of rate increase sent to policyholders must be included under the Rate/Rate Schedule Tab;
- Filings must be submitted under the proper TOI- and Sub-TOI to reflect Individual or Small Group;
- Filings must be complete and appropriately designated as filing type "Transitional Rate and/or Form";
- Filings must reference the SERFF tracking number of **all** previously approved transitional rate and/or form filings in order to document policies that have been continuously renewed since 2014; and
- Filings must include an attestation, signed by an officer of the issuer, confirming compliance with this Order.

LASTLY, IT IS ORDERED that issuers choosing to renew plans in accordance with federal guidance and this Order must submit rate filings to DIFS for review and approval before any rate increase can be imposed.

Any violation of this order will result in appropriate administrative action.

Patrick M. McPharlin
Director