PROGRAM MEMORANDUM
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Health Care Financing Administration

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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Applicability of the Health Insurance Portability and Accountability Act of 1996 to Secondary Coverage and Continuing Coverage

Markets: Group

I. Purpose

The purpose of this Bulletin is to convey the position of the Health Care Financing Administration on the following issues relating to the applicability of the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

(1) Whether comprehensive group health plan coverage that is secondary to other coverage meets the definition of an excepted benefit under HIPAA.

(2) If the secondary coverage is not an excepted benefit, whether current, continuing coverage under the primary plan is creditable coverage that must be applied to reduce a preexisting condition under the secondary coverage.

II. Background: *Excepted benefits*

Sections 2721(c) and (d) of the Public Health Service Act (PHS Act), as implemented in 45 CFR § 146.145(b), provide that HIPAA requirements do not apply to the provision of certain types of benefits, known as "excepted benefits." There are four categories of excepted benefits described in 45 CFR § 146.145(b)(2) through (b)(5). Subsection (b)(2) describes benefits that are excepted in all circumstances. Subsections (b)(3) through (b)(5) describe benefits that are excepted only if they meet additional conditions.

Subsection (b)(2)

The benefits that are excepted in all circumstances are:

- coverage only for accident (including accidental death or dismemberment) or disability income insurance;

- liability insurance;
- supplements to liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance (for example, mortgage insurance); and
- coverage for on-site medical clinics.

Subsection (b)(3)

This category includes dental or vision benefits that meet the regulations' definition of "limited scope" benefits, and certain long term care benefits specified in the regulations. However, those benefits are excepted benefits only if they are:

- provided under a separate policy, certificate, or contract of insurance; or
- are otherwise not an integral part of the group health plan (as determined under the regulations).

Subsection (b)(4)

This category includes:

- a policy that covers only a specified disease or illness, such as a cancer-only policy; or
- a hospital indemnity or other fixed dollar indemnity insurance policy.

These policies are excepted benefits only if all of the following conditions are met:

(1) The benefits are provided under a separate policy, certificate, or contract of insurance;

(2) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(3) The benefits are paid with respect to an event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.

Subsection (b)(5)

This category of benefits includes**:**

- Medicare supplemental policies defined in section 1882(g)(1) of the Social Security Act;
- coverage supplemental to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other health benefit plans for the uniformed services of the United States; and

- "similar supplemental coverage provided to coverage under a group health plan."[1]

These benefits are excepted only if the benefits are provided under a separate policy, certificate, or contract of insurance.

III. Secondary Coverage Not an "Excepted Benefit"

Comprehensive group health plan coverage is subject to HIPAA requirements unless the coverage qualifies as an excepted benefit. Some issuers have taken the position that coverage that pays secondary to other coverage in a particular situation "supplements" the primary benefits, and therefore should be considered to meet the criteria of subsection (b)(5). However, in order to be excepted under that provision, the coverage must first be a Medicare supplement policy, a policy that supplements CHAMPUS, or "similar" supplemental coverage provided to coverage under a group health plan. In addition, the coverage must be provided under "a separate policy, certificate, or contract of insurance." Comprehensive, expense-incurred, group health plan coverage that pays secondary under a coordination of benefits provision does not meet any of these criteria. Nor does it meet the criteria for any other category of excepted benefits. A comprehensive, expense-incurred plan or policy is not listed in subsection (b)(2). In addition, by definition, it cannot be "limited scope dental or vision benefits," "long term care benefits," a specified illness policy, or an indemnity policy.

A Medicare supplemental policy is, by definition, a policy that does not duplicate any Medicare benefits. It only covers what Medicare does not cover. Since it is only designed to cover "gaps" in Medicare, in most cases it will not make payment until Medicare has determined what it will pay. A supplement to CHAMPUS serves the same purpose for individuals enrolled in CHAMPUS. Medicare supplements or CHAMPUS supplements therefore have no utility to anyone not enrolled in those programs for their primary coverage. To qualify as "similar supplemental coverage provided to coverage under a group health plan," the coverage would have to be specifically designed to perform a similar function. In the preamble to the April 8, 1997 regulations, we stated: "Such supplemental coverage cannot duplicate primary coverage and must be specifically designed to fill gaps in primary coverage, coinsurance, or deductibles." We would expect that only very large employer plans would be candidates for such development of a

[1]As enumerated in section 2791(c)(4) of the PHS Act.

separate, supplemental product by an issuer. However, we know of no such plans.[2] By contrast, secondary coverage, such as dependent coverage under a group health plan for a spouse who has other primary coverage, is not sold as a separate policy designed for the express purpose of supplementing the dependent spouse's other coverage. In the absence of the spouse's other coverage, the group health plan would pay primary benefits. The mere fact that a group health plan contains a coordination of benefits provision does not make it "similar supplemental coverage provided to coverage under a group health plan," as described in subsection (b)(5). The coordination clause in the group health plan would become effective whether the spouse's primary coverage is under Medicare, under another group health plan, or under any other form of creditable coverage.

