PROGRAM MEMORANDUM
INSURANCE COMMISSIONERS
INSURANCE ISSUERS

Department of Health and Human Services

Centers for Medicare and Medicaid Services

Transmittal No. 02-04 **Date** September 2002

Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Characteristics of Bona Fide Associations, and How Selling Coverage Exclusively Through Them Affects an Issuer's Guaranteed Availability Obligations Under Title XXVII of the PHS Act

Market: Group and Individual

I. Purpose

This bulletin clarifies several of the characteristics of bona fide associations (BFAs) as defined in title XXVII of the Public Health Service Act (PHS Act)[i]. It also discusses how selling coverage exclusively through them affects an issuer's obligations under the group market and individual market guaranteed availability requirements of title XXVII. This is the third 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. Characteristics of BFAs

A. Purpose for Maintaining the Association

One of the criteria for determining whether an association is a BFA is that the association "has been formed and maintained in good faith for purposes other than obtaining insurance." It has come to our attention that some associations have created or are creating membership "classes" or "subcategories" whereby only certain members of the association are permitted to purchase a health insurance product or products. To the extent the opportunity to purchase the health insurance is the only real distinction between the association members who are not in the class or subcategory and those who are, depending on the circumstances, the class or subcategory may be considered to be a separate association that is not bona fide, because it has not been formed and maintained in good faith for purposes other than obtaining insurance.

B. Criteria Related to Health Factors

The statute and regulations specify that an association does not meet the definition of a BFA if it "condition[s] membership on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee)." (See section 2791(d)(3)(C) of the PHS Act, implemented by 45 CFR 144.103). Therefore, an association can still be considered bona fide if it conditions membership on any non-health factors[iii], as long as the association meets all other

requirements of a BFA. Whether membership is based on a health factor is determined by the relevant facts and circumstances. Regardless of how an association characterizes its membership criteria, a state insurance department (or CMS, in states in which CMS is directly enforcing title XXVII) may make its own determination whether a given association that is issuing coverage or through which a health insurance issuer is marketing a product or products, is in practice conditioning membership on a health factor.

In addition to not conditioning membership in the association on any health factor relating to an individual or employer member, an association that wishes to be considered bona fide must make health insurance coverage offered through the association available to all members regardless of any health factor relating to such members (or individuals eligible for coverage through a member). (Sections 2791(d)(3)(D) of the PHS Act, implemented by 45 CFR 144.103).

Both of these criteria for meeting the definition of a BFA use the same statutory term – health status-related factor – as is used in section 2702 of the PHS Act, implemented by 45 CFR 146.121(b), which generally prohibits group health plans and group health insurance issuers from establishing any rule for eligibility to enroll for benefits, or any premium or contribution disparity, that discriminates based on a health status-related factor. The definition of that term, at section 2791(d)(9), cross-references the factors described in section 2702(a)(1).

Although these provisions (the criteria for a BFA that are related to health factors and the nondiscrimination requirements) serve different purposes, we believe that because they are based on the same concern --avoiding discrimination based on health factors--the specific nondiscrimination requirements of section 2702 can shed light on congressional intent underlying the more generally stated criteria for BFAs. Both the BFA criteria and the nondiscrimination requirements discuss criteria —

- for being allowed into the plan or association, respectively, and
- for how individuals are treated once they are in the plan or association, respectively.

We believe that both BFA criteria that are related to health factors can reasonably be read broadly, to encompass any membership eligibility or coverage eligibility rule that leads to people being treated differently by the association or issuer providing coverage through the association, based on a health factor. The regulation that implements the nondiscrimination provision, at 45 CFR 146.121(b), might be useful to states in interpreting the scope of these two health factor related criteria for BFAs[iv]. For example, a state could require that to qualify as a BFA, an association may not permit one member to obtain coverage immediately upon joining the association, while permitting another member to obtain coverage only after spending a certain amount of time as a member, if the distinction is based on a health factor (See 45 CFR 146.121(b)(1)(ii)(C)).

