Guidance Regarding the Federal Health Insurance Market Rules and NYS Insurance Law in Relation to Guaranteed Availability and Renewability

The U.S. Department of Health and Human Services ("HHS") promulgated regulations that implement provisions of the federal Affordable Care Act in relation to guaranteed availability and guaranteed renewability (45 CFR Part 147). The HHS regulations differ from state law requirements in some respects. The information below is intended to provide guidance to insurers (including HMOs, unless otherwise indicated) with respect to federal and state requirements relating to guaranteed availability and renewability.

Guaranteed Availability. The HHS regulations provide that an insurer that offers health insurance coverage in the individual or group market must offer to any individual or employer in the state all approved commercial products that are offered and available for sale in the applicable market, and must accept any individual or employer that applies for any of those products, subject to permissible restrictions related to (1) open enrollment and special enrollment periods; (2) special rules for network plans; and (3) application of capacity limits. These are the only exceptions to the federal guaranteed availability rules. Any exceptions to guaranteed availability that would be permitted by state law or regulation that are broader than the federal exceptions described below are no longer permissible (*See* 42 U.S.C. § 300gg-1; 45 CFR 147.104(a)).

Any non-grandfathered health plans that were previously approved on a single case basis and are in current compliance with all applicable state and federal laws and regulations must be made generally available to any other large group that seeks that same coverage.

Minimum Participation Requirements. Minimum participation requirements in state law are preempted on application and renewal for large groups and also for small groups which apply for coverage during the annual open enrollment period. (*See* 45 CFR 147.104(b)(1)(i); 45 CFR 147.106(b)(3); N.Y. Ins. Law § 4235(c)(1)(A); N.Y. Pub. Health Law § 4406(1); and 11 NYCRR 360.3(a)(1)(ii).) Limitations and prohibitions on minimum participation requirements are described below.

- **HMOs** – Health maintenance organizations may not impose minimum participation requirements in the large group or small group markets.
- **NYSOH** – Insurers may not impose minimum participation requirements in the New York State of Health ("NYSOH").
- **Large Group Market** – Insurers may not impose minimum participation requirements on the initial offering of large group coverage. Likewise, insurers may not impose minimum participation requirements on the renewal of the coverage.
- **Small Group Market** – Insurers are strongly encouraged to refrain from imposing any minimum participation requirements in the small group market. Insurers (other than HMOs) may continue to impose minimum participation requirements in the small group market outside the NYSOH. However, if a small group cannot meet the insurer's minimum participation requirements, an insurer must still permit the group to enroll during an annual open enrollment period that begins November 15 and extends through December 15 of each year. The annual open enrollment period applies to coverage issued or renewed between November 15th and December 15th and coverage applied for between November 15th and December 15th with an effective date of January 1st. Insurers may impose minimum participation requirements on renewal outside of the open enrollment period but only to the extent the same requirements were imposed upon the group's initial application for coverage.

Open Enrollment in the Individual Market. For the 2018 plan year, the annual open enrollment period is November 1, 2017 through January 31, 2018. (*See* 45 CFR 147.104(b)(1) and N.Y. Ins. Law 4328(b)(4)(A).)

Special Enrollment Periods in the Individual Market. In addition to the annual open enrollment period, insurers in the individual market must provide a sixty-day special enrollment period after the occurrence of one of the following triggering events described below. (*See* 45 CFR 147.104(b); 45 CFR 155.420; and N.Y. Ins. Law 4328(b)(4)(A).)

