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**Title:** Insurance Standards Bulletin Series--INFORMATION

**Subject:** Application of Individual and Group Market Requirements under Title XXVII of the

Public Health Service Act when Insurance Coverage Is Sold to, or through,

Associations

**Markets:** Individual and Group

# I. <u>Purpose</u>

This Bulletin affirms the applicability of previous guidance concerning whether health insurance coverage sold to or through associations is individual or group coverage for purposes of the requirements of Title XXVII of the Public Health Service Act ("PHS Act"), in light of the enactment of the Patient Protection and Affordable Care Act, Public Law 111-148, and the Health Care and Education Reconciliation Act, Public Law 111-152 (collectively, the "Affordable Care Act").

# II. Background

Since the enactment of the Affordable Care Act in March 2010, the Centers for Medicare & Medicaid Services ("CMS") has received numerous inquiries from State regulators, consumers, issuers, and others on how health insurance coverage sold to or through associations ("association coverage") is treated under the PHS Act with respect to the changes made to the PHS Act by the Affordable Care Act. For purposes of this Bulletin, given that "association coverage" is not defined in the PHS Act, the term means health insurance coverage <sup>1</sup> offered to collections of individuals and/or employers through entities that may be called associations, trusts, multiple employer welfare arrangements ("MEWAs"), <sup>2</sup> purchasing alliances, or purchasing cooperatives.

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<sup>&</sup>lt;sup>1</sup> CMS's authority under Title XXVII of the PHS Act applies to health insurance coverage and nonfederal governmental plans. CMS does not have authority over self-insured association coverage, although such coverage may be regulated by the States and, if the coverage is employment-based, by the Department of Labor ("DOL").

<sup>&</sup>lt;sup>2</sup> The requirements of Title XXVII of the PHS Act apply to individual and group health insurance coverage provided through MEWAs. In addition, private group health plan coverage (whether insured or self-funded) generally is subject to the requirements of Part 7 of the Employee Retirement Income Security Act ("ERISA"), including group health coverage provided through MEWAs. Other ERISA provisions, such as ERISA section 101(g), also impose requirements on MEWAs. The DOL administers ERISA. For further information, please refer to the DOL's MEWA Guide (www.dol.gov/ebsa/Publications/mewas.html).

### III. Discussion

Although the Affordable Care Act revised and added to Title XXVII of the PHS Act, it did not modify the underlying PHS Act framework for determining whether health insurance coverage issued through associations was individual or group health insurance coverage. The analysis set forth in CMS Insurance Standards Bulletin Transmittal No. 02-02 (August 2002), summarized below, remains authoritative for determining when association coverage is considered individual or group coverage under Title XXVII of the PHS Act.<sup>3</sup>

In short, the test for determining whether association coverage is individual or group market coverage for purposes of Title XXVII of the PHS Act is the same test as that applied to health insurance offered directly to individuals or employers. Association coverage does not exist as a distinct category of health insurance coverage under Title XXVII of the PHS Act.<sup>4</sup>

#### A. Individual Market

Under Title XXVII of the PHS Act, "individual market coverage" is any health insurance coverage that is not offered in connection with a group health plan. PHS Act § 2791(e)(1)(A); 45 C.F.R. § 144.103. A group health plan is defined in PHS Act section 2791(a)(1) as an employee welfare benefit plan under ERISA section 3(1). Consequently, coverage issued through an association, but not in connection with a group health plan, is not group health insurance coverage for purposes of the PHS Act. The fact that the same such coverage may be categorized as group market for State law purposes has no bearing on its categorization under the PHS Act. 45 C.F.R. § 144.102(c). <sup>5</sup>

### B. Group Market

Conversely, the term "group market" refers to health insurance coverage offered in connection with a group health plan. 45 C.F.R. § 144.103. The group market is divided into the small group market and the large group market, depending on the number of employees employed by the employer. PHS Act § 2791(e)(2)-(6).

The PHS Act derives its definitions of group health plan and employer from the ERISA definitions of employee welfare benefit plan and employer. PHS Act § 2791(a)(1), (d)(6). Under ERISA

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<sup>&</sup>lt;sup>3</sup> This Bulletin is available at: <a href="https://www.cms.gov/HealthInsReformforConsume/downloads/HIPAA-02-02.pdf">https://www.cms.gov/HealthInsReformforConsume/downloads/HIPAA-02-02.pdf</a>.

<sup>&</sup>lt;sup>4</sup> Title XXVII of the PHS Act does recognize coverage offered through "bona fide associations," but only for purposes of providing limited exceptions from its guaranteed issue and guaranteed renewability requirements. PHS Act §§ 2731(f); 2732(b)(6), (e); 2741(e)(1); 2742(b)(5), (e). The bona fide association concept has no other significance under the PHS Act, and, importantly, does not modify or affect the analysis of whether health insurance coverage belongs to the individual or group market.

A "bona fide association," within the meaning of Title XXVII of the PHS Act, means an association that: (1) has been actively in existence for five 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 health status-related factors; (4) makes coverage available to all members regardless of any health status-related factor; (5) does not make coverage available other than in connection with members; and (6) meets any additional requirements imposed under State law. PHS Act § 2791(d)(3).

<sup>&</sup>lt;sup>5</sup> See also the preamble to the interim final regulation on the medical loss ratio (MLR) requirements of the PHS Act, 75 Fed. Reg. 74864, 74871 (Dec. 1, 2010) (explaining that certain group coverage under statutory accounting principles must be classified as individual coverage for MLRs under the PHS Act).

section 3(5), an employer is "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity." Thus, reference to ERISA is needed when establishing the existence of a group health plan and determining the identity of the "employer" sponsoring the plan. <sup>6</sup>

CMS believes that, in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not at the association-of-employers level. In these situations the size of each individual employer participating in the association determines whether that employer's coverage is subject to the small group market or the large group market rules.

In the rare instances where the association of employers is, in fact, sponsoring the group health plan and the association itself is deemed the "employer," the association coverage is considered a single group health plan. In that case, the number of employees employed by all of the employers participating in the association determines whether the coverage is subject to the small group market or the large group market rules.

### C. "Mixed" Associations

A "mixed" association exists where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member's circumstances. In this situation, the members of the association cannot be treated as if all of them belonged to same market. For example, it is not permissible under the PHS Act for mixed association coverage to comply only with the large group market rules, even with respect to its individual and small employer members. Accordingly, each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer.

# Where to get more information:

If you have any questions regarding this Bulletin, please email <u>phig@cms.hhs.gov</u> or call 877-267-2323, extension 61565.

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<sup>&</sup>lt;sup>6</sup> For additional information on identifying the situations where an ERISA plan exists at the association level, please refer to the following DOL guidance: (1) MEWA Guide (<a href="www.dol.gov/ebsa/Publications/mewas.html">www.dol.gov/ebsa/Publications/mewas.html</a>); (2) Adv. Op. 2008-07A (<a href="www.dol.gov/ebsa/regs/aos/ao2008-07a.html">www.dol.gov/ebsa/regs/aos/ao2008-07a.html</a>); (3) Adv. Op. 2001-04A (<a href="www.dol.gov/ebsa/regs/aos/ao2001-04a.html">www.dol.gov/ebsa/regs/aos/ao2001-04a.html</a>); and (4) Adv. Op. 2003-13A (<a href="www.dol.gov/ebsa/regs/aos/ao2003-13a.html">www.dol.gov/ebsa/regs/aos/ao2003-13a.html</a>).