PROGRAM MEMORANDUM
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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Agent Commissions and Application Processing Delays

Markets: Individual and Small Group

I. Purpose

The purpose of this Bulletin is to convey the position of the Health Care Financing Administration on insurance practices that are inconsistent with the guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The specific practices addressed in this Bulletin are:

1) Setting agent commissions for sales to HIPAA-eligible individuals[1] and/or small groups so low that agents are discouraged from marketing policies to, or enrolling, such individuals or groups; and
2) Unreasonably delaying the processing of applications submitted by HIPAA-eligible individuals or small groups.

In addition to the practices discussed in this Bulletin, we have been notified that some issuers may be offering coverage to HIPAA-protected individuals at rates well in excess of the general industry maximum in place before HIPAA of 200 percent of standard risk--in fact, reports indicate premium rates as high as 500 to 600 percent of standard risk. This practice of establishing rates to exclude HIPAA-protected persons is known as "rating up." We have been advised that issuers may be intentionally offering coverage at unaffordable rates, in order to avoid providing coverage to HIPAA-eligible individuals and small groups while appearing to comply with the guaranteed availability provisions of HIPAA. We are continuing to gather information about this problem.

II. Background

Guaranteed availability of health insurance coverage in certain instances is one of the main protections provided under HIPAA. Section 2711 of the Public Health Service Act (PHS Act) requires issuers that sell

[1] HIPAA contains two definitions of a HIPAA-eligible individual, one in the group market and one in the individual market. (See 45 C.F.R. §144.103, cross-referencing 45 C.F.R. §146.150(b) (group market definition) and 45 C.F.R. §148.103 (individual market definition).) For purposes of this bulletin, the term "HIPAA-eligible individual" will be used to refer to a HIPAA-eligible individual in the individual market. This will avoid the need to repeat the full phrase "HIPAA-eligible individual in the individual market."

health insurance coverage in the small group market to accept every small employer that applies for such coverage, even those whose eligible employees include individuals with serious medical problems. Section 2741 of the PHS Act provides that issuers who sell health insurance coverage in the individual market may not decline to offer certain coverage to HIPAA-eligible individuals (unless an approved alternative mechanism applies under State law in which case the rules under such alternative mechanisms would apply). Section 2741 defines a HIPAA-eligible individual as one who meets certain qualifications. Among other things, the individual must have maintained at least 18 months of health insurance coverage; must, most recently, have been covered under a group health plan; and must not have experienced a significant break in coverage, which is defined as a period of at least 63 days without coverage.

Issuers are also subject to certain requirements to furnish information to applicants. In the individual market, the regulation at 45 C.F.R. §148.120(a) requires issuers to act promptly to provide applicants information about available coverage options, including premiums and other costs. In the small group market, 45 C.F.R. §146.160(b)(2) requires any health issuer offering coverage to small groups to include as part of its marketing and solicitation material information about the benefits and premiums available under all health insurance coverage for which the employer is qualified. If premium information is supplied properly, issuers operating in either market should not need to delay the processing of applications in order to finalize price quotes.

HIPAA provides that entities furnishing certain kinds of health insurance coverage, including group coverage, must furnish certificates[2] to individuals whose coverage ends, and at various other times. Individuals may use these certificates to demonstrate that they have maintained health insurance coverage--referred to as "creditable coverage"--which would entitle them to the protections of HIPAA (including status as a HIPAA-eligible individual, as described above). However, the regulation at 45 C.F.R. §148.124(d) permits a HIPAA-eligible individual who for any reason does not have such a certificate to furnish alternative proof of coverage. The regulation specifies, at §148.124(d)(2), what kinds of documentation must be accepted, and how other evidence such as telephone calls and other third party verification must be permitted. In particular, an issuer must treat an individual as having furnished a certificate if he or she attests to the period of creditable coverage, presents relevant corroborating evidence of some creditable coverage during the period, and cooperates with the issuer's efforts to verify the individual's coverage.

As stated above, a significant break in coverage terminates an individual's status as a HIPAA-eligible individual in the individual market. The effect of a significant break in coverage is different in the small group market, where guaranteed availability applies to the group as a whole, providing protection to small employers rather than to individual employees in the group. Section 2701 of the PHS Act[3] protects individual participants in group health plans by limiting the amount of time the plan or issuer may

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[2] For purposes of this bulletin, the word "certificate" refers to "certificates of creditable coverage" as defined under HIPAA and not the certificates issued under a master group policy. (See 45 C.F.R. §146.115.)

[3] Parallel provisions of HIPAA's portability provisions under section 2701 of the PHS Act are contained in section 701 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 9801 of the Internal Revenue Code of 1986.

impose preexisting condition exclusion on a new enrollee. (Under this type of exclusion, the person is covered for all other plan benefits, but has to wait for a certain period of time before benefits are available with respect to the preexisting condition.) HIPAA provides, in general, that a group health plan cannot impose an exclusion period longer than 12 months (or 18 months for late enrollees), and that the exclusion period must be reduced (or eliminated) by the amount of the individual's prior "creditable coverage," which can include most kinds of health care coverage. A plan is not required, however, to count as creditable any coverage that is followed by a significant break in coverage - i.e., at least 63 days. If a significant break were to occur due to an issuer's delay in processing an application for group coverage, then clearly members of that group could be disadvantaged. Although the break would not completely foreclose the members' obtaining guaranteed coverage--as it can in the individual market--it could delay the start of their coverage, as well as subjecting certain individuals to preexisting condition exclusions.

Enforcement of HIPAA's standards against issuers of health insurance in both markets is to be performed in the first instance by the States, and by HCFA if a State fails to do so. Sections 2722(b) and 2761(b) of the PHS Act provide the major enforcement mechanism with respect to issuers within HCFA's jurisdiction: a civil monetary penalty in the amount of one hundred dollars per violation per day.

