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Cancellation of Nongroup Health Insurance Policies

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Introduction

Congress has expressed interest in health insurance cancellations, in light of media reports stating that individuals have received cancellation letters. While cancellations are not a new industry practice, additional attention has focused on the more recent cancellations given that many of the insurance market reforms included in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) will become effective beginning in 2014.¹ These cancellations and proposals to address them, including the Administration's recently announced transitional policy,² have been discussed in recent hearings and are the subject of legislative proposals.

This report provides background information about health insurance cancellations, non-renewals, and rescissions, including applicable federal rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and ACA. Given that the concern about insurance cancellations has largely focused on the nongroup market, this report discusses federal requirements and implementation issues that apply to nongroup coverage.³ One issue that is not addressed in this report is the Administration's authority to implement its transitional policy (described below); the authority issue is addressed in the CRS Legal Sidebar, *Obama Administration's "Fix" for Insurance Cancellations: A Legal Overview*.⁴

Background

The nongroup market is often referred to as a "residual" market, because the primary function of this market is to make insurance available to persons who cannot obtain employer-sponsored insurance (ESI) and do not qualify for publicly subsidized programs. Consequently, the covered population for this market is relatively small. In 2012, approximately 10.8 million individuals had coverage through the nongroup market (3.4% of the total U.S. population).⁵

While individuals who have nongroup coverage generally do not have access to ESI, many of them are, in fact, employed. A 2010 survey of non-elderly adults with nongroup coverage found that 70% worked, but for a variety of reasons did not have access to an employer plan, or could not afford the plan.⁶ In addition, some people use the nongroup market as a temporary source of coverage, such as those between jobs or early retirees who are not yet eligible for Medicare.

¹ The ACA provisions discussed in this report may apply to other insurance products beyond policies sold in the nongroup market. Given that the focus of this report is on nongroup policy cancellations, we consider ACA provisions solely in the context of the nongroup market.

² Letter from Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, to State Insurance Commissioners, November 14, 2013, <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.

³ Insurance cancellations may also be occurring in the small group market. Similar to nongroup policies, small group plans are subject to a number of ACA market reforms that become effective in 2014.

⁴ Available at <http://www.crs.gov/legalsidebar/details.aspx?ProdId=724&source=FeatureTopic>.

⁵ The number of covered lives in the nongroup market was obtained from SNL Financial. The 2012 total population estimate (313.9 million) was obtained from the United States Census Bureau's Population Estimates Program.

⁶ Kaiser Family Foundation, *Survey of People Who Purchase Their Own Insurance*, June 2010, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8077-r.pdf>.

Most individuals who have nongroup coverage stay in the market for a relatively short time. A study of nongroup coverage found that, between 1996 and 2000, almost half of covered individuals were in the market for less than 6 months, and about two-thirds were in the market for 12 months or less.⁷

Questions and Answers

What is a cancellation? Is it the same as a rescission? Is it the same as not renewing a policy?

A cancellation refers to termination of an existing insurance policy, whereby *future* medical services obtained by the former policyholder will not be covered under the cancelled policy. A rescission refers to *retroactive* cancellation, whereby both prior and future medical claims would not be paid by the insurance company that rescinded the policy. Pursuant to federal (and state) law, an issuer can cancel or rescind a policy at any point during the time period for which the policy was issued. A non-renewal refers to the situation when an insurance policy has reached the end of the time period for which the policy was issued, and the issuer decides not to allow that person to renew their policy.

For each of these scenarios, there are federal requirements with which issuers are required to comply.⁸ In other words, while insurance companies are allowed to cancel, rescind, or not renew a policy, they may only do so under certain circumstances (see **Table 1**). As displayed in the table, most of the federal rules regulating insurance cancellations, rescissions, and non-renewals became effective prior to ACA enactment.

Are issuers cancelling policies or not renewing policies? Is there a difference?

It is unclear from media reports whether the letters that policyholders are receiving are cancellations or non-renewals. However, based on the HIPAA rules outlined in **Table 1**, termination of policies for groups of individuals (as opposed to termination of a specific person's policy) may only occur if the entire policy is being discontinued. Given the information provided in a cursory review of recent media reports, it appears typical that the policy is being discontinued, in which case the affected individuals must be given adequate prior notice and offered alternative insurance options (see **Table 1**).

⁷ E. Ziller et al., "Patterns Of Individual Health Insurance Coverage, 1996–2000," *Health Affairs*, Vol. 23, No 6, Nov./Dec. 2004.

⁸ Individual states may also have requirements related to cancellations, rescissions, and non-renewals; see the department of insurance in each state for more information.

Why are issuers cancelling policies? Which ACA requirements may be influencing this decision?