While a BFA must make health insurance coverage offered by or through the association available to all members regardless of any health factor, it may refuse to make available to certain members, products the issuer or the association makes available to other members, as long as the distinction is not based on a health factor. Whether availability of coverage is based on a health factor is determined by the relevant facts and circumstances. Regardless of how an association characterizes its coverage availability criteria, a state insurance department (or CMS, in states in which CMS is directly enforcing title XXVII)

may make its own determination whether a given association through which a health insurance issuer is marketing a product or products, is in practice conditioning availability on a health factor.

C. Unavailability of Coverage to Non-Members

In order to be bona fide, an association –

> Does not make health insurance coverage offered through the association available other than in connection with a member of the association (emphasis added). (Sections 2791(d)(3)(E) of the PHS Act, implemented by 45 CFR 144.103)[v].

It is our understanding that some associations have created "affiliate" memberships of employers and/or individuals. In such cases, associations or issuers marketing coverage through them make coverage available to "affiliate members" under circumstances that call into question whether they actually belong to the association, or belong only for purposes of obtaining health insurance. We encourage states to apply all BFA criteria, such as the one under which an association cannot make coverage available to nonmembers, and the one dealing with the purpose of maintaining the association (discussed in Section II of this bulletin), to determine if an association's offering of coverage to "affiliate members" results in that association not meeting the criteria for a BFA.

D. Additional State Law Requirements for BFAs

Another criterion for an association to be bona fide under 45 CFR 144.103 is that the association "meets any additional requirements that may be imposed under State law." This makes clear that, just as title XXVII generally does not preclude states from regulating health insurance issuers, title XXVII also does not preclude (and in fact explicitly permits) states to impose additional criteria on associations in order to be bona fide.

III. The Small Group Market Guaranteed Availability Exception for Coverage Offered Exclusively Through BFAs

The general rule under 45 CFR 146.150(a)(1) is that any issuer that offers coverage in the small group market must:

Offer, to any small employer in the State, all products that are approved for sale in the small group market and that the issuer is actively marketing, and must accept any employer that applies for any of those products; ….

However, 45 CFR 146.150(f) creates the following exception:

> (f) Exception for coverage offered only to bona fide association members. Paragraph (a) of this section does not apply to health insurance coverage offered by a health insurance issuer if that coverage is made available in the small group market only through one or more bona fide associations (as defined in 45 CFR 144.103).

When read in context with the basic requirement that the issuer must offer "all products," we believe section 146.150(f) creates an exception for a specific health insurance product or products[vi]. In other words, to the extent a health insurance issuer makes a specific small group product or products available only through one or more BFAs, the issuer is not required to offer that product or those products to small employers outside the BFA. However, to the extent a health insurance issuer makes a specific small group product or products available other than exclusively through one or more BFAs, such as by making the product available through even one non-BFA, the issuer must make that product available to all small employers (subject to the exceptions in 45 CFR 146.150(c) – (e))[vii].

IV. How Coverage Sold Exclusively Through BFAs Affects the Individual Market Guaranteed Availability Requirements

A. In States Implementing a State Alternative Mechanism (SAM), What Must an Issuer Offering Coverage Exclusively Through One or More BFAs Do?

In States that have elected to guarantee availability of coverage for federally eligible individuals through some kind of state alternative mechanism (as permitted under section 2744 of the PHS Act), none of the individual market guaranteed availability requirements of section 2741 of the Act apply[viii]. Therefore, the exception from the requirement to provide guaranteed availability for coverage sold exclusively through one or more BFAs is irrelevant in such states. The provisions of the SAM dictate what issuers must or must not do. For instance, in states that have elected to use a high risk pool as the means of guaranteeing availability of coverage to federally eligible individuals, individual market issuers have no responsibilities to guarantee the availability of any kind of coverage to these individuals. In states that have implemented broader market reforms as their means of ensuring that issuers provide coverage to federally eligible individuals, the design of the SAM will dictate whether coverage sold through associations (whether or not they are bona fide) must be offered to federally eligible individuals.