Therefore, coverage which is an integral part of a group health plan and which only becomes secondary or supplemental when a coordination of benefits provision becomes operative is not an excepted benefit and is subject to HIPAA. Regardless of whether such coverage is primary or secondary, the rules for crediting of coverage apply.

IV. Background: *Creditable Coverage*

Under HIPAA, the right to offset a preexisting condition exclusion period under a group health plan, or to establish certain rights to purchase coverage in the individual market, depends upon the amount of prior "creditable coverage" that an individual has as of the

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[2]Coverage under a group health plan cannot be a Medicare supplement policy. See footnote 14 in the preamble to the April 8, 1997 regulations (62 FR 16903), which explains that retiree coverage under a group health plan that supplements an individual's Medicare coverage is not an excepted benefit because such coverage is specifically excluded from the definition of a Medicare supplemental policy in section 1882(g)(1) of the Social Security Act. That definition states, in relevant part:

". . . a Medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include … any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of labor organizations . . . ."

Although footnote 14 addressed only retiree coverage under a former employer's group health plan, the same exclusion from the definition of a Medicare supplemental policy applies to coverage provided in connection with an employer group health plan that is available to a Medicare beneficiary by virtue of a spouse's current employment status.

enrollment date in the new plan. This amount can be established by presenting a "certificate of creditable coverage" as described in 45 CFR § 146.115, or by means of other evidence.

45 CFR § 146.113(a)(1) identifies 10 types of creditable coverage:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- CHAMPUS, Tricare, or other health benefit plans for the uniformed services of the United States;
- a medical care program of the Indian Health Service or of a tribal organization;
- a State health benefits risk pool;
- the Federal Employees Health Benefits Program;
- a public health plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage; or
- a health benefits program for Peace Corps volunteers.

Creditable coverage does not, however, include:

- coverage consisting solely of excepted benefits, as defined in 45 CFR § 146.145;
- coverage for periods before a significant break in coverage, defined as a break of more than 63 full days;[3]
- waiting periods that a new employee must serve before becoming eligible for coverage under the employer's group health plan. (However, waiting periods do not count as a break in coverage. Also, any other creditable coverage an individual has is counted, even if it exists concurrently with a waiting period for a group health plan.)
- affiliation periods that a new employee must serve before becoming eligible for health insurance coverage provided by a health maintenance organization.

V. Continuing Coverage

It has been suggested that coverage that has not yet terminated need not be counted as "creditable coverage" to reduce a preexisting condition exclusion period. Nothing in title XXVII of the PHS Act or the implementing regulations provide any support for this position. In fact, the regulations at 45 CFR § 146.115 clearly contemplate that an individual can provide evidence of creditable coverage that is still in effect. 45 CFR § 146.115(a)(3)(ii) describes the information that is required to be included in a certificate.

[3] State law may extend this period for insured group health plans. 45 CFR § 146.143(c)(2)(iii).

Subparagraph (a)(3)(ii)(G) requires that the certificate state "the date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate." (Emphasis added.) Therefore, an issuer seeking to apply a preexisting condition exclusion to a new enrollee must give credit for coverage that is continuing under another form of creditable coverage and may not require that the previous coverage be terminated before granting credit for time already spent under that other form of coverage.

As noted above and as provided in 45 CFR § 146.111(a)(1)(iii), only creditable coverage that an individual has accumulated "as of the enrollment date" in the new plan is counted as creditable coverage.

VI. Example

The following example illustrates the policies explained above.

An individual has been enrolled in his employer's group health plan for seven months. His wife starts a new job and wants to add him to her employer's plan. However, he has asthma, and the new employer's plan imposes a 12-month preexisting condition exclusion. The issuer of the wife's employer plan's coverage argues that it does not have to apply the husband's seven months of creditable coverage to reduce the preexisting condition exclusion. The issuer takes the position that, because the wife's plan has a coordination of benefits provision that specifies that the wife's plan will be secondary to the husband's plan, the coverage under the wife's plan, being secondary coverage, only "supplements" the husband's plan, and therefore should be considered an excepted benefit, which is not subject to HIPAA's rules for crediting coverage. In the alternative, the issuer argues that even if the secondary coverage is not considered to be an excepted benefit, the coverage under the husband's primary plan cannot qualify as creditable coverage because it has not terminated.

In this example, the issuer must give the husband credit for his current coverage as of his enrollment date in the new secondary plan. However, since he only has had seven months of coverage, the issuer need only reduce the twelve-month preexisting condition exclusion by seven months. Therefore the husband must wait five months before the secondary plan will provide any benefits with respect to his asthma. After three months the husband argues that he has had another three months of creditable coverage under his primary plan, so the remaining two months of the exclusion should be offset. The issuer does not have to further reduce the exclusion period because only the creditable coverage he had already earned as of his enrollment date in his wife's plan must be applied to reduce a preexisting condition exclusion.

Where to get more information:

The regulations cited in this bulletin are found in Parts 144 through 146 of Title 45 of the Code of Federal Regulations (45 CFR §§ 144-146.) 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 Number	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	617-565-1257
Chicago	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Cynthia Garraway	312-353-8583
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