PROGRAM MEMORANDUM
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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: The Obligations Health Insurance Issuers Have to Association Members and Associations Under Title XXVII of the PHS Act With Respect to Guaranteed Renewability of Coverage

Market: Group and Individual

I. Purpose

This bulletin clarifies issuers' responsibilities under the guaranteed renewability provisions of Parts A and B of title XXVII of the Public Health Service Act (PHS Act) to individuals and employers that have coverage through associations, as well as to the associations themselves[i]. This is the second of several bulletins that the Centers for Medicare & Medicaid Services (CMS) intends to issue on questions relating to health insurance coverage provided through associations[ii].

II. Group Market

With respect to group health insurance coverage offered through associations, it is our understanding that most state laws view the association, but not the employer-members of the association, as a party to the insurance contract (i.e., the holder of the master policy). In many such states, the association has the right to guaranteed renewability of the contract under state law, but the individual employer-members of the association do not. In contrast, section 2712 of the PHS Act and implementing regulations at 45 CFR 146.152 require health insurance issuers to guarantee the renewal of coverage at the option of the "plan sponsor," unless a specific exception applies. A plan sponsor is generally the entity that maintains or establishes a "group health plan[iii]."

As discussed in our previous bulletin on association issues (02-02), a group health plan may exist at the level of the association or at the level of the individual employer-members that obtain coverage for their employees through the association. The application of the guaranteed renewability requirement in the PHS Act depends on which of these situations applies[iv].

A. A Group Health Plan Exists at the Association Level

In the extremely rare instances where a group health plan exists at the association level, the association is generally the plan sponsor, and the issuer must recognize the association's right under section 2712 to renew the coverage.

If the issuer makes the coverage available only through one or more associations, however, section 146.152(g) specifies that the reference to "plan sponsor" (in each provision of 45 CFR 146.152) is deemed to include each employer that gets its coverage through the association. In such cases, the issuer must extend the protections of 45 CFR 146.152 to each such employer. (If, however, the issuer makes the coverage available only through a "bona fide" association, the employer does not have a separate guaranteed renewability right if it leaves the association. We expect to discuss this situation, and other PHS Act situations involving the distinction between bona fide and non bona fide associations, more fully in future bulletins.)

B. A Group Health Plan Does Not Exist at the Association Level

In the far more common situations where a group health plan does not exist at the association level, it may be the employers that meet the definition of plan sponsor under the PHS Act[v]. Even though the association may be the holder of the master policy under state law, and may have a state law right to guaranteed renewability, it is only the plan sponsor that has the right to all the protections of 45 CFR 146.152.

Note that 45 CFR 146.152(b) states that a health insurance issuer may terminate or nonrenew group coverage if the plan sponsor either fails to pay premiums or contributions in accordance with the terms of the coverage, commits fraud or makes an intentional misrepresentation of material fact in connection with the coverage, or fails to comply with a material plan provision relating to employer contribution or group participation rules. The application of this provision also depends on whether the group health plan exists at the association or employer level. As previously stated, the plan sponsor generally would not be the association where a group health plan does not exist at the association level. Thus, in the common situations where each employer-member of the association maintains its own group health plan, the association's actions do not give an issuer a right to terminate or nonrenew the coverage of any employer-member of the association. Rather, the issuer must renew the coverage to each employer-member of the association, either through the association or through separate contracts with each employer-member of the association on an outside-the-association basis, unless an exception applies[vi]. We realize that this requirement is problematic in instances where the issuer does not have the identical product approved or filed in the group market, i.e., if the issuer only has the product approved or filed in a state's "association" market. Therefore, we encourage states to require issuers to get such products approved or filed in the group market, in order for issuers to prepare to be in compliance with title XXVII.

We would note that the small group guaranteed availability requirement at 45 CFR 146.150 requires an issuer to offer, to all small employers, all products that are approved in the small group market and that the issuer is actively marketing, and must accept any employer that applies for any such product. We would not consider renewing coverage under the circumstances described in this section of the bulletin to constitute "actively marketing" the product for purposes of 45 CFR 146.150.

