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Title: Insurance Standards Bulletin Series -- INFORMATION

Subject: State "Succeeding Carrier" or "Extension of Benefits" Laws and an Issuer's Obligation under HIPAA to Enroll an Eligible Individual Who is Disabled[1]

Markets: Group

I. Purpose

This bulletin conveys the position of the Health Care Financing Administration (HCFA) on the relationship between State "succeeding carrier" laws and the insurance reform provisions of Title XXVII of the Public Health Service Act (PHS Act), as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A number of States enacted these laws prior to HIPAA to address the situation in which an employer with a disabled employee or dependent switches its group health plan coverage from one issuer (the "prior carrier") to another (the "succeeding carrier"). This bulletin explains why a State succeeding carrier law cannot eliminate the succeeding carrier's legal obligation under federal law to enroll an individual who is disabled at the time that the original health insurance coverage is terminated. However, as discussed below, this does not preclude State laws from promoting better outcomes by imposing obligations over and above the Federal law requirements, or by providing rules for which carrier will actually make payment in a particular situation.[2]

Because many State laws are based on the "Group Coverage Discontinuance and Replacement Model Regulation" adopted by the National Association of Insurance Commissioners (NAIC Model), this bulletin will set forth general principles based on the NAIC Model. A number of issuers and State regulators have inquired whether a State law based upon the Model is consistent with an issuer's duties

[1]The term "disabled individual," is used in this bulletin to include an individual who is receiving inpatient hospital services on the date of replacement coverage or is covered under an extension of benefits provision. Similarly, the term "disability" is used herein to refer to the state of being hospitalized on the date of replacement coverage or covered under an extension of benefits provision.

[2]For example, while under the PHS Act the legal obligation of the succeeding carrier to enroll the individual for benefits is absolute, State law might provide that another carrier has the obligation to pay for the services, so that there is no cost (or a reduced cost) to the succeeding carrier for the benefits it would otherwise be legally obligated to cover.

to provide coverage under the PHS Act. Even if a State's law is not identical to the Model, the principles discussed here should provide useful guidance. For the reader's convenience, a copy of the NAIC's Group Coverage Discontinuance and Replacement Model Regulation is attached to this bulletin. The Model is published and copyrighted by the NAIC. Permission to reprint it here has been graciously given by the NAIC.

II. Background

A. NAIC Model

Under the NAIC Model, when group health coverage is discontinued, the prior carrier must continue to provide benefits for a specified period of time for covered individuals who are totally disabled.[3] This obligation is the same whether or not the group health plan purchases replacement coverage.

However, if the plan obtains replacement coverage that is similar to the old coverage, section 7.B describes the extent to which the prior carrier remains liable for any extension of benefits, while section 7.C addresses the obligations of the succeeding carrier. In particular, the Model addresses the situation in which an individual was disabled at the time the plan changed carriers, and the succeeding carrier has an "actively-at-work" or "nonconfinement" clause that would preclude coverage for the disabled individual.

B. PHS Act

The following provisions of the PHS Act control the interaction between that Federal statute and any succeeding carrier provisions that apply under State law.

1. Section 2702 of the PHS Act, 42 U.S.C. §300gg-1, states that issuers that offer coverage to group health plans "may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan" based on any of the listed "health status-related factors." The statute makes clear that disability is one of these health factors (Section 2702(a)(1)(H)).

2. Section 2701, 42 U.S.C. §300gg, permits an issuer to impose preexisting condition exclusions for group health insurance coverage, but places substantial restrictions on that ability. In general, the exclusion:

- cannot be based on a medical condition if medical advice, etc. was not received during the six month period before the individual became covered under the group health plan, or began a waiting period for coverage.

- cannot last longer than 12 months (or 18 months for late enrollees)

[3] Under Section 6.A of the Model, every policy or contract must provide "a reasonable provision for extension of benefits in the event of total disability at the date of the discontinuance of the group policy or contract." Section 6.D specifies that for hospital or medical expense coverages other than dental and maternity, the requirement is satisfied by an extension of at least 12 months under comprehensive or "major medical" coverages, and at least 90 days under other types of hospital or medical expense coverages. This bulletin in only concerned with the types of coverages described in Section 6.D.

? must be reduced by creditable coverage

3. Section 2723(a) of the PHS Act, 42 U.S.C. §300gg-23(a), specifies that State laws will only be preempted under certain limited circumstances, which are discussed below.

C. Preemption--In General

"Preemption" is a term of art that refers to the situation in which Federal law supersedes State law. The courts have established guidelines for determining whether, and to what extent, State laws are preempted. The clearest indication of preemption is through the inclusion by Congress of an express preemption provision in a statute, such as in section 2723(a) of the PHS Act. That section specifies that State law will generally be preempted only if it "prevents the application of" a provision or requirement of Part A of Title XXVII. The legislative history indicates that this is intended to be the "narrowest" preemption of State laws.[4]

General case law on preemption provides additional guidance in determining what constitutes the scope of the preemption. One basis on which courts have found preemption is if compliance with both Federal and State law is, in effect, physically impossible. See Louisiana Public Service Commission v. Federal Communications Commission, 476 U.S. 355 (1986). In light of the statutory language that State law will not be preempted unless it "prevents" compliance with the PHS Act, the legislative history that indicates that preemption will be limited to the "narrowest" of circumstances, and the general case law on preemption, HCFA takes the position that State law "prevents the application" of a PHS Act provision if the State law makes it impossible for a party to comply with the PHS Act. If a State law simply permits but does not require an issuer to do something that is prohibited under the PHS Act, the State law would not be applicable. The issuer simply could not take advantage of the State law provision.