III. Agent Commissions

We have become aware that some issuers are attempting to discourage the offering of policies to HIPAA-eligible individuals in the individual market, or to small groups containing high risk individuals, by withholding commissions from agents for sales to such individuals or small groups. Agents have sent us copies of notices from a number of issuers stating they will not pay or will reduce commissions and bonuses for sales to high risk groups and/or HIPAA-eligible individuals. If an issuer pays agents less through all forms of agent compensation (commissions, bonuses, or other rewards) for high risk individuals and groups than it pays for those with better risk profiles, this act constitutes a circumvention of the insurance reform provisions of HIPAA.

Several States have taken action, under their Unfair Trade Practices Acts or their rating authority, to combat the practice of unfairly reducing or eliminating agent commissions. Typically, a State's Unfair Trade Practices Act prohibits any action by an issuer to deflect bad risks away from itself and toward other issuers. Some States that have prior approval of rates have also attacked this practice by declaring that issuers who alter commission structures to deter agents from soliciting or processing applications from HIPAA-protected individuals or groups are using an unapproved rate because the approved rate filing was based on calculations that assumed a certain commission rate. HCFA strongly encourages States to continue to use their authority to take actions against these practices.

While Federal law currently provides no direct equivalent to these State authorities for taking action against such practices, we believe that these and other comparable marketing or distribution practices constitute failure on the part of issuers to offer required coverage to HIPAA-eligible individuals or small employers. The regulation at 45 C.F.R. §146.150(a), provides that issuers in the group market must offer coverage to any small employer and may not decline to offer coverage to eligible individuals under the

group plan. With respect to the individual market,(unless an approved alternative mechanism applies under State law in which case the rules under such alternative mechanisms would apply), 45 C.F.R. §148.120 provides that issuers may not decline to offer coverage to HIPAA-eligible individuals (except to limit the types of coverage it offers to its two most popular or to two representative policies, as permitted by the statute).

The guaranteed issue provisions of the statute generally require that issuers' normal conduits for receiving applications and offering coverage be open to HIPAA-eligible individuals or small employers. Issuers commonly use agents as an important part of their marketing and distribution system, and ordinarily compensate these agents by paying commissions on the coverage they sell. Commission payment is included among the costs used to calculate the premium rate for a given form of coverage. For an issuer to modify the normal operation of its marketing and distribution system so as not to attract its fair share of the high risk individuals and small groups protected by HIPAA does not accord with the intent of the statute to protect these individuals and groups. HCFA will carefully monitor such practices and will take appropriate enforcement action to the extent the practices are found, under the regulations, to constitute a failure to offer coverage.

IV. Application Processing Delays

Another abuse involves issuers' delaying action on applications for coverage submitted by HIPAA-eligible individuals or by small employers, so as to cause the individual or group to incur a significant break in coverage. Such delays are inconsistent with HCFA regulations as described below.

A significant break in coverage has a different effect in the individual and small group markets. Group health plans are not required to take into account coverage from a period prior to a significant break to reduce or eliminate a preexisting condition exclusion, and participants may thus lose benefits they would have been entitled to had there been no delay. In the individual market, a person must (among other requirements) have 18 months of creditable coverage without a significant break to qualify as a HIPAA-eligible individual. A significant break terminates the status of a HIPAA-eligible individual and thus leaves a person without guaranteed access to coverage.

With respect to the group market, we have received reports that issuers held applications for lengthy periods before delivering premium quotes. As mentioned in the Background section above, if issuers comply with the requirement to furnish small employers with marketing information listing the benefits and premiums available under all coverage options, such processing delays should not occur. HCFA will examine these delays carefully to determine whether the marketing information requirements have been violated. HCFA will take appropriate enforcement action to the extent these delays are found, under the regulations, to constitute a failure to offer coverage.

Similarly, we have been notified that some individual market issuers may be causing HIPAA-eligible individuals to incur significant breaks in coverage by delaying premium quotes and by then quoting premiums that the applicants are not likely to find acceptable. (Under the interim final rule, this kind of delay does not count toward a significant break in the individual market if the HIPAA-eligible individual

ultimately purchases the coverage offered. However, if the individual cannot afford the quoted rate, and wishes to look elsewhere, status as a HIPAA-eligible individual may have been forfeited due to the break in coverage.) HCFA will monitor processing delays affecting HIPAA-eligible individuals to determine whether an issuer has violated the requirement to furnish information, including premium information, promptly. HCFA will take appropriate enforcement action to the extent these delays are found, under the regulations, to constitute a failure to offer coverage.

We have also received reports that some individual market issuers have caused unreasonable delays by demanding that an applicant furnish all supporting documentation to establish status as a HIPAA-eligible individual before an application for coverage will be accepted. In particular, we have heard that some issuers have insisted that an applicant obtain a certificate to prove that he or she has met a particular eligibility requirement, for example, having elected and exhausted continuation coverage[4], rather than allowing the individual to present other evidence of coverage, or contacting the employer plan from which the applicant last obtained coverage. Cooperation between issuers offering individual coverage and entities that have furnished creditable coverage can permit a HIPAA-eligible individual to move from expiring continuation coverage to a new policy with no break in coverage. HCFA will monitor and take appropriate enforcement action, when issuers are found to have refused applications from HIPAA-eligible individuals based on requirements for documentation that are inconsistent with the regulations.

If you have questions about this Bulletin, call the HIPAA Insurance Reform Help Line at 410-786-1565.

[4] "Continuation coverage" may be either; (1) "COBRA continuation coverage" as mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or (2) similar State mandated continuation coverage.