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Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Application of Group and Individual Market Requirements Under Title XXVII of the Public Health Service (PHS) Act When Insurance Coverage is Sold To, or Through, Associations

Market: Group and Individual

I. Purpose

This Bulletin:

- Explains how to determine whether insurance coverage sold through associations is group, or individual, coverage under the PHS Act.
- Clarifies how the PHS Act group-to-individual portability requirements are applied when an individual's most recent coverage is through an association.

This bulletin is expected to be the first of several that will discuss issues related to the application of title XXVII provisions to health insurance coverage offered by or through associations.

II. Background

Neither title XXVII nor the regulations define the term "association." The context of the statute, however, makes clear that the term is intended to encompass any entity through which health insurance is offered to a collection of employers and/or individuals, including but not limited to entities known as trusts, multiple employer welfare arrangements (MEWAs), purchasing alliances, or purchasing cooperatives.

Title XXVII does not impose any requirements on associations except to the extent the association is self-funded and is subject to state laws that regulate insurance, and meets the PHS Act definition of an "issuer." The requirements of title XXVII would therefore apply as they would to any other issuer; but it is because the entity is an issuer, not because it is an "association." The group market requirements on issuers can be found in Part A of title XXVII and the regulations at 45 CFR Parts 144 and 146[i]. The individual market requirements on issuers can be found in Part B of title XXVII and the regulations at 45 CFR Parts 144 and 148[ii].

III. Individual vs. Group Market Coverage

We are aware that many states categorically regulate health insurance coverage offered through associations as "group" coverage. However, for the purpose of determining whether any particular insurance coverage is group rather than individual coverage within the meaning of title XXVII, it is irrelevant whether there is an association involved, and it is also irrelevant whether state law classifies association coverage as "group" coverage for purposes of state insurance laws.

Regulations at 45 CFR 144.102(c) state the following:

> Coverage that is provided to associations, but is not related to employment, is not considered group coverage under 45 CFR parts 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under State law.

Thus, the test for determining whether health insurance coverage offered through an association is group market coverage, or individual market coverage, for purposes of title XXVII, is the same test as that applied to health insurance offered directly to employers or individuals. If the health insurance is offered in connection with a group health plan as defined at 45 CFR 144.103, it is considered group health coverage for purposes of title XXVII[iii]. If the health insurance offered to an association member is offered other than in connection with a group health plan, or is offered to an association's employer-member that is maintaining a group health plan that has fewer than two participants who are current employees on the first day of the plan year, the coverage is generally considered individual health insurance coverage for purposes of title XXVII.

Note that for purposes of title XXVII, health insurance is considered to be offered in connection with a group health plan either because a group health plan exists at the association level, or, more commonly, because an employer-member or employee-organization member of the association maintains a group health plan[iv]. Some associations have a "mixed" membership, in which:

- Some coverage provided through the association is in connection with an employment-based group health plan (and therefore is subject to the group market requirements of title XXVII, unless the group health plan has fewer than two employee-participants on the first day of the plan year, in which case the coverage is subject to the individual market requirements of title XXVII), and
- Some coverage is provided to association members without any connection to a group health plan (and therefore is subject to the individual market requirements of title XXVII).

Also, to the extent an association has any members that are small employers (which are defined generally as employers with two to 50 employees), the issuer is subject to the requirements that apply to small group coverage, such as those related to disclosure, with respect to any small employer in the association[v].

IV. Portability from the Group to the Individual Market

Under Part B of title XXVII, certain individuals (i.e., Federally eligible individuals) are guaranteed the right to purchase individual coverage without underwriting, if they meet specific criteria. See section 2741(b) and 45 CFR 148.103. One criterion is that the person's most recent coverage must have met the title XXVII definition of group health plan coverage[vi]. Another criterion is that the group health coverage was not terminated on the basis of fraud or nonpayment of premiums. The following sections explain how these requirements are applied when the most recent coverage was through an association.

A. Requirement that Most Recent Coverage be Group Coverage

If an individual's most recent coverage was issued in connection with a group health plan, as described above, he or she could qualify as a Federally eligible individual, provided all the other criteria for Federal eligibility are satisfied. However, association coverage that is not provided in connection with a group health plan as defined in title XXVII does not provide a basis for Federal eligibility, regardless of whether the association coverage is otherwise classified as group coverage under state law.

It should be noted, however, that the PHS Act generally does not preclude states from enacting standards that are more consumer-friendly than the standards included in the PHS Act. Therefore, even if an individual's most recent coverage was, under the PHS Act, individual market coverage obtained through an association, a state portability requirement could give such individuals a right to purchase subsequent individual health coverage. This portability would, however, result from the more generous state law, not the PHS Act. A state to which an individual moved would not have to recognize such association-based coverage as group coverage for purposes of group-to-individual portability.