B. In Federal Fallback States, Must an Issuer Offer, to Federally Eligible Individuals, BFA-Only Products?

In states that have not implemented an alternative mechanism to guarantee coverage to federally eligible individuals in the individual market, the PHS Act requires health insurance issuers to offer, to all federally eligible individuals, either: (1) all products the issuer actively markets in the individual market, or (2) either the issuer's two most popular policy forms or two representative policy forms, as described in regulations at 45 CFR 148.120(c). However, the regulations at 45 CFR 148.120(g)(2) implementing PHS Act section 2741 state the following:

An issuer offering health insurance coverage only in connection with group health plans, or only through one or more bona fide associations, or both, is not required to offer that type of coverage in the individual market.

This provision means that in a federal fallback state, an issuer that chooses to offer all its individual market products to federally eligible individuals is not required to offer, to federally eligible individuals, any product the issuer makes available only through one or more BFAs.

Additionally, if an issuer selling in the individual market has both BFA-only products and other individual market products and wants to offer only its two most popular individual market products, as defined in 45 CFR 148.120(c)(2), the products the issuer offers only through one or more BFAs are not required to be considered in determining which are the two most popular policies. Rather, the issuer must offer to such individuals its two most popular products that are offered other than exclusively through BFAs. However, to the extent an issuer offers to federally eligible individuals either all its individual market products, or its two most popular products, any of those products the issuer makes available even through only one non-BFA must be made available to federally eligible individuals on an outside-the-association basis or calculated in the mix of policies taken into consideration when determining which are the issuer's two most popular policies, respectively.

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] Bona fide association means, 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 a 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. 45 CFR 144.103

The regulations do not define the term "association." The context of the statute, however, makes clear that the term is intended to encompass any entity through which health insurance is offered to a collection of employers and/or individuals, including but not limited to entities known as trusts, multiple employer welfare arrangements (MEWAs), purchasing alliances, or purchasing cooperatives.

[ii] Bulletin No. 02-02 explained how to determine which market rules apply to association coverage. Bulletin No. 02-03 explained the obligations health insurance issuers have to association members and associations with respect to guaranteed renewability of coverage.

[iii] When CMS, the Department of Labor and the Department of the Treasury issued interim final regulations on the nondiscrimination provisions contained in section 702 of ERISA, section 2702 of the PHS Act, and section 9802 of the Code, the three Departments adopted the use of the term "health factor" as a shorthand term for the statutory term "health status related factor." We use these terms interchangeably in this bulletin since they are synonymous. See 45 CFR 146.121(a) for a definition of the term "health factor." The term means, in relation to an individual, any of the following health status-related factors: health status; medical condition (including both physical and mental illnesses), as defined in 45 CFR 144.103; claims experience; receipt of health care; medical history; genetic information, as defined in 45 CFR 144.103; evidence of insurability; or disability.

[iv] Those regulations state that rules for eligibility that a group health plan or issuer cannot vary based on health status include, but are not limited, to rules relating to¬

a) Enrollment;
b) The effective date of coverage;
c) Waiting (or affiliation) periods;
d) Late and special enrollment;
e) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);
f) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;
g) Continued eligibility; and
h) Terminating coverage (including disenrollment) of any individual under the plan.

[v] Of course, we would consider making coverage available to dependents of association members, or to dependents of employees that work for employer-members of associations, to be making coverage available "in connection with" a member of the association.

[vi] When CMS was developing the April 8, 1997 interim regulations, industry representatives expressed the concern that we not interpret this exception to the guaranteed availability requirement so narrowly that only issuers whose entire business consisted of selling association products could take advantage of the exception. Accordingly, the regulations and the preamble did not limit applicability of this exception to the issuer's entire business. Instead, the exception is interpreted to apply to discrete products that are sold exclusively through BFAs.

[vii] The exceptions to guaranteed availability include special rules for network plans, application of financial capacity limits, and exceptions for failure to meet certain minimum participation or contribution rules.

[viii] See 45 CFR 148.103 for the definition of a federally eligible individual.