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Memorandum

From: Bruce D. Platt

To: HMOCAP Board of Directors, Florida Department of Financial Services, Florida Office of Insurance Regulation

Date: September 4, 2015

Subject: Grace Period

QUESTION PRESENTED

If the Florida Health Maintenance Organization Consumer Assistance Plan (the "HMOCAP") assumes coverage of subscribers who were previously enrolled in an HMO that was found to be insolvent, is the HMOCAP required to offer these members any specific grace period for paying their premiums? If so, how long must the grace period be, and can the HMOCAP retroactively cancel coverage to the last day for which premium was paid?

SHORT ANSWER

A Florida HMO that becomes insolvent may have had coverage sold through the federal exchange and subject to federal statutes and regulations governing such coverage, as well as the Florida Insurance Code, and coverage that was not sold through the federal exchange. For both types of commercial coverage, we believe the best interpretation is that the HMOCAP can set a reasonable grace period, and that it can retroactively cancel coverage after such grace period has expired. However, the best evidence of the coverage provided by the HMOCAP will be the insolvent HMO's contracts with its members, and it may be difficult to change the termination language in such contracts. Therefore, the HMOCAP may be required to comply with the termination language in such insolvent HMO's contracts, unless and until it is able to modify such language.

ANALYSIS

I. Florida Law

In a situation where a Florida HMO with commercial subscribers is found to be insolvent by a court of competent jurisdiction, for those commercial subscribers the HMOCAP is required to "[g]uarantee, reinsure, assume or provide coverage for or cause to be guaranteed, assumed, or covered all of the subscriber contracts of the insolvent HMO subject to the terms and conditions of [Part IV of Chapter 631, Florida Statutes]."[1] The statute continues by stating that the HMOCAP shall "[c]over all services that would have been covered by the subscribers' contracts with the insolvent HMO" during the period of the HMOCAP's coverage responsibility.[2] Part IV of Chapter 631 and the HMOCAP's Plan of Operation and Policies and Procedures provide more detail as to how the HMOCAP can fulfill its responsibilities. Specifically, Section 631.817, Florida Statutes, provides guidance as to when a subscriber receiving coverage through the HMOCAP loses eligibility for such coverage, and Paragraph (2)(b) of this statute provides that "A person shall cease to be covered by the plan upon failure to pay, or failure to have paid on their behalf, premiums as set by the board. Coverage shall cease following a reasonable grace period as set by the board."[3]

I believe the best interpretation of the language above is that the HMOCAP is not required to assume all of the provisions of the subscriber contracts that were entered with the insolvent HMO. Paragraph (2)(a) states that the HMOCAP must "cover the services that would have been covered by the subscribers' contracts" – not the contracts themselves. Paragraph (2)(a) appears to require some type of assumption of the insolvent HMO's subscriber contracts, but it continues that such assumption is subject to the terms and conditions of Part IV of Chapter 631. Section 631.817, Florida Statutes, which is within Part IV, specifically allows the HMOCAP's Board to set a "reasonable grace period" for such coverage. Therefore, it appears that, pursuant to Florida Statutes, the HMOCAP is required to offer a grace period, and that the HMOCAP Board of Directors has flexibility in establishing such a grace period so long as it is "reasonable."

In determining a reasonable grace period, the HMOCAP Board may want to look at Florida's statutory grace period required for HMOs. Although the HMOCAP is not a licensed insurance company or health maintenance organization, and the HMO statutes do not apply to the HMOCAP, the statutory requirements presumably are reasonable. Section 641.31(15), Florida Statutes requires that HMOs offer a grace period of at least 10 days, so presumably a 10-day grace period is reasonable.

[1] Section 631.818(1)(a), Fla. Stat.
[2] Section 631.818(1)(b), Fla. Stat. (emphasis added)
[3] Emphasis added. Although Florida Statutes do not explicitly address the Department of Financial Service's and Office of Insurance Regulation's oversight specific to grace periods, it is presumed for purposes of this memorandum that the Department and Office would be involved in any determination as to the appropriate, reasonable grace period.

Florida Statutes also allow for an HMO to retroactively cancel coverage upon failure to pay premium.[4] As with the HMO statutory grace period requirement, this is not directly applicable to the HMOCAP. However, this also helps demonstrate that cancellation for non-payment of premium, after the grace period has expired, is traditional and accepted practice.

Notwithstanding, there also is an argument that the HMOCAP is bound by the termination language in the insolvent HMO's contracts. As noted above, Section 631.818(1)(a), Florida Statutes, specifically references the insolvent HMO's contracts, and it uses language such as "assume" and "reinsure." A court or regulatory agency may find that this language requires the HMOCAP to provide the same coverage, under the same terms, as in the insolvent HMO provided. Probably more important, the insolvent HMO's contract is the only coverage document that provides the conditions for the coverage – if the HMOCAP does not assume these contracts, how does the member know its coverage rights and responsibilities? Arguably, the HMOCAP would be required, at least initially, to provide the same termination and grace period requirements as contained in the insolvent HMO's contract. Pursuant to the language in Section 631.817, Florida Statutes, the HMOCAP Board could set a different "reasonable grace period", but it would have to notify the members and amend their contract to do so.