B. Nonpayment of Premiums by Associations

The regulations at 45 CFR 148.103 state that one of the criteria for determining whether an individual is eligible for portability into the individual market is that the individual's most recent coverage must not have been terminated "because of nonpayment of premiums or fraud." In our June 1999 Bulletin No. 99-02, Issues Related to Eligible Individual Status Under the Health Insurance Portability and Accountability Act of 1996, we clarified that nonpayment of premiums or fraud on the part of an individual's most recent employer that resulted in termination of the insurance contract through which all previously covered employees obtained coverage does not disqualify a person from Federal eligibility. For the same reasons articulated in that bulletin to support that conclusion, we are now clarifying that the fact that an individual lost group coverage because the association failed to pay premiums or committed fraud does not preclude the individual from being a Federally eligible individual.

Where to get more information

The regulations cited in this Bulletin are found in Parts 146 and 148 of title 45 of the Code of Federal Regulations (45 CFR 146, 148). Information about the PHS Act is also available on CMS' Web site at http://www.cms.hhs.gov/hipaa1

If you have any questions regarding this bulletin, call the HIPAA Health Insurance Reform Help line toll free at 1-877-267-2323, ext. 61565.

[i] Regulations at 45 CFR 144.103 define the terms "group health insurance coverage," "health insurance coverage," and "group health plan." Group market requirements include:

- Limits on preexisting condition exclusion periods (45 CFR 146.111),
- Rules relating to creditable coverage (45 CFR 146.113),
- Certification and disclosure of coverage (45 CFR 146.115),
- Special enrollment periods (45 CFR 146.117),
- Limits on HMO affiliation periods (45 CFR 146.119),
- Prohibitions against discrimination against individuals based on a health factor (45 CFR 146.121),
- Guaranteed availability of coverage for employers in the small group market (45 CFR 146.150),
- Guaranteed renewability of coverage for employers (45 CFR 146.152),
- Disclosure of information to small employers (45 CFR 146.160),
- Requirements related to the Mental Health Parity Act of 1996 (45 CFR 146.136),
- Requirements related to the Newborns' and Mothers' Health Protection Act of 1996 (45 CFR 146.130), and
- Requirements related to the Women's Health and Cancer Rights Act of 1998 (PHS Act section 2706). Coverage sold in connection with a group health plan that, on the first day of the plan year, has at least two active-employee participants, is subject to the group market requirements. Coverage sold to group health plans with fewer than two active-employee participants on the first day of the plan year is subject to the PHS Act's individual market requirements (see 45 CFR 144.102). However, states may instead elect to apply the PHS Act's group market requirements to such coverage.

[ii] The regulations at 45 CFR 144.103 define the terms "individual health insurance coverage," "individual market," and "short-term limited duration insurance." Individual market requirements include:

- Guaranteed renewability to individuals (45 CFR 148.122),
- Certification and disclosure of coverage (45 CFR 148.124),
- Rules requiring issuers in states that are not using an acceptable alternative mechanism to guarantee coverage to Federally eligible individuals (45 CFR 148.120) and to promptly identify such individuals and offer them coverage (45 CFR 148.126),
- Requirements related to the Newborns' and Mothers' Health Protection Act of 1996 (45 CFR 148.170), and
- Requirements related to the Women's Health and Cancer Rights Act of 1998 (PHS Act section 2752).

[iii] For more information on what constitutes a group health plan, see our November 2000 Bulletin No. 00-06, 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.

[iv] Whether a group health plan exists, and whether it exists at the association level, or as is far more common, at the individual employer level, is under the jurisdiction of the U.S. Department of Labor's Pension and Welfare Benefits Administration.

[v] The definitions of employer and employee for purposes of the PHS Act are taken from the definitions of those terms in ERISA. See 45 CFR 144.103. Note that some of the requirements relating to small group coverage apply differently when an issuer sells to "bona fide associations," as defined in title XXVII. We expect to clarify such distinctions in a future bulletin.

[vi] For this purpose, it is sufficient that the plan meets the definition of a "group health plan" at 45 CFR 144.103, regardless of whether the plan is subject to the group health plan requirements in Part 7 of ERISA or title XXVII of the PHS Act, and regardless of whether the insurance coverage sold to the plan is subject to the PHS Act's group market requirements. See CMS Bulletin No. 00-02, Issues Related to Eligible Individual Status Under Section 2741(b) of the Public Health Service Act.