III. Individual Market

With respect to health insurance coverage offered in the individual market through associations, it is our understanding that laws in many states have traditionally viewed the association, but not the individual member of the association, as a party to the insurance contract. Therefore, in many such states, an association would have the right to guaranteed renewability of the contract, but an individual member of an association would not. However, in cases where the health insurance product is made available only through one or more associations, the PHS Act at section 2742(e) and implementing regulations at 45 CFR 148.122(h) make clear that individual-market health insurance issuers must satisfy all the requirements of 45 CFR 148.122, both with respect to individuals who obtain coverage through the association and with respect to the association through which the individuals obtain coverage. Among those requirements, 45 CFR 148.122(c) permits an issuer, in instances where the association fails to pay premiums or contributions in accordance with the terms of the coverage, or commits fraud or makes an intentional misrepresentation of material fact in connection with the coverage, to terminate or nonrenew the master policy with the association. However, the issuer must offer that identical coverage to each individual member of the association through separate contracts on an outside-the-association basis, unless an exception applies. We realize that this requirement is problematic in instances where the issuer does not have the identical product approved or filed in the individual market. Therefore, we encourage states to require issuers to get such products approved or filed in the individual market, in order for issuers to prepare to be in compliance with title XXVII. We note that the individual market guaranteed availability requirement in 45 CFR 148.120, which applies in states that are not using an alternative mechanism to guarantee coverage to Federally eligible individuals as described in 45 CFR 148.128, requires issuers to offer such individuals all products the issuer actively markets in the individual market (or its two most popular or two representative products). We would not consider the renewal of policies as described in this paragraph to constitute "actively marketing" the product for purposes of 45 CFR 148.120.

If an individual member of the association is the party that fails to pay premiums or contributions in accordance with the terms of the coverage, or commits fraud or makes an intentional misrepresentation of material fact in connection with the coverage, the issuer must continue to offer the coverage to every other individual member of the association, through the master contract with the association, unless an exception applies[vii].

IV. Mixed Associations Composed of Employer-Members and Individual-Members

As we noted in bulletin 02-02, some associations have a "mixed" membership in which some coverage provided through the association is in connection with an employment-based group health plan (and therefore constitutes group health coverage for purposes of the guaranteed renewability and other provisions of title XXVII) and some coverage is provided to association members without any connection to a group health plan (and therefore constitutes individual health coverage for purposes of the guaranteed renewability and other provisions of title XXVII). In the former case, an issuer's obligations

under the PHS Act's guaranteed renewability requirements with respect to the association and its employer members are consistent with those discussed in Section II of this bulletin.

In the latter case, an issuer's obligations with respect to the association and its individual members are consistent with those discussed in Section III of this bulletin.

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.

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[i] This bulletin does not discuss the guaranteed renewability requirements found in section 703 of ERISA and in section 9803 of the IRS Code that apply to group health plans that are multiemployer plans or that are multiple employer welfare arrangements. The U.S. Department of Labor and the U.S. Department of Treasury, respectively, have administrative jurisdiction over these requirements.

[ii] Bulletin No. 02-02 was the first bulletin relating exclusively to association issues. It explained how to determine which market rules apply to association coverage.

[iii] 45 CFR 144.103 defines "plan sponsor" as follows: "Plan sponsor" has the meaning given the term under section 3(16)(B) of ERISA, which states "(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan." 45 CFR 144.103 defines "group health plan" as follows: "Group health plan means an employee welfare benefit plan (as defined in section 3(1) of ERISA) to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the PHS Act and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. For more information on what constitutes a group health plan, see our November 2000 Bulletin No. 00-06, Circumstances Under Which Health Insurance Regulated as Individual Coverage Under State Law is Subject to the Group Market Requirements of the Health Insurance Portability and Accountability Act of 1996.

[iv] Whether a group health plan exists, and whether it exists at the association level, or as is far more common, at the individual employer level, is under the jurisdiction of the U.S. Department of Labor's Pension and Welfare Benefits Administration.

[v] We use the word "may" because the plan sponsors could be the employers or, for example, one or more employee organizations. See the definition of plan sponsor in footnote iii.

[vi] The exceptions to the group market guaranteed renewability requirement include nonpayment of premiums (45 CFR 146.152(b)(1)), fraud (45 CFR 146.152(b)(2)), violation of participation or contribution rules (45 CFR 146.152(b)(3)), enrollees' movement outside the service area (45 CFR 146.152(b)(5)), association membership ceases (45 CFR 146.152(b)(6)), discontinuing a particular product (45 CFR 146.152(c)), discontinuing all coverage (45 CFR 146.152(d)), and uniform modification of coverage (45 CFR 146.152(f))

[vii] The exceptions to the individual market guaranteed renewability requirement include nonpayment of premiums (45 CFR 148.122(c)(1)), fraud (45 CFR 148.122(c)(2)), movement outside the service area (45 CFR 148.122(c)(4)), association membership ceases 45 CFR 148.122(c)(5)), discontinuing a particular type of coverage (45 CFR 148.122(d)), discontinuing all coverage (45 CFR 148.122(e)), and uniform modification of coverage (45 CFR 148.122(h)).