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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Circumstances Under Which Health Insurance Regulated As "Individual" Coverage Under State Law Is Subject To The Group Market Requirements Of The Health Insurance Portability And Accountability Act Of 1996 (HIPAA)

Market: Group

I. Purpose

This Bulletin conveys the position of the Health Care Financing Administration (HCFA) that health insurance coverage that is characterized as an individual policy[1] under State law may nonetheless be subject to the group market requirements contained in Part A of Title XXVII of the Public Health Service Act (PHS Act), as added by HIPAA, if the coverage is provided in connection with a group health plan. The bulletin also provides guidance on factors that are relevant in determining whether a policy is being offered in connection with a group health plan.

II. Background

Title XXVII of the PHS Act contains two basic types of requirements that apply to health insurance issuers. The first type of requirement applies to issuers that offer group health insurance coverage, which is defined as coverage "offered in connection with" a group health plan. The second type applies to issuers that offer individual health insurance coverage, which is defined as coverage offered to individuals "other than in connection with a group health plan." These are the only definitions of group and individual health insurance coverage that are relevant for purposes of determining whether Title XXVII requirements apply to a particular issuer[2].

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[1] In this Bulletin, unless otherwise indicated, the term "insurance policy" refers to any insurance policy or other contract (including contracts issued by a health maintenance organization) that provides "health insurance coverage" as defined in Section 2791(b)(1) of the PHS Act. "Health insurance coverage" is defined in that section as:

> *benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.*

[2] Of course, to the extent the policy offers an excepted benefit, whether it is in the group or individual market, neither the group market nor the individual market rules under Title XXVII apply to it.

III. Discussion of Factors Relevant to Determining Whether Coverage is Offered in Connection With a Group Health Plan.

The definition of a group health plan in section 2791(a) of the PHS Act incorporates by reference the Employee Retirement Income Security Act (ERISA) definition of an employee welfare benefit plan[3]. Specifically, to the extent an employee welfare benefit plan provides medical care to employees and their dependents, it is considered to be a "group health plan[4]." Through this reference, Title XXVII relies on established principles under ERISA with respect to what an employee welfare benefit plan is and how it works. For a discussion of what constitutes an employee welfare benefit plan, see the Department of Labor's Advisory Opinions, including AO 94-26A (July 11, 1994), AO 94-22A (July 1, 1994), AO 90-08A (April 11, 1990), and AO 83-03A (January 17, 1983) and regulations in 29 C.F.R. 2510.3-1(j). Ordinarily, as the advisory letters indicate, a determination of whether there is an employee welfare benefit plan depends on the facts and circumstances surrounding the extent of the employer's involvement. For example, with respect to whether there is a group health plan, one significant factor would be the extent to which the employer makes contributions to health insurance premiums.

Note, however, that section 2721(e) of the PHS Act provides that certain partnership arrangements that would not otherwise meet the ERISA definition of an employee welfare benefit plan are considered to be group health plans for purposes of the PHS Act. (Under section 3(1) of ERISA, as incorporated in section 2791(a) of the PHS Act, a plan that provides benefits only to partners in a partnership and not to at least one "common law" employee of the partnership is not considered an employee welfare benefit plan. See 29 CFR §2510.3-3(b), -3(c)(1), (2).)

Accordingly, when insurance coverage is sold in connection with an arrangement that meets the PHS Act definition of a group health plan, the fact that the particular form of coverage is regulated under State law as an individual policy, as opposed to a group policy, is not the deciding factor[5].

IV. Applicable Group Market Requirements

If it is determined that health insurance policies have been or are being provided in connection with a group health plan, then the issuer is subject to the group market requirements of Title XXVII. These fall into two basic categories--requirements that protect the rights of employers to purchase and renew health insurance; and requirements that protect the rights of individuals under a group health plan.

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[3] Section 2791(a)(1) of the PHS Act defines a "group health plan" as:

> *an employee welfare benefit plan (as defined in section 3(1) of [ERISA]) to the extent that the plan provides medical care (as defined in [section 2791(a)(2) of the PHS Act] and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.*

[4] Accordingly, an employee welfare benefit plan that does not provide "medical care" is not a group health plan for purposes of the PHS Act.