- An individual gains a dependent or becomes a dependent through birth, adoption or placement for adoption or foster care, or through a child support order or other court order;
- An individual gains a dependent or becomes a dependent through marriage and the individual or the individual's spouse had minimum essential coverage for one or more days during the 60 days prior to marriage;
- An individual loses a dependent or is no longer considered a dependent through divorce, legal separation, or through the death of the individual or a dependent;
- An individual's, spouse's or dependent's enrollment or non-enrollment in another health plan is unintentional, inadvertent, or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities;
- An individual, spouse or dependent adequately demonstrates that the insurer substantially violated a material provision of its contract in relation to the enrollee;
- An individual, spouse or dependent is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;
- An individual, spouse or dependent was not previously a citizen, national or lawfully present individual and subsequently gains such status;
- If an individual, spouse or dependent is an Indian, as defined in 25 U.S.C. 450b(d), the individual, spouse or dependent may enroll in a health plan or change from one health plan to another one time per month;
- An individual, spouse or dependent demonstrates to the NYSOH or an insurer that they meet other exceptional circumstances as the NYSOH may provide;
- An individual is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, and is enrolled in minimum essential coverage, and the individual and the individual's dependents seek to enroll in coverage separate from the perpetrator of the abuse;
- An individual, spouse or dependent applies for Medicaid or Child Health Plus coverage during the annual open enrollment period and are determined ineligible for Medicaid or Child Health Plus coverage after the open enrollment has ended; or
- An individual, spouse or dependent adequately demonstrates to the NYSOH that a material error related to plan benefits, service area, or premium influenced the decision to purchase a qualified health plan through the NYSOH.

Insurers must also provide a sixty-day special enrollment period prior to or after the occurrence of one of the following triggering events:

- An individual, spouse or dependent involuntarily loses minimum essential coverage, including COBRA or state continuation coverage;
- At the end of the plan or policy year for an individual, spouse or dependent enrolled in a non-calendar year group health plan or individual health insurance coverage, even if the individual, spouse or dependent has the option to renew the coverage;
- An individual, spouse or dependent is determined newly eligible for advance payments of the premium tax credit because the coverage they are enrolled in will no longer be employer-sponsored minimum essential coverage (including as a result of an employer discontinuing or

changing available coverage within the next 60 days) provided that the individual, spouse or dependent is allowed to terminate existing coverage;

- An individual, spouse or dependent loses eligibility for Medicaid coverage (including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy) but not including other Medicaid programs that do not provide coverage for primary or specialty care;
- An individual, spouse or dependent becomes eligible for new health plans because of a permanent move and the individual, spouse or child had minimum essential coverage for one or more days during the 60 days prior to the move; or
- An individual, spouse or dependent is no longer incarcerated.

Plan Selection Limitations in the Individual Market. Insurers may limit plan selection for an individual, spouse or dependent utilizing certain special enrollment periods as described below. (*See* 45 CFR 147.104(b) and 45 CFR 155.420(a)(4).)

- If an individual, spouse or dependent becomes newly eligible for cost-sharing reductions and is not enrolled in a silver level health plan, the individual, spouse or dependent can only change to a silver level health plan.
- If an individual gains a dependent, the dependent may be added to the individual's current health plan. If the individual's current health plan's rules do not allow the dependent to enroll, the individual and the individual's dependent may change to another health plan within the same metal level of coverage (or to one metal level higher or lower if no health plan is available at the individual's current metal level).
- An insurer may limit the plan selection of an individual, spouse or dependent to another health plan within the same metal level of coverage (or to one metal level higher or lower if no health plan is available at the current metal level) for any triggering event listed in the Special Enrollment Periods in the Individual Market section above, except the following:
    - An individual, spouse or dependent involuntarily loses minimum essential coverage;
    - An individual, spouse or dependent enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the enrollment activities, as evaluated and determined by NYSOH or the insurer;
    - An individual, spouse or dependent are determined newly eligible or ineligible for advanced payments of the premium tax credit or have a change in eligibility for the cost-sharing reductions;
    - An individual, spouse or dependent is an Indian, as defined in 25 U.S.C. 450b(d);
    - An individual, spouse or dependent demonstrate to the NYSOH or the insurer that you meet other exceptional circumstances that NYSOH may provide; or
    - An individual, spouse or dependent are the victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and the individual and dependent seek to enroll in coverage separate from the perpetrator of the abuse or abandonment.

