PROGRAM MEMORANDUM
INSURANCE COMMISSIONERS
INSURANCE ISSUERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. 99-03 **Date** September 1999

Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Group Size Issues under Title XXVII of the Public Health Service Act

Markets: Group and Individual

I. Purpose

The purpose of this Bulletin is to convey the position of the Health Care Financing Administration on three issues related to employer group size under Title XXVII of the Public Health Service (PHS) Act, as added by Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Bulletin will address the following issues:

(1) Which types of employees must be counted to determine who is a small or large employer in the group market in order to apply the guaranteed availability requirements of Title XXVII, and the requirements added to Title XXVII by the Mental Health Parity Act of 1996 (MHPA).
(2) How the Title XXVII guaranteed renewability requirements apply to employers whose size shifts between the small and large group markets after purchasing coverage in one or the other of these markets, and how this issue affects the mental health parity requirements; and
(3) How the guaranteed renewability requirement applies to small employers that shrink to fewer than two employees after purchasing group coverage.

II. Background

Title XXVII of the PHS Act contains certain group market provisions that apply only to small employers, and others that apply only to large employers.

A. Definitions

Small Employer

Section 2791(e)(4) of the PHS Act, and the regulations at 45 CFR §144.103, define a small employer as "…an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year."

Large Employer

Section 2791(e)(2) defines a large employer as "…an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year."

Employee

Section 2791(d)(5) states that the term "employee" has the meaning given such term under section 3(6) of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) as amended. That section of ERISA states that the term "employee" means "any individual employed by an employer" (emphasis added). The Department of Labor, through its Pension and Welfare Benefits Administration (PWBA), is responsible for the administration, interpretation, and enforcement of Title I of ERISA, including the definition at section 3(6). According to the Department of Labor, for purposes of section 3(6) of ERISA, whether an employer-employee relationship exists is determined by applying common law principles and taking into account the remedial purposes of ERISA.

However, once it has been determined that there is an employer-employee relationship with respect to a particular individual, the question of whether the employee is, for example, full-time or part-time becomes irrelevant for purposes of determining employer size under the PHS Act. Therefore, the individual must be counted because the definition of an employee under the PHS Act includes "any" employee of an employer.

Participant

Section 2791(d)(11) states that the term "participant" has the meaning given such term under section 3(7) of ERISA. That section of ERISA states that the term "participant" means ". . . any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such organization, or whose beneficiaries may be eligible to receive any such benefit."

Treatment of "Very Small Plans"

Section 2721(a), and the regulations at §146.145(a), state that "the requirements of part 146 do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees." Part 146 includes both the guaranteed availability and guaranteed renewability provisions.

In addition, coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year is included in the definition of the "individual market," although a State may elect to regulate the coverage as coverage in the small group market. (Section 2791(e)(1)(B).)

Plan Year

The regulations at §144.103 define plan year as… "the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is: (1) the deductible/limit year used under the plan; (2) if

the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year; (3) if the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year; or (4) in any other case, the plan year is the calendar year."

B. Group Market Provisions that are Linked to Employer Size

Guaranteed Availability

Guaranteed availability of health insurance coverage for small employers is one of the main protections provided under HIPAA. Section 2711, and the regulations at §146.150, require issuers that sell health insurance coverage in the small group market to accept every small employer that applies for such coverage. The issuer must also accept every "eligible individual" who applies for enrollment under the terms of the small employer's group health plan, even those individuals with serious medical problems[1].

Guaranteed Renewability

Guaranteed renewability of health insurance coverage is another protection provided under HIPAA. Section 2712 (a), and the regulations at §146.152(a), require issuers that sell health insurance coverage in either the small or the large group markets to renew coverage at the option of the plan sponsor of the plan. Under section 2712 (b), and the regulations at §146.152(b), an issuer may nonrenew coverage only for the following reasons:

- the employer fails to pay premiums timely, commits fraud or makes an intentional misrepresentation of material fact under the terms of the coverage, or violates participation or contribution rules;
- the issuer is ceasing to offer coverage in a market;
- there are no longer any plan enrollees living, residing or working in the service area of a plan with a network requirement; or
- if coverage was made available only through a bona fide association, the employer's association membership has ended[2].

