STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION

Bulletin 2011-17- INS

In the matter of

Guaranteed Renewability of Health Benefit Plans

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Issued and entered
this 19th day of December 2011
by R. Kevin Clinton
Commissioner

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), P.L. 104-191, and applicable regulations, an issuer of group and individual health insurance coverage may nonrenew or discontinue health insurance coverage based only on one or more of the following:

(1) *Nonpayment of premiums.* The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.
(2) *Fraud.* The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.
(3) *Violation of participation or contribution rules (group market only).* The plan sponsor has failed to comply with a material plan provision relating to any employer contribution or group participation rules permitted under 45 CFR § 146.150(e) in the case of the small group market or under applicable State law in the case of the large group market.
(4) *Termination of coverage.* The issuer is ceasing to offer coverage in the market in accordance with applicable regulations and State law.
(5) *Enrollees' movement outside service area.* For network plans, there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the

> issuer applies the same criteria it would apply in denying enrollment in the plan under 45 CFR § 146.150(c).
> (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.

See 45 CFR §§ 146.152, 148.122. An issuer that terminates a particular product must give 90 days' notice to plan sponsors or individual policyholders (as applicable); must offer the plan sponsor or individual the option to purchase, on a guaranteed issue basis, all other coverage the issuer offers in that market; and must discontinue the product uniformly, without regard to claims experience or health status of participants, dependents, or beneficiaries under a particular health plan. 45 CFR § 146.152(c).

Also under HIPAA, an issuer may elect to discontinue offering <u>all</u> health insurance coverage in the small or large group market, or both markets, in a State in accordance with applicable State law only if:

> (1) The issuer provides notice in writing to the applicable State authority and to each plan sponsor (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 days prior to the date the coverage will be discontinued; and
> (2) All health insurance policies issued or delivered for issuance in the State in the market (or markets) are discontinued and not renewed.

See 45 CFR § 146.152(d).

The Patient Protection and Affordable Care Act of 2010 ("ACA"), enacted on March 23, 2010, preserves HIPAA's guaranteed renewable requirements and exceptions, and requires that all health benefit plans other than grandfathered plans be guaranteed renewable as of January 1, 2014. See 42 USC § 300gg-42 (individual coverage); 42 USC § 300gg-12 (group coverage).

HIPAA and the ACA do not "supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of either statute. 45 CFR § 146.143(a).

Like HIPAA and the ACA, Michigan insurance law requires health benefit plans issued by commercial carriers, health maintenance organizations, and nonprofit health care corporations to be guaranteed renewable, with certain exceptions that are substantially similar to those found in HIPAA. See, e.g., MCL 500.2213b, 500.3539, 500.3711, and

550.1401e. Under MCL 500.2213b and 550.1401e, guaranteed renewal is not required if the issuer "no longer offers that particular type of coverage in the market." Consistent with HIPAA and the ACA, OFIR interprets this provision to include circumstances in which an issuer decides to stop offering a particular insurance product.

Consumers and issuers should note that HIPAA provides certain consumer protections in the event of a plan cessation. In addition to the notice requirements described above, HIPAA requires issuers of group health plans to furnish certificates of creditable coverage upon the cessation of plan coverage. 29 USC § 1181.

Under MCL 500.201 and 500.2236, the Commissioner has authority to review insurance policy forms to ensure that they conform to the requirements of the Insurance Code and are not inconsistent with state and federal law. Accordingly, the Commissioner will continue to review health benefit plan forms for conformity with guaranteed renewability requirements under Michigan law, HIPAA, and the ACA.

Any questions regarding this bulletin should be directed to:

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