Special Enrollment Period for Pregnant Women. Insurers must allow a pregnant woman to enroll in individual coverage at any time during the pregnancy. Coverage must be effective on either the first day of the month in which the woman received certification from a health care professional that she was pregnant unless she opts to have coverage effective on the first day of the month following certification. (*See* Insurance Law § 4328(b)(4)(B).)

Special Enrollment Periods Under ERISA. Insurers in both the group and individual markets must also establish special open enrollment periods for qualifying events as defined in Section 603 of the federal Employment Retirement Income Security Act of 1973.

Special Rules for Network Plans.

- **Employer Service Area**. Insurers may limit the employers that may apply for coverage in the group market to those with eligible employees in the group market who live, work, or reside in the insurer's service area.
- **Individual Service Area.** Insurers may limit individuals who may apply for coverage in the individual market to those who live or reside in the insurer's service area.
- **Temporary Waiver.** Insurers may apply to the Superintendent of Financial Services for a temporary waiver of the requirement for open enrollment upon a showing that (1) the existing provider network is unable to provide adequate care to additional persons and (2) it is not reasonably possible to expand the network to allow enrollment of any of these additional persons. Applications for such waivers shall include a plan for management of membership growth and expansion of capacity, including a demonstration that all market segments are being served in a balanced fashion and that any denial of coverage in accordance with the waiver is done uniformly to all employers and individuals without regard to claims experience or any health status-related factor. Any approval of such requests will be subject to periodic updates in a frequency to be determined by the Superintendent to ensure that conditions giving rise to the request continue to exist and that reasonable efforts to adjust the provider network continue to be made. (*See* 45 CFR 147.104(c) and 11 NYCRR 360.3(a)(6).)

Requirements for Minimum Employer Contributions to Premium. Insurers may not impose minimum contribution requirements at any time in the small or large group markets (*see* 45 CFR 147.104(b)(1)(i); 11 NYCRR 360.3).

Eligibility Requirements. The following eligibility restrictions are not permissible for individual, small group or large group coverage (this list does not identify every impermissible eligibility requirement, but only those for which DFS has received inquiries):

- Overinsurance limitations.
- Limitations on eligibility when an individual or small group has had health insurance coverage terminated within the previous twelve months for failure to pay premiums.
- Refusal to issue coverage because an individual is eligible for or covered under another group or individual plan.
- Refusal to issue coverage if a group or individual applying for coverage was previously bankrupt.
- That a particular insurer be the sole carrier for the group in order for coverage to be issued.
- Requirements for a minimum number of contracts or a specific combination of contracts as a prerequisite to issuing a group policy.
- Requirements that a minimum number of employees participate irrespective of the employer's actual size (for example, that all small groups must cover at least five employees).
- Requirements that a percentage of the employees live, work or reside in the service area in order to issue the coverage to the employer group. However, insurers can require that an employee live, work or reside in the service area in order to be covered.

The above practices are prohibited not only in cases where the insurer is the sole insurer, but also where there are two or more different insurers offered to a particular group (sometimes referred to as "slice offerings") (*see* 45 CFR 147.104).

Guaranteed Renewability. Except as provided in Insurance Law §§ 3216(g), 3221(p)(2), 4304(c)(2) and 4305(j)(2), and 45 C.F.R. 147.106(h), an insurer offering coverage in the individual or group market must renew or continue in force the coverage at the option of the group policyholder or individual policyholder.

Healthy NY. As of January 1, 2014 the Healthy NY program is only available to small employers. All Healthy NY products issued on and after January 1, 2014 are identical to the standard gold plan. All eligibility requirements for the Healthy NY program remain unchanged and apply year-round regardless of any open or special enrollment periods afforded by the Affordable Care Act.

Questions Regarding this Guidance May Be Directed to:

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