

PROGRAM MEMORANDUM

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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: How Selling Coverage Exclusively Through Bona Fide Associations Affects an Issuer's Guaranteed renewability Under Title XXVII of the PHS Act

Market: Group and Individual

I. Purpose

This bulleting discusses how selling coverage exclusively through bona fide associations (BFAs) affects an issuer's obligations under the group market and individual market guaranteed renewability requirements of title XXVII of the Public Health Service Act (the PHS Act). This is the fourth of several bulletins that the Centers for Medicare & Medicaid Services (CMS) intends to issue on questions relating to health insurance coverage provided through associations.

The second bulletin in the series, Bulletin No. 02-03, explained the general obligations health insurance issuers have both to association members and to the associations themselves with respect to guaranteed renewability of coverage, regardless of whether the association meets the title XXVII criteria for being considered a BFA. The current bulletin explains CMS's position regarding one specific exception to the guaranteed renewability requirements in each market (group and individual)ⁱ. This exception applies only to coverage sold exclusively by or through BFAsⁱⁱ.

II. Background

Section 2791(d)(3) of the PHS Act, and implementing regulations at 45 CFR 144.103, define the term "bona fide association" to mean, with respect to health insurance coverage offered in a state, an association that meets the following conditions:

- 1) Has been actively in existence for at least 5 years.
- 2) Has been formed and maintained in good faith for purposes other than obtaining insurance.
- 3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee).
- 4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through ha member).

- 5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.
- 6) Meets any additional requirements that may be imposed under State law.

Any given requirement in title XXVII applies to health insurance coverage in a particular market unless a specific exception to that requirement applies. The exception to guaranteed renewability that is discussed in this bulletin applies only to health insurance coverage that is offered or provided exclusively by or through an association that meets all the BFA criteria.

III. The Group Market and Individual Market Guaranteed Renewability Exceptions for Coverage Offered Exclusively Through Bona Fide Associations

The group market regulations at 45 CFR 152(a) state the following:

(a) *General rule.* Subject to paragraphs (b) through (d) of this section, a health insurance issuer offering health insurance coverage in the small or large group market is required to renew or continue in force the coverage at the option of the plan sponsor.

Regulations at 45 CFR 146.152(b)(6) state that the following is an exception to 45 CFR 146.152(a):

(6) *Association membership ceases.* For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

Similarly, the individual market regulation at 45 CFR 148.12(b) state the following:

(b) *General rules.* (1) Except as provided in paragraph (c) of this section an issuer must renew or continue in force the coverage at the option of the individual.

Regulation at 45 CFR 148.122(c)(5) state that the following is an exception to 45 CFR 148.122(b)

(5) *Association membership ceases.* For coverage made available in the individual market only through one or more bona fide associations, the individual's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

A question has been raised, with respect to these guaranteed renewability exceptions, about the proper interpretation of the phrase the [employer's or individual's] membership in the association ceases." Reading the statute as a whole, we believe that this phrase clearly refers only to the situation in which a particular employer (or individual) voluntarily leaves the BFA, or, due to circumstances not determined by the BFA, no longer meets the BFA's non-health-factor-related membership requirements. The issuer is not relieved of the guaranteed renewability requirement with regard to a specific BFA member if, for example, membership is simply no longer possible, such as if the association ceases to exist.

The statute itself makes clear that employers and individuals are entitled to HIPAA protections regardless of whether coverage happens to be provided through an association. In particular, issuers in the group market are required to renew coverage “at the option of the plan sponsor,” and section 2712(e) makes clear that if the coverage is offered only through an association (whether or not a BFA), the renewal option applies to the employer members of the association, regardless of whether the association, or the employer members, are the plan sponsor. Thus, the employer’s guaranteed renewability right is not compromised if the association, rather than the individual employer, that has, for instance, failed to pay premiums, committed fraud, or made an intentional misrepresentation of material fact.

If the association member is an individual, then the individual is entitled to guaranteed renewability under section 2742(a) regardless of whether the coverage is provided through an association. Section 2472(e) makes clear that an association’s right to guaranteed renewability is separate from, and in addition to, the individual’s right.

Accordingly, if employers or individuals lose BFA membership because they leave the association, the issuer does not have to renew the coverage. Similarly, if the employers or individuals lose eligibility for membership because, due to a change in their own circumstances, they no longer meet the BFA’s membership criteria, they are not entitled to renew the coverage (as long as those criteria are not health status related). However, if the loss of eligibility or loss of membership results from circumstances that are dictated by , or caused by a change in the BFA (such as if the BFA changes its eligibility requirements, or ceases to exist), the issuer must renew coverage even if the BFA is no longer involved.ⁱⁱⁱ Therefore, for example, with regard to a BFA that offered membership to licensed physicians and nurses, an issuer would not be required to offer renewal of coverage to an individual who simply quit the BFA. Nor would an issuer have to offer renewal of coverage to an individual whose membership in the BFA ceased because he or she no longer met the BFA’s requirement of being a licensed physician or nurse. However, we take the position that if, for example, the BFA changed its membership criteria so that nurses were no longer eligible for membership, the issuer would have to offer renewal of coverage to any nurse who lost membership in the BFA because the BFA changed its membership criteria.

We would note that in order to be able to take advantage of the exceptions from guaranteed availability with respect to insurance issued exclusively through BFAs, an issuer cannot “make coverage available” outside a BFA. We would not consider renewing BFA-only coverage under the circumstances discussed in this section of this bulletin to be “making coverage available” outside the BFA.

Where to get more information

The regulations cited in this bulletin are found in Parts 146 and 148 of Title 45 of the Code of Federal Regulations (45 CFR 146,148). Information about the PHS Act is also available on CMS’ Web site at <http://www.cms.hhs.gov/hipaa1>

If you have any questions regarding this bulletin, call the HIPAA Health Insurance Reform Help Line toll free at 1-877-267-2323, extension 61565.

ⁱ Section 2712(b)(6) of the PHS Act contains an exception to the group market guaranteed renewability requirements. This provision is implemented by regulation at 45 CFR 146.152(b)(6). Section 2742(b)(5) of the PHS Act contains a parallel exception to the individual market requirements. This provision is implemented by regulations at 45 CFR 149.122(c)(5).

ⁱⁱ The first bulletin on association coverage, Bulletin No. 02-02, explained how to determine which market rules apply to association coverage. The third bulletin in the series, Bulletin 02-04, dealt with criteria for determining whether an association is a BFA and discussed how selling coverage exclusively through BFAs affects an issuer's obligations under the group market and individual market guaranteed availability requirements of title XXVII.

ⁱⁱⁱ In Bulletin No. 02-03, we encouraged states to require issuers to get approval, or file, in the individual or group market, products issuers market to individuals or employers through associations, in order for issuers to prepare to be in compliance with such a guaranteed renewability requirement.