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Health Care Financing Administration

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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Issues Related to Eligible Individual Status Under the Health Insurance Portability and Accountability Act of 1996

Markets: Individual Market in States Where the Federal Fallback rules[1] are in Effect

I. Purpose

The purpose of this Bulletin is to convey the position of the Health Care Financing Administration (HCFA) concerning the rights of "eligible individuals" to guaranteed availability of health insurance coverage in the individual market. These protections are provided under section 2741 of the Public Health Service Act (PHS Act), as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and as implemented in regulations at 45 CFR Part 148. This Bulletin:

(1) Addresses an issuer's responsibility for determining whether an applicant for coverage in the individual market is an eligible individual[2] before accepting applications for, or offering, any individual market product (including conversion coverage);
(2) Clarifies that an individual can be an eligible individual even if the individual's most recent group health plan coverage was terminated due to the plan sponsor's nonpayment of premiums or fraud;
(3) Clarifies that issuers may collect medical underwriting information from eligible individuals, but may use it only for the purpose of determining premium rates;
(4) Clarifies that it is permissible to offer other products to eligible individuals, in addition to those subject to the guaranteed availability requirement;
(5) Clarifies issuer obligations when offering conversion policies at the end of a period of COBRA continuation coverage; and
(6) Addresses issuer responsibilities to assist eligible individuals in arranging seamless coverage.

[1] Title XXVII of the Public Health Service Act (PHS Act), as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), contains requirements for guaranteed availability of individual health insurance to certain individuals with prior group health insurance coverage. The term "federal fallback rules" refers to the minimum federal requirements for guaranteed availability set forth in section 2741 of the PHS Act and implemented by the regulations at 45 CFR § 148.120. These are the rules that apply if a State does not implement an "alternative mechanism" under section 2744 of the PHS Act and 45 CFR § 148.128.

[2] Title XXVII of the PHS Act, as added by HIPAA, contains two definitions of an "eligible individual," one in the group market and one in the individual market. (See 45 CFR § 144.103, which cross-references 45 CFR § 146.150(b) (the group market definition, based on section 2711(a)(2) of the PHS Act) and 45 CFR § 148.103 (the individual market definition, based on section 2741(b) of the PHS Act). For purposes of this Bulletin, the term "eligible individual" refers only to the individual market.

II. Background

Guaranteed Availability

Section 2741 of the PHS Act and the implementing regulations at 45 CFR § 148.120(a)(1) set forth the general rule that issuers that sell health insurance coverage in the individual market must offer all policy forms that they actively market in that market to "eligible individuals," and may not impose any preexisting condition exclusions on those individuals. There are two exceptions to this rule:

- If a State implements an acceptable alternative mechanism under State law, the rules of the alternative mechanism apply; and
- If a State does not implement an acceptable alternative mechanism under State law, the issuer may choose to offer eligible individuals only two policies, which must meet certain specified criteria and which cannot impose any preexisting condition exclusions.

Definition of Eligible Individual

The regulations at 45 CFR § 148.103 define an eligible individual as an individual who meets specified conditions. In general, an eligible individual is an individual:

1) Who has at least 18 months of "creditable coverage," the most recent of which was under a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with such a plan);
2) Who is not eligible for coverage under another group health plan, Medicare, or Medicaid and does not have any other health insurance coverage;
3) Whose most recent coverage was not terminated because of fraud or nonpayment of premiums; and
4) Who either was not offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or a similar State program, or who, if COBRA or similar State-mandated continuation coverage was offered, has elected and exhausted such continuation coverage.

Creditable Coverage

Creditable coverage includes most kinds of health benefits, but does not include any coverage preceding a break in coverage of 63 or more days during all of which the individual does not have any creditable coverage. (However, State law may provide for a longer break period.) Time spent in a waiting period or a health maintenance organization's affiliation period does not count for the individual as creditable coverage or against the individual as a break in coverage, although it is possible that the individual can have creditable coverage from another source during the waiting period or affiliation period. Creditable coverage can be demonstrated by a "certificate of creditable coverage" or by other evidence. Certain entities that provide health coverage, including health insurance issuers; group health plans, including governmental and church plans; Medicare; and State Medicaid programs are required to provide certificates of creditable coverage.