An issuer may cancel policies for a variety of reasons (e.g., changing priorities of the organization) or in response to a variety of conditions (e.g., changing regulatory environment). Given that ACA generally allows issuers to enter, expand, contract, or exit the private health insurance market, cancellations have been and may continue to be one strategy that issuers employ to achieve specific or broad business objectives.

While ACA does not require issuers to cancel existing insurance policies, ACA contains multiple provisions that directly affect what policies may be offered in the nongroup market. An issuer may consider such provisions as it decides whether to continue to offer or cancel policies, and under which conditions. The following briefly describes selected ACA provisions and implementation issues that may directly affect an issuer's decision to continue or cancel nongroup coverage.

- Grandfathered Policies⁹—ACA establishes grandfathering standards which allow nongroup policies—that were in force on the date of ACA enactment (March 23, 2010) and continue to be in force—to be exempt from all but a handful of ACA's market reforms (see **Table 2**).
 - While there is no sunset date for the grandfathering provision, moderate changes to a policy may cause it to lose grandfathered status. Compared to grandfathered policies, non-grandfathered policies are required to comply with more ACA market reforms (see **Table 2**). Each issuer makes the determination about whether a policy is grandfathered or not. Such determinations are not required to be reported; therefore, there is no comprehensive source of data on grandfathered coverage.
- Market Reforms¹⁰—ACA establishes market reforms that impose requirements on insurance companies relating to the offer, issuance, generosity, and pricing of health policies, among other requirements.
 - The impact of these reforms on issuers and the policies they offer will vary by state, depending on state market reforms that are already effective.¹¹
- Effective Dates—ACA's market reforms become effective either prior to 2014 or in 2014 (see **Table 2**). All prior-2014 reforms are currently in effect. The actual date when the 2014 reforms become effective will vary by policy. ACA's market reforms are generally effective for policy years beginning on or after January 1, 2014.¹²

⁹ ACA §1251. For additional information about these issues, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*.

¹⁰ ACA §§1001, 1002, 1003, 1201, and 1311. For brief descriptions of ACA's market reforms and a table indicating applicability of a given reform to nongroup policies, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

¹¹ For listings of selected pre-2014 health reforms in the nongroup market, by state, see "Protections in Individual Insurance Markets," Kaiser Family Foundation, <http://kff.org/state-category/health-insurance-managed-care/>.

¹² ACA §1255. 78 *Federal Register* 13429.

- Given that the effective date of the 2014 market reforms will vary from policy to policy, some current policies are allowed to continue intact into 2014. For example, consider a hypothetical scenario in which a person obtains a nongroup policy with coverage beginning on September 1, 2013, with a duration of six months. Such a policy would be allowed to be in force through the end of the term, which would be February 2014.
- On November 14, 2013, President Obama announced a transitional policy that allows health insurance issuers to choose to continue coverage that would otherwise be cancelled.¹³ Pursuant to the policy, state insurance commissioners may choose whether to enforce compliance with specified ACA market reforms. Presumably, if state insurance commissioners choose not to enforce compliance, then issuers of nongroup policies may renew coverage for individuals who would otherwise receive cancellation notices.¹⁴ Pursuant to this transitional policy, coverage that is renewed for a policy year between January 1, 2014, and October 1, 2014, will not have to comply with specified ACA market reforms, provided the coverage meets certain conditions.

Is it possible for an individual to have coverage in 2014 that is not in compliance with ACA requirements that go into effect in 2014?

Yes. There are a few different ways an individual could have a nongroup policy in 2014 that is not in compliance with ACA requirements. First, an individual could continue to have coverage in a grandfathered policy; grandfathered policies do not have to comply with all of the ACA requirements that go into effect in 2014 (see **Table 2**).

Second, as noted, the ACA market reforms that are not already in effect go into effect for policy years that begin on or after January 1, 2014. If an individual is covered under a policy that has a renewal date in July 2014 (for example), then the individual's policy does not necessarily have to comply with the ACA market reforms until it is renewed in July 2014.

Third, media reports indicate that some issuers offered policyholders the option to early-renew their nongroup coverage in 2013. Provided it is allowed under state law,¹⁵ an issuer may allow policyholders who would typically renew their policies in 2014 (per the terms of the contract) to renew their policies prior to 2014. For example, instead of renewing a policy in January 2014, an individual could be given the opportunity to renew the contract in November 2013. Going forward, the individual's contract year would be November–October. If an existing policy was

¹³ Letter from Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, to State Insurance Commissioners, November 14, 2013, <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.

¹⁴ It should be noted that the transitional policy applies to coverage offered in the small group market as well; however, the focus of this report is the nongroup market.

