

PROGRAM MEMORANDUM INSURANCE COMMISSIONERS INSURANCE ISSUERS

Department of Health
and Human Services

Centers for Medicare &
Medicaid Services

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Title: Insurance Standards Bulletin Series -- INFORMATION

Subject: Federal Eligibility Under HIPAA After Group Health Plan Termination

Market: Individual and Other (i.e., Risk Pool and other sources of coverage under a State Alternative Mechanism).

I. Purpose

This bulletin conveys the position of the Centers for Medicare & Medicaid Services that, upon termination of a group health plan, the participants and beneficiaries who were covered under the plan (including those responsible for its termination) are not considered to have lost coverage due to nonpayment of premiums. Therefore, such individuals may qualify as federally eligible individuals under HIPAA, provided they satisfy all other criteria for federal eligibility.

II. Background

Under HIPAA, federally eligible individuals are guaranteed the right to purchase individual coverage, without any preexisting condition exclusions.ⁱ Among the criteria for federal eligibility in 45 CFR 148.103 is that the individual's most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any of these plans)ⁱⁱ and that "[t]he individual's most recent coverage was not terminated because of nonpayment of premiums or fraud..."

III. Discussion

It has come to our attention that at least one individual market health insurance issuer that is required to offer coverage to federally eligible individuals in a number of states, is not recognizing certain individuals as federally eligible. Specifically, the issuer is refusing to recognize individuals whose most recent coverage was through a group health plan, but who, as owners or officers of the employer sponsoring the group health plan (or perhaps through some other position of authority) made the decision to terminate the group health plan, thereby causing the group health insurance issuer to no longer receive premiums. The individual market issuer maintains that the individuals who made the decision to terminate the group health plan (and who consequently lost coverage under that plan) are not federally eligible because their most recent group health plan coverage was terminated due to their nonpayment of premiums.

However, it is our view that such individuals lost their coverage due to the fact that the group health plan terminated. In this circumstance, all participants and beneficiaries who were covered under the plan have lost coverage due to the plan's termination, not due to failure to pay premiums, even those directly responsible for terminating the group health plan.

Where to get more information:

The regulations cited in this bulletin are found in Parts 144 and 148 of title 45 of the Code of Federal Regulations (45 CFR 144, 148). Information about the Public Health Service Act, including the statutory provisions referred to in this bulletin, is also available on CMS' Web site at <http://www.cms.hhs.gov/hipaa1>

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

ⁱ 45 CFR 148.120(a) and 148.128(a)

ⁱⁱ A group health plan is defined as "an employee welfare benefit plan (as defined in section 3(1) of ERISA) to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the PHS Act and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise." 45 CFR 144.103.