COBRA Continuation Coverage

Employers with 20 or more employees are usually required to offer people who lose their group health plan a temporary extension of their group health coverage under COBRA. State law may also impose similar requirements on companies with fewer than 20 employees. COBRA requires an employer to allow a person who loses coverage under the employer's group health plan to remain covered under the employer's group health plan coverage for a certain length of time after losing a job or having work hours reduced; after a spouse's death or a divorce; after a dependent child ceases to be a dependent child; after the covered employee becomes entitled to Medicare; and, for retired employees, after a bankruptcy of the employer causes a loss of coverage. However, the person may have to pay both the employee and employer share of the premium, with up to an added 2% for administrative costs.

Conversion Coverage

In contrast to COBRA continuation coverage, which is group market coverage, individuals losing group coverage may also be offered "conversion" coverage. Although conversion coverage may only be available to former members of the group health plan, it is individual market coverage.

III. Issuer's Obligation to Identify Eligible Individuals

Under 45 CFR § 148.120(a) (1), in a State that has not implemented an acceptable alternative mechanism, the basic rule is that an issuer may not decline to offer coverage or deny enrollment under any policy form that it actively markets. However, if the issuer chooses to limit the coverage options it offers to eligible individuals to two policy forms, as permitted by statute and regulations, then it may not decline to offer coverage or deny enrollment under those two policy forms. The issuer is deemed to meet these requirements if it:

- Provides information to the applicant about all available coverage options that the issuer makes available to eligible individuals; and
- Enrolls the individual in the selected coverage.

The regulations at 45 CFR § 148.126 clearly describe in detail the responsibility of issuers offering coverage in the individual market to determine whether any applicant is an eligible individual. Under the regulations, the issuer must:

- Exercise reasonable diligence in making the determination;
- Make the determination promptly based on the application, or on additional information it has promptly requested;
- Allow an eligible individual to demonstrate creditable coverage by means other than certificates of creditable coverage, as described in 45 CFR § 148.124(d); and
- Promptly issue policies to applicants it determines to be eligible individuals.

The regulations clearly make no distinction based on an applicant's knowledge of his or her rights under the statute, nor is the issuer's compliance conditioned upon the type of policy for which the applicant has applied.

Some issuers and their agents may be avoiding the obligation to offer coverage to eligible individuals by not informing applicants of their rights to protection under HIPAA unless the individual specifically asks about such protections. Practices that create potential problems include the following:

- An issuer does not attempt to identify an applicant as an eligible individual unless and until the applicant states he or she is seeking coverage on a guaranteed available basis, or the applicant is required to state other key words such as HIPAA;
- If an eligible individual applies for an underwritten policy and is turned down, an issuer requires the individual to file a second application (and subjects the individual to a second application process) after turning down the initial application for the underwritten product;
- An issuer conditions the issuer's consideration of an eligible individual's application for an underwritten policy on the applicant's agreement to relinquish his or her rights as an eligible individual; and
- An issuer will not accept anything but a certificate of creditable coverage as proof of eligibility rather than following the requirements of 45 CFR § 148.124(d) of the regulations regarding individuals' ability to demonstrate creditable coverage without a certificate.

Regarding this last practice, the regulations at 45 CFR § 148.124(d) permit an eligible individual who for any reason does not have a certificate of creditable coverage to furnish alternative proof of coverage. The regulations at 45 CFR § 148.124(d)(2) specify the kinds of documentation that must be accepted, and explain how other evidence such as telephone calls and other third party verification may be used. In particular, an issuer must treat an individual as having furnished a certificate if he or she attests to the period of creditable coverage, presents relevant corroborating evidence of some creditable coverage during the period, and cooperates with the issuer's efforts to verify the individual's coverage.

