

# PROGRAM MEMORANDUM INSURANCE COMMISSIONERS INSURANCE ISSUERS

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Health Care Financing  
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**Title:** Insurance Standards Bulletin Series--INFORMATION

**Subject:** Issue Related to Eligible Individual Status Under Section 2741(b) of the Public Health Service Act

**Markets:** Individual Market

## **I. Purpose**

The purpose of this bulletin is to further clarify the position of the Health Care Financing Administration (HCFA) regarding who qualifies as an “eligible individual” for purposes of obtaining health insurance coverage in the individual market on a guaranteed issue basis.<sup>1</sup> (This bulletin supplements HCFA’s bulletin “Issues Related to Eligible Individual Status Under the Health Insurance Portability and Accountability Act of 1996,” *Program Memorandum/ Insurance Commissioners/ Insurance Issuers*, Transmittal No. 99-02, June 1999.) This bulletin addresses the extent to which all States (regardless of whether they are implementing an alternative mechanism or the federal minimum standard),<sup>2</sup> and issuers that are required to offer coverage to eligible individuals on a guaranteed issue basis,<sup>3</sup> must

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<sup>1</sup>Title XXVII of the Public Health Service (PHS) Act, as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), contains two definitions of an “eligible individual,” one in the group market and one in the individual market. (See 45 CFR 144.103, cross-referencing 45 CFR 146.150(b) (group market definition, based on section 2711(a)(2) of the PHS Act) and 45 CFR 148.103 (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.

<sup>2</sup>The term “federal minimum standard” refers to minimum federal requirements for guaranteed availability, as set forth in section 2741 of the PHS Act and implemented at §148.120 of the regulations, that apply in a State that does not implement an alternative mechanism under section 2744 of the PHS Act and §148.128 of the regulations.

<sup>3</sup>For ease of reference, “issuers,” as used in this bulletin, means those issuers that are required to offer coverage to eligible individuals on a guaranteed issue basis under a State’s alternative mechanism, and all issuers in States that do not implement an alternative mechanism.

recognize certain creditable coverage as coverage under a group health plan (or health insurance coverage offered in connection with a group health plan) for purposes of determining whether an individual meets the “eligible individual” requirement of section 2741(b)(1)(B) of the PHS Act. Section 2741(b)(1)(B) requires that an individual’s most recent creditable coverage must have been under a group health plan. Specifically, this bulletin addresses whether States, and issuers, must recognize as coverage under a group health plan--

- coverage under an employer-sponsored plan in which only one employee participates;
- coverage of an employee under an individual policy;
- coverage of a business owner;
- coverage of partners in a plan maintained by partners in a partnership.

## **II. Background**

### Guaranteed Availability

Part B of Title XXVII of the PHS Act sets forth three alternative means of ensuring that health coverage in the individual market is available to “eligible individuals” on a guaranteed issue basis with no preexisting condition exclusions: States may enforce the federal minimum standard, implement an acceptable alternative mechanism under State law, or do nothing and allow the Federal Government to enforce the federal minimum standard. The federal minimum standard gives health insurance issuers two options with respect to their individual market products: they can guarantee issue all their products, or two products, which may be either the two most popular products or two representative products.

### Definition of “Eligible Individual”

An eligible individual is one who meets the conditions specified in section 2741(b) of the PHS Act, including having at least 18 months of creditable coverage, the most recent of which was under a group health plan, governmental plan or church plan (or health insurance coverage offered in connection with such a plan).<sup>4</sup> This definition applies

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<sup>4</sup>For ease of reference, we will refer to this coverage collectively as “coverage under a group health plan.” The term “group health plan” is defined at section 2791(a)(1) of the PHS Act to mean an employee welfare benefit plan under section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA) to the extent that the plan provides medical care to employees or dependents. Certain group health plans are not subject to ERISA or to the group market requirements of HIPAA. For instance, governmental and church plans generally are not

regardless of the method the State has chosen to guarantee availability of coverage to these individuals (that is, via a State alternative mechanism, federal minimum standard, or direct federal enforcement).<sup>5</sup>

### **III. Definition of a Group Health Plan**

#### **In General**

As noted above, section 2741(b)(1)(B) of the PHS Act provides that in order for an individual to qualify as an “eligible individual,” the individual’s most recent prior creditable coverage must have been “under a group health plan.”<sup>6</sup> The only condition necessary for the coverage to meet this criterion is that the plan meet the PHS Act definition of “group health plan,” which is defined in section 2791(a)(1) as “an employee welfare benefit plan (as defined in section 3(1) of [ERISA]) to the extent that the plan provides medical care . . . to employees or their dependents . . . .” As noted previously, it is not necessary that the plan itself be subject to ERISA or HIPAA requirements. Nor is it necessary that the insurance coverage sold to the plan be subject to the HIPAA group market requirements. For example, the insurance coverage might be regulated by the State as individual market coverage because the plan only covers one employee, or because the employer purchases separate individual market policies for employees.