¹⁵ The practice of early renewal is not regulated under federal law, but some states may have laws that regulate issuers' renewal practices. For example, some states have prohibited the practice of early renewals in the nongroup market, and others have indicated dates by which policies issued in 2013 must end in 2014. For more information, see the Commonwealth Fund Blog, *The Affordable Care Act's Early Renewal Loophole: What's at Stake and What States Are Doing to Close It*, <http://www.commonwealthfund.org/Blog/2013/Aug/The-Affordable-Care-Acts-Early-Renewal-Loophole.aspx>.

renewed in October 2013 with a 12-month contract, the policy will not have to comply with 2014 ACA market reforms until it renews in October 2014.

Finally, on November 14, 2013, President Obama announced a transitional policy that allows health insurance issuers to choose to continue coverage that would otherwise be cancelled.¹⁶ Pursuant to this transitional policy, coverage that is renewed for a policy year between January 1, 2014, and October 1, 2014, will not have to comply with specified ACA market reforms, provided the coverage meets certain conditions:

- the coverage was in effect October 1, 2013; and
- the issuer provides notice to all individuals that did or would have received a cancellation notice that explains which ACA market reforms will not be reflected in their coverage under the policy, their options for obtaining a policy that reflects all ACA market reforms, and the potential for receiving financial assistance if they obtain coverage through an exchange.

It should be noted that these avenues do *not guarantee* that an individual will be able to have a nongroup policy in 2014 (and beyond) that does not comply with ACA requirements. The options available to individuals will vary from state to state and possibly person to person. For example, in a state that allows issuers to renew coverage (either through early renewal or under the transitional policy) and currently allows issuers to set rates based on an individual's characteristics (such as health status), an issuer may continue to price policies on those characteristics.

How many policies have been cancelled? How many individuals are in policies that have been cancelled?

There is no comprehensive source of data related to insurance cancellations. Given that insurance regulation is and continues to be the primary responsibility of the states, state departments of insurance are in the best position to regulate cancellations. However, unless a state has the resources and intent to monitor cancellations and require issuers to report relevant data, such information will be available in a patchwork fashion, at best.¹⁷ Given the lack of a comprehensive reporting mechanism regarding cancellations and offers of renewal, it is also not possible to develop reliable estimates on the number of individuals who renewed policies through "early renewal" or who will be offered transitional policies.

In addition, each issuer makes the determination about whether a policy is grandfathered or not. Such determinations are not required to be reported; therefore, there is no comprehensive source of data on grandfathered coverage.

¹⁶ Letter from Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, to State Insurance Commissioners, November 14, 2013, <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.

¹⁷ The difficulty in obtaining timely, accurate, and comprehensive information on this topic is illustrated by one of the cancellation estimates reported in the media; the Associated Press (AP) has recently reported that "based on an AP survey in which about half the states reported data" cancellations affect at least 3.5 million individuals in the nongroup market. <http://www.usnews.com/news/politics/articles/2013/11/07/canceled-policies-could-be-a-plus-for-new-markets>.

If a person’s nongroup policy is cancelled, what options does the person have for obtaining a new policy in the nongroup market in 2014?

A person may obtain nongroup coverage through an exchange or in the insurance market outside of an exchange.¹⁸ For policy years beginning on or after January 1, 2014, issuers offering coverage inside or outside exchanges do not have to offer coverage to individuals outside of the specified open enrollment period unless an individual qualifies for a special enrollment period. The events that qualify a person for a special enrollment period are outlined in regulations;¹⁹ they include the loss of “minimum essential coverage.” In other words, if a person receives a cancellation notice from his/her issuer in June 2014, the person would likely qualify for a special enrollment period and would be able to enroll in a policy offered inside or outside the exchange.

Issuers do not have to effectuate coverage earlier than specified effective dates, but they may agree to do so.²⁰ The open enrollment periods and effective dates of coverage for policy years beginning on or after January 1, 2014, are the same for policies offered inside and outside exchanges (**Table 3**).

¹⁸ For brief summaries of private health insurance plans that may be offered inside and outside of exchanges, see CRS Report R43233, *Private Health Plans Under the ACA: In Brief*.

¹⁹ 45 CFR §155.420.

²⁰ According to 45 CFR §155.410(c)(2), if an exchange demonstrates to HHS that all of its participating issuers agree to effectuate coverage in a shorter timeframe than what is described in **Table 3**, then the exchange may implement earlier effective dates.