In States where HCFA enforces these provisions, failure to comply may subject the issuer to civil money penalties. Under 45 CFR § 148.202(e), an issuer may be relieved of a penalty if it did not know, "and exercising reasonable diligence would not have known," that it was violating a requirement of the statute or regulations. Subsection (e)(3)(iii) makes clear that "the burden is on the issuer to establish to the satisfaction of HCFA that it did not know, and exercising reasonable diligence could not have known" of the violation.

An issuer does not exercise "reasonable diligence" in making a determination whether applicants are eligible individuals unless it makes a reasonable effort to determine whether <u>any applicant for any type of coverage</u> in the individual market (including medically underwritten and conversion products) is an eligible individual, regardless of whether the individual knows or believes he or she has this status, and regardless of whether he or she specifically applied for a HIPAA product.

Reliance by an issuer on agents or brokers does not constitute "reasonable diligence" unless the issuer has made reasonable efforts to ensure that its agents and brokers are in continual compliance with the regulations. While many issuers may have conducted initial agent/broker training in HIPAA requirements in 1997 and 1998, it is not clear that all issuers are continuing to provide in-service training

on how to screen for HIPAA eligibility and on what the law requires them to do once an eligible individual is identified.

IV. Nonpayment of Premiums or Fraud as a Basis for Denying Eligible Individual Status

As stated above, one of the criteria for being an eligible individual is that an individual's most recent coverage must not have been canceled for nonpayment of premiums or fraud. Neither the statute nor the regulations clearly state whether the fraud had to have been committed by the individual him or herself. The definition of an eligible individual in section 2741(b)(3) of the PHS Act requires that the individual's most recent coverage "was not terminated based on a factor described in paragraph (1) or (2) of section 2712(b) [of the group market provisions] (relating to nonpayment of premiums or fraud)." Those group market provisions permit nonrenewal of group coverage if "the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments," or if "the plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage."

The statute does not penalize the individual for nonpayment of premiums or fraud by the previous plan sponsor, because section 2741 cross-references "a factor" described in section 2712(b), and not "an action" described in that section. While the action in section 2712 is that of a plan sponsor, the "factors" are: failure to pay premiums in accordance with the terms of the health insurance coverage, performing an act that constitutes fraud, or making an intentional misrepresentation of material fact. Accordingly, section 2741(b)(3) should be interpreted as applicable only where the individual him or herself has performed any of the actions referred to as factors described in section 2712(b)(1) or (2). This interpretation is supported by the fact that remedial statutes such as HIPAA are to be "liberally construed, to give effect to the humane purpose of the legislature." Grier v. Kennan, 64 F.2d 605, 607 (8th Cir. 1933). See also Bruhn's Freezer Meats v. U.S.D.A., 438 F.2d 1332 (8th Cir. 1971).

Therefore, nonpayment of premiums or fraud on the part of the individual's most recent employer that resulted in termination of coverage for all previously covered employees is not considered a reason to disqualify a person from guaranteed availability in the individual market.

V. Medical Underwriting of Eligible Individuals

As long as there is no State law to the contrary, an issuer may require an eligible individual to complete a medical history questionnaire as part of the application for an individual market policy. However, because eligible individuals are guaranteed access to coverage, issuers are not permitted to underwrite to determine whether to accept or reject these individuals. Guaranteed availability of health insurance coverage with no preexisting condition exclusion, regardless of health status, is one of the main protections of HIPAA. While underwriting based on health status may not be used for the purpose of determining whether to accept or reject an eligible individual, or of applying a preexisting condition exclusion, underwriting for the purpose of determining premium rates is permissible unless State law

prohibits or restricts it. In addition, issuers may underwrite based on health status to determine whether eligible individuals also qualify for underwritten policies.

VI. Offering of Multiple Products to Eligible Individuals

In a "federal fallback" State, an issuer that offers its two most popular or two representative policies to eligible individuals is also free to offer these individuals other policies that require underwriting and that may impose a preexisting condition exclusion so long as the issuer clearly explains to the eligible individual that he or she has a guaranteed right to purchase the two most popular or two representative policies, which cannot impose a preexisting condition exclusion.