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subject to ERISA. (See sections 4(b)(1) and (2) of ERISA.) Also, plans that have fewer than two participants as current employees and self-funded plans of non-Federal governmental plan sponsors may be exempt from the group market requirements of HIPAA. (See section 732(a) of ERISA and section 2721(a) and (b) of the PHS Act.) However, for purposes of this bulletin, it does not matter whether a plan is subject to ERISA or the group market requirements of HIPAA. Rather, the only factor relevant to this bulletin is whether a plan meets the definition of a “group health plan” under section 2791(a)(1) of the PHS Act.

<sup>5</sup>Of course, a State may adopt a more generous definition of “eligible individual.” Section 2762(a) of the PHS Act provides that “nothing in this part [B of Title XXVII of the PHS Act (the HIPAA individual market rules)] (or part C [of Title XXVII] insofar as it applies to this part) shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of this part.”

<sup>6</sup>Under sections 701(c)(1) of ERISA and 2701(c)(1) of the PHS Act, the term “creditable coverage” does not include coverage consisting solely of excepted benefits (as defined under sections 733(c) of ERISA and 2791(c) of the PHS Act). Also, HIPAA does not apply to any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits. (See sections 732(b) of ERISA and 2721(c) of the PHS Act.)

## Group Health Plans With Only One Employee

The Department of Labor (DOL) regulations at 29 CFR 2510.3-3(b) make clear that a plan “under which no employees are participants covered under the plan” (emphasis added) cannot meet the definition of an employee benefit plan. Accordingly, a plan with only one employee can meet this definition. Thus, even if a group health plan has only one current employee as a participant, the plan can meet the definition of an employee welfare benefit plan under section 3(1) of ERISA, and the coverage can therefore be “under a group health plan,” notwithstanding the fact that the plan may not be subject to the HIPAA group market rules.

## Group Health Plan Coverage Provided Through Individual Policies

In addition to regulations promulgated at 29 CFR Part 2510, DOL has issued various Advisory Opinions on the subject of what constitutes an employee welfare benefit plan under section 3(1) of ERISA. In general, these advisory opinions indicate that a determination of whether an arrangement constitutes a group health plan depends on the facts and circumstances of the case, including the extent of the employer’s involvement, such as contributions to premiums.<sup>7</sup> Therefore, even if an employer purchases separate individual health insurance policies for its employees, to the extent such an arrangement provides medical care to employees or their dependents and meets the definition of an employee welfare benefit plan under section 3(1) of ERISA and implementing regulations, the coverage under those policies constitutes coverage under a group health plan.

Accordingly, an individual who had coverage in either of the situations described above as his most recent prior creditable coverage meets the requirement of section 2741(b)(1)(B). That person would qualify as an “eligible individual” under section 2741(b) of the PHS Act if all other requirements for eligible individual status are met. States, and issuers, must recognize such an individual as an “eligible individual,” and make coverage available on a guaranteed issue basis with no preexisting condition exclusions.

### Examples

*Example 1:* Mrs. Smith is one of three employees of a small company, and the only employee that participates in the group health plan sponsored by her employer. (The other two employees are eligible to participate in the plan but have declined to do so because they have other group health coverage. Under the issuer’s group participation rules, 75 percent of eligible employees must participate in the plan. However, in this case the issuer’s participation rules provide that employees who are eligible to participate in the group health plan but are enrolled in other group health coverage are not considered for

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<sup>7</sup>See, for example, the following DOL Advisory Opinions (AOs): 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).

purposes of applying the 75 percent minimum participation rule. Therefore, the 75 percent rule is considered to have been met by the enrollment only of Mrs. Smith.) The company collects Mrs. Smith's share of the health plan premiums via payroll deduction, and forwards that amount along with the company's share of the premiums to the issuer. In addition, the company has direct involvement over the design and structure of the plan. The facts and circumstances in this example regarding the employer's involvement with the health plan are similar to those found in DOL advisory opinions in which the Department found the plan to constitute an employee welfare benefit plan under section 3(1) of ERISA.

The company goes out of business, which causes plan coverage to cease. Mrs. Smith seeks to obtain coverage in the individual market as a HIPAA "eligible individual." Her State has implemented the HIPAA individual market rules via a State alternative mechanism, under which enrollment in the State's high risk pool is available to HIPAA eligible individuals on a guaranteed issue basis with no preexisting condition exclusions. The State must recognize Mrs. Smith's prior coverage as coverage under a group health plan. If the coverage is her most recent creditable coverage, and she meets all other requirements necessary to qualify as an eligible individual, the State must allow Mrs. Smith to enroll in its high risk pool without regard to any preexisting conditions.