Table I. Federal Rules Applicable to Nongroup Coverage Cancellations, Rescissions, and Non-Renewals

Prior to and Under ACA

Rule	Applicability
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	<p>In general, nongroup issuers are required to continue and renew coverage at the option of covered individuals.</p> <p>However, issuers are allowed to discontinue or not renew policies for certain individuals, provided the issuers comply with federal law (and any applicable state rules), if any of the following conditions apply:</p> <ul style="list-style-type: none"> • Individual does not pay premiums; • Individual commits fraud; • Individual no longer lives or works in the service area, in the case of coverage based on a network; or • Individual ceases to be a member of an association through which coverage is provided. <p>Issuers may also uniformly terminate coverage for a group of individuals, if it is done without regard to health factors.^a To do so, issuers must:</p> <ul style="list-style-type: none"> • provide 90 days' prior notice to individuals that the coverage is being discontinued. • offer to each individual whose coverage is being terminated the option to purchase any other nongroup policy being offered by the issuer in the area. <p>HIPAA did not specifically address rescissions.^b</p>
ACA	<p>ACA builds on HIPAA requirements.</p> <p>ACA prohibits issuers from rescinding policies, unless an individual has committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan.</p> <ul style="list-style-type: none"> • Issuer must provide at least 30 days' prior notice to the individual before coverage may be rescinded.

Source: CRS analysis of relevant federal law and implementing regulations/guidance.

Notes: Individual states may have their own requirements related to insurance cancellations, rescissions, and non-renewals; see the department of insurance in each state.

- a. The rules for the uniform termination of coverage are specific to the scenario in which an issuer discontinues one type of coverage in a state, but continues to offer other policies in that state's nongroup market. Other federal rules apply in situations when an issuer exits out of a given state's nongroup market entirely. Under that scenario, an issuer must provide 180 days' prior notice to affected individuals, and are prohibited from re-entry into that state's nongroup market for five years.
- b. While the HIPAA statute did not explicitly reference rescissions, HHS provided testimony which seemed to indicate that that the Administration broadly interpreted the HIPAA rules described in the table to include rescissions. See "Rescission of Individual Health Insurance Policies," testimony to the Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.

Table 2. Applicability of Selected ACA Market Reforms to Nongroup Policies, by Grandfathered Status and Policy Year

ACA / PHSA Reference	Provision	Nongroup Market	
		Grandfathered Policies	Non-Grandfathered Policies
Reforms effective for policy years beginning prior to January 1, 2014			
§1003	Rate Review		√
§1001/§2711	Prohibition on Lifetime Dollar Limits	√	√
§1001/§2711	Restricted Annual Dollar Limits		√
§1001/§2712	Prohibition on Rescissions	√	√
§1001/§2713	Coverage of Preventive Health Services with No Cost-sharing		√
§1001/§2714	Extension of Dependent Coverage	√	√
§1001/§2718	Medical Loss Ratio (MLR)	√	√
§1001/§2719	Appeals Process		√
§1255	Coverage of Preexisting Health Conditions for Children		√
§1001/§2719A	Patient Protections		√
§1001/§2715	Uniform Explanation of Coverage Documents	√	√
§1001/§2717	Reporting Requirements Regarding Quality of Care		√
Reforms effective for policy years beginning on or after January 1, 2014			
§1001/§2711	Prohibition on Annual Limits		√
§1201/§2705	Nondiscrimination Based on Health Status (X)		√
§1201/§§2702-2703	Guaranteed Issue & Guaranteed Renewal (X)		√
§1201/§2704	Coverage of Preexisting Health Conditions – All (X)		√
§1201/§2709	Nondiscrimination Regarding Clinical Trial Participation (X)		√
§1201/§2701	Rating Restrictions (X)		√
§1201/§2706	Nondiscrimination Regarding Health Care Providers (X)		√
§1302	Essential Health Benefits (X)		√
§1302	Minimum Actuarial Value (X)		√
§1302	Maximum Out-of-Pocket Limits (X)		√

Source: CRS analysis of ACA and its implementing regulations.

Notes: An **(X)** indicates a reform with which non-grandfathered coverage would not have to comply under the Administration's transitional policy outlined in: Letter from Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, to State Insurance Commissioners, November 14, 2013, <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.

Table 3. Open Enrollment Periods and Effective Dates of Coverage in the Nongroup Market Beginning in 2014

	Open Enrollment Period	Effective Dates of Coverage
Policies that begin in 2014	October 1, 2013-March 31, 2014	<p>If enrolled prior to December 15, 2013, the effective date of coverage is January 1, 2014</p> <p>If enrolled between the 1st and 15th of January, February, or March 2014, the effective date of coverage is the 1st of the next following month</p> <p>If enrolled between the 16th and the last day of December 2013, or January, February, or March 2014, the effective date of coverage is the 1st of the second following month</p>
Policies that begin after 2014	October 15-December 7 of preceding calendar year	If enrolled during the open enrollment period, the effective date of coverage is the 1 st day of following benefit year

Source: 45 CFR § 155.410.

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