VII. Offering Conversion Policies at the End of COBRA

If an issuer operates in both the group and individual markets, its group market/COBRA operational staff must exercise reasonable diligence in identifying eligible individuals and in explaining their HIPAA rights to them. An individual who has exhausted COBRA continuation coverage will generally have at least 18 months of creditable coverage, the most recent of which has been under a group health plan. (Under COBRA continuation coverage, the individual continues under the group health plan coverage even though he or she is no longer a member of the group, and may be required to pay the full premium.) If the group health plan provides for offering a conversion policy at the end of COBRA continuation coverage, the issuer is likely to be required by the contract between the employer and the issuer to explain this option to the individual. However, the issuer, if it is also offering policies in the individual market, must also explain the individual's HIPAA rights and disclose to the individual that taking the conversion policy will terminate the individual's eligibility for HIPAA individual market protections (a guaranteed available product with no preexisting condition exclusion). Therefore, for an issuer operating in both the group and individual markets, the most prudent action to take would be to treat any application for a conversion product at the end of COBRA continuation coverage as an application for a HIPAA product, too, and offer both conversion and guaranteed issue products to the applicant.

VIII. Arranging for Seamless Coverage

Some issuers have not accepted an individual's application until the individual's COBRA coverage has actually terminated and the individual can prove that the COBRA coverage has been exhausted. Further, some issuers have required that the individual provide the certificate that is required to be issued at the end of COBRA coverage as proof of exhaustion of COBRA coverage. One issuer's individual market operational staff claimed it could not proceed to process an individual's application until it received a certificate of creditable coverage from the same issuer's group market operations.

By imposing such requirements, the issuer is preventing the individual from arranging for a seamless transition from COBRA coverage to individual market coverage. Ordinarily, documentation verifying the individual's COBRA election date and a certificate of creditable coverage, obtained upon request, showing that the coverage is continuing, should provide sufficient evidence that the individual will exhaust COBRA benefits by a given date.

An eligible individual is defined as an individual who "has at least 18 months of creditable coverage . . . as of the date on which the individual seeks coverage under this part." We interpret "the date on which the individual seeks coverage" to mean the date on which the individual wishes coverage to begin, not the application date. Similarly, while an individual is not eligible for coverage to begin until, for example, COBRA continuation coverage is exhausted, nothing in the statute or regulations precludes the issuer from accepting applications before the individual's eligible individual status is effective. The regulations at 45 CFR §§ 148.120 and 148.126 make clear that the issuer must act promptly in order to be in compliance with the guaranteed availability provisions. An issuer is not acting "promptly" if it fails to accept an application from an individual who submits the application in time to arrange for seamless coverage, and who provides reasonable evidence of the date that his or her eligible individual status will be effective.

Where to get more information:

The regulations cited in this bulletin are found in Parts 144 through 148 of Title 45 of the Code of Federal Regulations (45 CFR §§ 144-148). Information about HIPAA is also available on HCFA's website at www.hcfa.gov/hipaa.

If you have any questions regarding this Bulletin, call the HIPAA Insurance Reform Help Line at (410) 786-1565 or your local HCFA Regional Office (see attached list of contact numbers and the geographic areas served by each region)

HCFA REGIONAL OFFICE CONTACTS

Region	Regional Geographic Areas	Contact name	Contact Phone
Atlanta	Alabama, Florida, Georgia, Kentucky, Mississippi, Tennessee, North Carolina, South Carolina	Selwyn White	404-562-7427
Boston	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Nancy Grano	617-565-1289
Chicago	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Cynthia Garraway	312-353-8583
Dallas	Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Karen Herbelin	214-767-6301
Denver	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Dick Palmer	303-844-7030
Kansas City	Iowa, Kansas, Missouri, Nebraska	General number for the Kansas City Regional Office Insurance Reform Team	816-426-5472
New York	New Jersey, New York, Puerto Rico, Virgin Islands	Robert Cochrane	212-264-3885
Philadelphia	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Bertha Finney	215-861-4259
San Francisco	American Samoa, Arizona, California, Guam, Nevada, Northern Mariana Islands, Hawaii	Eileen Turner	415-744-3674
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