*Example 2:* Mr. Jones is one of 17 employees who works for a small company. His employer contributes to the cost of individual health insurance policies for each employee. The employer pays half the cost, collects employees' share of the premiums via payroll deduction, and forwards the premiums to the issuer(s). The facts and circumstances in this example regarding the employer's involvement with the health plan are similar to those found in DOL advisory opinions in which the Department found the plan to constitute an employee welfare benefit plan under section 3(1) of ERISA. Mr. Jones' employment-related coverage ceases when he quits his job and moves to another State. The federal minimum standard applies in the State to which he has moved. He seeks to obtain coverage in the individual market as a HIPAA "eligible individual." All issuers that offer health insurance coverage in the individual market in the State must recognize Mr. Jones' prior coverage as coverage under a group health plan. If the coverage is his most recent creditable coverage, and he meets all other requirements necessary to qualify as an eligible individual, Mr. Jones may obtain coverage on a guaranteed issue basis, with no preexisting condition exclusions, from any issuer in the individual market in the State.

#### **IV. Coverage of a Business Owner**

A business owner and spouse may be participants in a group health plan as long as there are one or more common law employees obtaining benefits under the plan in addition to

the business owner and spouse.<sup>8</sup> Thus, a business owner and spouse can qualify as eligible individuals if under the plan that they maintained for themselves one or more employees also participated. Section 3(6) of ERISA defines “employee” as “any individual employed by an employer.” This includes any individuals who meet the common law master/servant test for determining who is an employee, such as based on the degree of employer control over the individual. See National Mutual Insurance Company v. Darden, 503 U.S. 318 (1992).

On the other hand, as noted above, under the DOL regulation at 29 CFR 2510.3-3(b), a plan “under which no employees are participants covered under the plan” (emphasis added) cannot meet the definition of an employee benefit plan. With respect to the definition of an “employee,” a business owner and spouse “shall not be deemed to be employees” (29 CFR 2510.3-3(c)(1)). Thus, if a business owner has no common law employees, the plan cannot meet the definition of an employee welfare benefit plan, and, in turn, cannot meet the definition of a group health plan. Therefore, coverage under the plan cannot be “coverage under a group health plan” for purposes of meeting the definition of an “eligible individual.”<sup>9</sup> (However, see section V. If self-employed individuals are partners, a plan maintained by the partnership may constitute an employee welfare benefit plan that is a group health plan for HIPAA purposes, even if the plan would not be an employee welfare benefit plan for other purposes.)

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<sup>8</sup>See sections 2721(e)(3)(B) of the PHS Act and 732(d)(3)(B) of ERISA. See also, for example, DOL Advisory Opinion letter 99-04A (February 4, 1999).

<sup>9</sup>Nothing prohibits a State from regulating health insurance coverage of a self-employed individual as group health plan coverage under State law, even if that coverage is not provided in connection with an employee welfare benefit plan. Also, such an individual may qualify as an “eligible individual” in that State in the event that the coverage ceases, and, as noted in footnote # 5, the State has adopted a more generous definition of “eligible individual” than is provided in HIPAA. However, nothing in HIPAA would require another State to recognize the individual as an “eligible individual” (in the event the individual were to move to another State) because the individual’s most recent period of coverage would not have been under an employee welfare benefit plan. This situation is distinguishable from that in which the individual’s health insurance coverage is provided in connection with an employee welfare benefit plan (regardless of whether the coverage is regulated by the State as group or individual market coverage). In that situation, all States must recognize the coverage as group health plan coverage for purposes of section 2741(b)(1)(B) of the PHS Act.

## **V. Coverage of Partners in a Partnership**

Sections 2721(e)(3)(A) of the PHS Act and 732(d)(3)(A) of ERISA designate partners in a partnership as *participants* in connection with a group health plan maintained by the partnership. Moreover, sections 2721(e)(1) of the PHS Act and 732(d)(1) of ERISA provide that even if a plan maintained by a partnership otherwise would not be an employee welfare benefit plan, the plan shall be treated as an employee welfare benefit plan for HIPAA purposes to the extent that the plan provides medical care to present or former partners in the partnership or to their dependents. (Under sections 2721(e)(2) of the PHS Act and 732(d)(2) of ERISA, the term *employer* includes the partnership in relation to any partner.)

Thus, for HIPAA purposes, health benefit plans maintained by a partnership for partners and their dependents are group health plans even if they otherwise do not constitute employee welfare benefit plans under ERISA. Accordingly, States, and issuers, must recognize coverage under such partnership plans as coverage under a group health plan. If that coverage is an individual's most recent creditable coverage, and the individual meets all other requirements under section 2741(b) of the PHS Act, the individual is an "eligible individual" for purposes of qualifying for individual market coverage on a guaranteed available basis with no preexisting condition exclusions.

### **Where to get more information:**

The regulations cited in this bulletin are found in Part 2510 of Title 29 and Parts 144-148 of Title 45 of the Code of Federal Regulations (29 CFR 2510; 45 CFR 144 - 148). Information about HIPAA also is 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 or your local HCFA Regional Office (see attached list of contact numbers and the geographic areas served by each region).

## HCFA REGIONAL OFFICE CONTACTS

<u>Region Number</u>	<u>Regional Geographic Areas</u>	<u>Contact Name</u>	<u>Contact Phone</u>
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	Linda Deramus	214-767-6484
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
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