Mental Health Parity

Mental health parity requirements apply only in the large group market. Section 2705, as added by the MHPA, and the regulations at §146.136, generally prohibits a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and

---

[1] Section 2711(a)(2) states that . . . "the term 'eligible individual' means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined--(A) in accordance with the terms of such plan, (B) as provided by the issuer under rules of the issuer which are uniformly applicable in a State to small employers in the small group market, and (C) in accordance with all applicable State laws governing such issuer in such market."

[2] Note that in the group market, individual employees (called "participants" in an ERISA-covered plan) and their dependents (called "beneficiaries" in an ERISA-covered plan that provides dependent coverage) do not have the right of guaranteed renewability. Instead, participants and beneficiaries are protected from discrimination in eligibility (or continued eligibility) to enroll in a group health plan or group health insurance coverage offered in connection with a group health plan, based on a health status-related factor, by the nondiscrimination provisions in section 2702, and the regulations at §146.121. Unless prohibited by other Federal law or by State law, individuals may be terminated from the plan by the plan sponsor or the issuer for reasons that are not related to a health status-related factor.

mental health benefits from imposing lower annual or lifetime dollar limits on mental health benefits than it imposes on medical and surgical benefits. However, section 2705(c)(1) provides that small employer plans are exempt from the mental health parity requirements, as are large employer plans that can demonstrate an increased cost of at least one percent due to the application of the mental health parity requirements. (Section 146.136(e) and (f).)

C. Preemption

The preemption provision of the PHS Act that pertains to the guaranteed availability, guaranteed renewability, and mental health parity requirements is found in section 2723(a)(1), and the regulations at §146.143(a). This section states the general rule that the group market provisions of part A of Title XXVII of the PHS Act, and related definitions in part C, do not preempt State laws unless State law "prevents the application of" any of the group market provisions.

III. Counting Employees for the Purpose of Determining Which Market Rules Apply

Some State laws that define whether an employer is a small or large employer have not adopted the definition of "employee" used in section 2791 and the regulations at §144.103. Instead, these laws specify that only "eligible" employees are to be counted, with that term being defined in various ways, such as to include only full-time employees. Since the PHS Act definition includes "any" individual employed by an employer, any less expansive definition will exclude some employees who should be counted.

For example, for purposes of the PHS Act, an employer with 10 part-time employees is entitled to guaranteed availability of coverage because it has two or more employees. If, however, State law provides for counting only "full-time" employees, this employer would be considered to have no employees, and, having fewer than two employees, it would be denied the PHS Act protections. Under these circumstances, the State law would prevent the application of the PHS Act requirement, and would be preempted.

If an employer in the same State had 45 full-time employees, and 20 part-time employees, it would meet the definition of a "large" employer under the PHS Act, but would be a "small" employer under State law. Since the employer would still qualify for guaranteed availability in the small group market, the State law would not prevent the application of the guaranteed availability provision. However, since large employers (defined by the PHS Act as having more than 50 employees) are entitled to protections under the MHPA, the State law does prevent the applicability of the MHPA under these facts, and would be preempted with respect to MHPA. In theory, the State could adopt two different definitions of an employee, one that would apply for purposes of MHPA, and another that would apply for purposes of guaranteed availability.

IV. Employers Whose Size Shifts Between the Small and Large Group Markets

We have been asked whether small employers that grow beyond 50 employees can continue to renew the coverage they purchased on a guaranteed available basis in the small group market. The general rule set forth in section 2712(a), and the regulations at §146.152(a), makes clear that a health insurance issuer "offering coverage in the small or large group market is required to renew or continue in force the coverage at the option of the plan sponsor." (Emphasis added.) The exceptions to this rule set forth in section 2712(b), and the regulations at §146.152(b), do not include the situation in which the employer that sponsors the group health plan grows from a small employer to a large employer, or the reverse, between the time the policy is purchased and the time it comes up for renewal.