II. Federal Law

Federal law also requires grace periods for qualified health plan ("QHP") coverage offered pursuant to the Patient Protection and Affordable Care Act ("PPACA"), but even if the insolvent HMO offered QHPs, the HMOCAP does not appear to be subject to these PPACA requirements. Presumably, some of an insolvent HMO's commercial coverage would have been qualified QHP coverage offered over the Exchange, and such coverage would have been required to meet all of the applicable federal statutes and regulations, including those applicable to termination of such coverage. One of the applicable regulations, Rule 45 C.F.R. § 156.270, requires that a QHP issuer provide grace period of three months under certain circumstances, and the coverage can only be retroactively terminated for two months (requiring the issuer to pay for one month of coverage without premium). However, there are strong arguments as to why this would not apply to coverage provided by the HMOCAP.

a. HMOCAP Coverage Should not be QHP

The first argument as to why the 3-month grace period of §156.270 does not apply to the HMOCAP is that the coverage should no longer be considered a QHP. As stated above, the HMOCAP arguably is not required to assume the existing contracts of the insolvent HMO, but instead is required to provide similar coverage, and the new coverage would not be a QHP.[5]

[4] Section 641.3108, Fla. Stat.

[5] There may be several reasons why the new coverage would not be a QHP. For example, the new coverage would not be "certified" as required pursuant to 42 U.S. Code § 18021. See also the definition of QHP as provided in 45 C.F.R. § 155.20

Because the new coverage provided by the HMOCAP would not be a QHP, it is not subject to the QHP grace period requirements.

Even if the HMOCAP were to be required to assume the insolvent HMO's QHP coverage, it should no longer be considered QHP coverage upon such an assumption. Rule 45 C.F.R. § 156.810 provides the basis and process of decertification of a QHP. Generally, decertification of a QHP requires 30 days' notice, but HHS can use an expedited decertification process under certain circumstances. In December, insurance company CoOportunity Health was placed in rehabilitation by the Iowa insurance department, and was subsequently placed in liquidation effective February 28, 2015. According to the company's website,[6] liquidation caused the revocation of the QHP status:

> In addition, now that CoOportunity Health has been placed into liquidation, it has lost its Qualified Health Plan (QHP) status. This means that starting March 1, policyholders will no longer receive advance premium tax credits (APTCs) and they will be responsible for paying their entire premium if they retain their CoOportunity Health policy.

Presumably such QHP decertification would also apply with other insurance or HMO insolvencies. Therefore, even if the HMOCAP were considered to have assumed an insolvent HMO's QHP contracts, they would no longer be considered QHPs upon liquidation.[7]

b. The HMOCAP Should not be a QHP Issuer.

Even if the HMOCAP coverage was considered to be QHPs, the 3-month grace period of §156.270 is limited to "QHP issuers," and the HMOCAP should not be considered a QHP issuer. Federal regulations define a QHP issuer as "a health insurance issuer that offers a QHP in accordance with a certification from an Exchange."[8] The HMOCAP does not have a certification from an exchange, and arguably the HMOCAP is not even a "health insurance issuer."[9] As the HMOCAP should not be considered to be a QHP issuer, the grace period requirements should not apply to it.

[6] http://www.cooportunityhealth.com/

[7] However, if the HMOCAP were to assume the same contracts, the contractual language should be reviewed to determine if there are contractual grace period and cancellation requirements that must be followed.

[8] 45 C.F.R. §155.20

[9] 45 C.F.R. § 144.103 defines a health insurance issuer as follows: "Health insurance issuer or issuer means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). This term does not include a group health plan." The HMOCAP obviously is not a health insurance company or insurance organization. Although the term "insurance service" does not appear to be defined in federal law, the HMOCAP does provide insurance services in that it provides health coverage for a premium. However, the HMOCAP is not licensed to engage in the business of insurance.

CONCLUSION

Rule Section 156.270 appears to contain the only applicable, federal grace-period requirements and, therefore, if this Rule is not applicable it appears that the Florida Insurance Code would control. As stated above, we believe the best interpretation of the Florida Insurance Code is that coverage provided by the HMOCAP is not subject to any specific grace period. Rather, we believe the HMOCAP Board has the ability to set a reasonable grace period for the coverage provided. However, a Court or Regulatory Agency may determine that the HMOCAP is bound by the termination and grace period language in the insolvent HMO's coverage documents, at least until the HMO is able to amend such language.