[5] See, for example, Massachusetts Casualty Ins. Co. v. Reynolds, 113 F.3d 1450 (6th Cir. 1997)(individual policies constituted employee welfare benefit plan), cited with approval in Agrawal v. Paul Revere Life Ins. Co., 205 F.3d 297, 301 (6th Cir. 2000); Peterson v. American Life & Health Ins. Co., 48 F.3d 404 (9th Cir. 1995)(individual policy and group policy together constituted employee welfare benefit plan); O'Brien v. Mutual of Omaha Insurance Company, 99 F. Supp. 2d at 748 (individual policy purchased by employee was not an employee welfare benefit plan because employer did not establish or maintain a plan); du Mortier v. Massachusetts General Life Ins. Co., 805 F. Supp. 816 (C.D. Ca. 1992) (same).

Employer Rights

Guaranteed Availability

A key requirement of Title XXVII, found at section 2711(a) of the PHS Act, relates to guaranteeing the availability of health insurance coverage offered in the small group market. This provision requires each health insurance issuer "that offers health insurance coverage in the small group market in a State [to] accept every small employer (as defined in section 2791(e)(4)) . . . that applies for such coverage." This provision also requires such issuers to accept for enrollment every "eligible individual" who meets specified conditions.

Therefore, in order to determine whether an issuer is subject to section 2711(a) of the PHS Act, a critical question is whether the issuer offers the particular coverage in the small group market. Section 2791(e)(5) of Title XXVII (42 USC 300gg-91(e)(5)) defines "small group market" as:

> *the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents)* ***through a group health plan maintained by a small employer.***

(Emphasis added.) As long as the employer is a "small employer" and establishes and maintains a "group health plan" as defined by Title XXVII (in which at least two current employees participate as of the first day of the plan year), any health insurance coverage that is considered under the federal law to be obtained in connection with the plan is obtained in the small group market. Issuers offering such coverage would be subject to the guaranteed availability requirements of section 2711(a) of the PHS Act.

For purposes of Title XXVII, the mere fact that coverage is provided through a contract viewed by State law as an "individual" insurance contract does not necessarily prevent it from being characterized as coverage sold in the small group market for purposes of Title XXVII. Similarly, the policy that provides the coverage does not have to be labeled a "group" policy under State law in order for Title XXVII's group market requirements to apply. Furthermore, the employer need not be a party to the insurance policy, or arrange or pay for it directly, in order for its coverage to be considered group health plan coverage. As mentioned earlier, a determination of whether there is a group health plan depends upon the particular facts and circumstances surrounding the employer's involvement.

Guaranteed Renewability

If it has been determined that a particular insurance policy has been sold in connection with a group health plan, then for purposes of Title XXVII, the policy is renewable under the terms of section 2712 of the PHS Act, which specifies that the coverage is renewable at the option of the plan sponsor (the employer or employee organization). Therefore, while this renewal right may indirectly benefit individual employees under the federal law, only the employer has the right to renew the policy. However, to the extent the policy is considered for purposes of a State law to be "individual coverage," it is possible that State law might give the individual enrollees renewal rights beyond what is available under the title XXVII group market renewability requirements. Title XXVII does not prevent a state from

establishing, implementing or continuing in effect such a State law, as long as the State law does not "prevent the application of" the federal renewability requirements[6].

Individuals' Rights Under Title XXVII When Covered Under a Group Health Plan

If coverage is determined to be sold in connection with a group health plan, then eligible individuals who are enrolled, or wish to enroll under the coverage, are entitled to the rights described in sections 2701 and 2702 of the PHS Act, and 45 CFR Parts 144 and 146. Among other limitations, the issuer:

- may only impose preexisting condition exclusions on an individual's coverage under a group health plan if the issuer meets the requirements of section 2701 of the PHS Act, including the requirement to reduce any exclusion period by the amount of prior creditable coverage.
- must provide special enrollment rights to certain individuals who lose other coverage or gain new dependents through marriage, birth or adoption.
- cannot refuse to enroll any individual in the group health plan or vary any individual's premium or contribution based on the individual's health status.

Where to get more information:

The regulations cited in this Bulletin are found in Part 2510 of Title 29 and Parts 144 and 146 of Title 45 of the Code of Federal Regulations (29 CFR 2510; 45 CFR 144 - 146). Information about the PHS Act requirements is also available on HCFA's website at http://hipaa.hcfa.gov. The DOL Advisory Opinions cited in this bulletin are available on DOL's website at http://www.dol.gov/dol/pwba or by contacting the Pension and Welfare Benefits Administration, Public Disclosure Room at 202-219-8771.

If you have any questions regarding this Bulletin, call the HIPAA Insurance Reform Help Line at (410) 786-1565.

[6] See section 2723(a) of the PHS Act, and the discussion of preemption under State law in Section IV of Bulletin 00-03.