This result is also consistent with Executive Order 13132 of August 4, 1999 (See 64 Fed. Reg. 43, 255 (August 10, 1999)), which states that "Agencies shall construe… a Federal statute to preempt State law only where the statute contains an express preemption provision or there is some other clear evidence that the Congress intended preemption of State law, or where the exercise of State authority conflicts with the exercise of Federal authority under the Federal statute."

III. Analysis

Section 7 of the NAIC Model appears to address the situation in which the succeeding carrier has an actively-at-work or nonconfinement clause that would permit the carrier to refuse to enroll a disabled individual who had been covered by the prior carrier. This provision predated the HIPAA amendments to the PHS Act, and these clauses are no longer permitted to the extent that they would deny enrollment of an individual because of a health factor. We have explained this analysis in

[4] See House Conf. Rep. No. 104-736, at 205 (1996), reprinted in 1996 U.S. Code Cong. & Admin. News 2018.

Bulletin 00-01, with respect to nonconfinement clauses.[5] We expect future regulations to address the issue of actively-at-work provisions. However, while such provisions may be permissible in some situations, an actively-at-work provision that is used to discriminate against an individual based on a health factor, such as disability, is not permitted.[6]

Section 7.C.(1) of the NAIC Model currently states:

"Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and actively-at-work and nonconfinement rules) shall be covered by that carrier's plan of benefits."

(Emphasis added.) If the underlined words are deleted, because nonconfinement clauses and certain actively-at-work clauses are impermissible under the PHS Act, then section 7.C.(1) of the Model would appear simply to require the succeeding carrier to enroll the disabled individual and provide coverage under the regular terms of the replacement policy. This would be consistent with the PHS Act, assuming the prior carrier covered the disabling condition. It would also seem to make section 7.C.(2) inapplicable, since that section addresses the responsibilities of the prior and succeeding carriers with respect to a disabled individual who cannot satisfy an actively-at-work or nonconfinement clause.

As noted above, section 2702 of the PHS Act contains an absolute legal prohibition against a carrier's refusing to enroll an otherwise eligible individual based on a disability or other health factor. As also explained above, if a State law simply permits but does not require an issuer to do something that is prohibited under the PHS Act, the State law would not be applicable. Thus if the State law purported to relieve a succeeding carrier of legal responsibility for enrolling an individual, on the basis that the individual was covered by a prior carrier under a State extension of benefits requirement, the State law would not apply.[7]

However, to the extent the State law requires coverage more extensive than required under the PHS Act, the State law could still apply. For example, in a situation that involves replacement coverage, the nondiscrimination provision of the PHS Act only applies to the succeeding carrier. Therefore, the State law obligation of the prior carrier is unaffected by the PHS Act requirement. If, for example, section 2701 of the PHS Act permitted the succeeding carrier to impose a preexisting

[5] A nonconfinement clause generally is a plan or policy provision that delays an individual's effective date of coverage based on whether the individual is either: (1) confined to a hospital; (2) disabled; or (3) eligible for benefits under another plan's or policy's extension of benefits provision which is based on hospitalization or disability.

[6] This would include, for example, actively-at-work provisions that treat individuals on sick leave or disability leave less favorably than individuals on other types of leave.

[7] We believe the State law would be preempted if it prohibited the succeeding carrier from covering the individual.

condition exclusion on an individual's disabling condition, the prior carrier's extension of benefits obligation would presumably require it to provide coverage under State law.[8]

Some States have taken the position that succeeding carrier laws simply operate as coordination of benefits provisions. We believe that this may, as a practical matter, be true when all that is at stake is which carrier pays for particular services. However, in a managed care environment we cannot agree that this is true as a legal matter. If, for example, a disabled individual was eager to switch to a provider that is only available through the succeeding carrier's network of providers, we do not believe that a State law could deny the individual the right granted by HIPAA to enroll in the succeeding carrier's coverage. We are sensitive to the fact that some States may view succeeding carrier laws as a way to protect certain disabled individuals from being suddenly required to change medical providers because of a change in carriers, where the carriers have limited provider networks. States are free to implement State requirements in a way that protects the interests of the disabled individuals without preventing the application of the Federal requirement. Since 1997, the PHS Act has clearly left it within the States' authority to enforce the nondiscrimination and preexisting condition exclusion provisions under their own laws. Therefore in the event there is any dispute about which carrier is required to provide coverage, States have the authority to enforce the various provisions in a way that guarantees that the individual is protected.

Where to get more information:

The regulations cited in this bulletin are found in Part 146 of Title 45 of the Code of Federal Regulations (45 CFR §146). Information about the PHS Act is also available on HCFA's website at http://hipaa.hcfa.gov.

If you have any questions regarding this Bulletin, call the HIPAA Insurance Reform Help Line at (410) 786-1565.

[8]We are providing this example for illustration, although this situation would only occur in the unlikely event that the succeeding carrier's preexisting condition exclusion would meet all of the requirements of section 2701 of the PHS Act. (i.e., the disabling event occurred prior to the individual's enrollment date in the group health plan; the individual had been covered under the prior carrier for less than the maximum 12 months (18 months for a late enrollee); and the individual did not have enough other creditable coverage to completely eliminate the preexisting condition exclusion.)