Therefore, the employer that grows beyond 50 employees has the option of keeping the product it purchased in the small group market even though a wider selection of group coverage may be available to it as a large employer. (Generally, more issuers are willing to sell in the large group market and tend to offer larger employers a wider selection of products from which to choose.) However, since the guaranteed availability provisions only apply to small employers, if the employer drops the coverage it purchased in the small group market, it will not be able to purchase the same coverage again on a guaranteed available basis if it no longer meets the definition of a small employer.

Similarly, for a large employer that shrinks below 50 employees, the law guarantees the right to continue to renew the coverage purchased in the large group market. We understand that some policies state that the policy cannot be renewed if the employer drops below a specified size. These clauses are no longer valid if the issuer is subject to HIPAA's guaranteed renewability requirements. However, if an employer whose size has dropped below 50 employees voluntarily drops the coverage issued in the large group market, the employer may not be able to get that policy back. The employer will only be guaranteed a right to purchase new coverage that is offered in the small group market. If the employer again grows into the large group market, the issuer could deny that policy to the employer because there is no guaranteed availability requirement in the large group market.

V. Small Employers Shrinking to Less Than Two Employees

Questions have been raised as to the applicability of the guaranteed renewability requirement to the situation in which a small employer had two or more employees when it purchased coverage originally, but has shrunk to the point that it fails to meet the tests contained in section 2791(e)(4) and (e)(1)(B)(i).

As noted above, under section 2721(a) and the regulations at §146.145(a), the guaranteed renewability requirement does not apply to group health insurance offered in connection with a plan that, on the first day of the plan year, does not have at least two participants who are current employees. Since employer size is assessed on the first day of the plan year, coverage cannot be terminated until the first renewal date following the beginning of a new plan year, even if the issuer knows as of the beginning of the plan year that the employer no longer has at least two participants who are current employees. A State may, however, elect to regulate coverage offered in connection with a group with fewer than two

participating employees as coverage in the small group market. Approximately one-quarter of the States have extended the lower boundary of the small group market to encompass certain individuals in very small groups that would otherwise be treated under section 2791(e)(1)(B)(i) as being in the individual market.

Moreover, HIPAA's minimum group market requirements would not supplant contract terms that are more generous. If coverage that was originally issued in the small group market contains a renewal provision that requires guaranteed renewability at the option of the plan sponsor, regardless of whether the group shrinks below two current employees at the start of the plan year, HIPAA would not invalidate the contract provision.

Also, HIPAA does not require an issuer to terminate the coverage of an employer that due to its size fails to qualify for group market protections under §146.145. If the issuer voluntarily permits the employer's coverage to renew or otherwise continue in force, State law rather than HIPAA will govern when and under what conditions the employer may terminate the coverage. Please note, however, that even though HIPAA's group market protections do not apply, the coverage still will be regarded as group coverage for the purpose of determining whether employees qualify for portability into the individual market.

Individuals whose coverage is nonrenewed because the group has shrunk to fewer than two employees may be "eligible individuals" for purposes of transitioning into the individual market. The individual would, of course, have to meet all of the criteria for being an eligible individual that are identified in section 2741(b), and the regulations at §148.103. Most notably, the individual would have to have had at least 18 months of creditable coverage (unless State law provides for a shorter period), and the most recent coverage would have to have been under a group health plan. In the situation in which the coverage was nonrenewed because the employer dropped below two employees, the coverage meets this test because the nonrenewed coverage was originally issued as group health insurance offered in connection with a group health plan. The individual also cannot have any other coverage available such as Medicare, Medicaid, or another group health plan. If other group health plan coverage is available to the individual (for instance, through a spouse's employment), the law gives the individual a special enrollment right under that other plan based on the nonrenewal of this dwindling group's policy, rather than guaranteed availability in the individual market.

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
Seattle	Alaska, Idaho, Oregon, Washington	Bill Collins	206-615-2391