PROGRAM MEMORANDUM
INSURANCE COMMISSIONERS
INSURANCE ISSUERS

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Transmittal No. 08-01 Date: May 2008

Title: Insurance Standards Bulletin Series -- INFORMATION

Subject: Circumstances Under Which Supplemental Health Insurance Coverage Satisfies the Requirements for Excepted Benefits Under Section 2791(c) of the Public Health Service Act

Markets: Group and Individual

I. Purpose

This Bulletin provides guidance on factors that are relevant in determining whether supplemental health insurance coverage provided to coverage under a group health plan qualifies as excepted benefits pursuant to 45 CFR sections 146.145 (c)(5)(i)(C) and 148.220 (b)(6).

II. Background

HIPAA Health Reform and Related Legislation

Titles I and IV of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, (HIPAA) amended the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (Code), and the Public Health Service Act (PHS Act) to improve portability, access, and continuity with respect to group health plan coverage provided in connection with employment. These laws include limitations on preexisting condition exclusions, require issuance of certificates of creditable coverage, provide special enrollment rights, and prohibit discrimination on the basis of any health factor. Later amendments to these laws provide protections relating to mental health parity, hospital lengths of stay following childbirth, and post-mastectomy coverage. Regulations issued by the Departments of Labor, the Treasury, and Health and Human Services (the Departments) on these group market provisions are contained in 29 CFR Part 2590, 26 CFR Part 54, and 45 CFR Parts 144 and 146. Additional reforms were provided in the PHS Act for health coverage in the individual market and are contained in 45 CFR Parts 144 and 148.

In general, these health reform provisions apply to group health plans (generally plans established or maintained by employers or employee organizations, or both) and health insurance issuers in the group or individual market. However, these provisions do not apply to certain excepted benefits. In general, if benefits under a plan or coverage are

excepted benefits, then plans and issuers do not have to comply with certain health reform requirements, including those requirements stated above, and the coverage may not qualify as creditable coverage.

Supplemental Health Insurance Coverage

One category of excepted benefits is supplemental coverage. Benefits that are provided under supplemental plans are excepted only if provided under a separate policy, certificate, or contract of insurance and is either Medicare supplemental health insurance (also known as Medigap or MedSupp insurance), is TRICARE supplemental health coverage, or is "similar supplemental coverage provided to coverage under a group health plan." The regulations specify that one requirement to be similar supplemental coverage is that the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles (but does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision). 26 CFR 54.9831-1(c)(5)(i)(C), 29 CFR 2590.732 (c)(5)(i)(C), and 45 CFR 146.145(c)(5)(i)(C).

Coordination of Administration

Various scenarios have come to the attention of the Departments that raise concerns about whether all of the coverage that is being marketed as similar supplemental coverage actually qualifies as such.

Section 104 of HIPAA requires the Secretaries of Labor, the Treasury, and Health and Human Services to ensure that guidance under HIPAA issued by the Departments that relates to the same matter be administered so as to have the same effect at all times. In accordance with section 104 of HIPAA, each of the Departments is issuing guidance concerning the characteristics of "similar supplemental coverage" that qualifies as benefits excepted from certain health reform requirements. The guidance being issued has been developed on a coordinated basis by the Departments. HHS is also issuing this guidance on what constitutes similar supplemental coverage for the individual market.

III. Analysis

We will apply the following guidelines when evaluating whether supplemental health insurance coverage can reasonably be considered to be an excepted benefit within the meaning of section 2791(c)(4) of the PHS Act, and 45 CFR sections 146.145(c)(5)(i)(C) and 148.220(b)(6):

- Separate Policy, Certificate, or Contract of Insurance. We will apply this requirement from 45 CFR 146.145(c)(5) by focusing on whether the supplemental policy is issued by an entity other than the entity that provides the primary coverage under the plan. This standard is consistent with the regulatory requirement that any other type of supplemental policy be similar to Medicare supplemental health insurance or TRICARE supplemental coverage. In those situations the primary coverage is provided by the government, and the

supplement is provided by a private issuer. We will review closely a situation when an issuer splits one product into two separate policies, and then merely labels one as "supplemental" to the other.

- Designed to Fill Gaps in Primary Coverage. As required by 45 CFR 146.145(c)(5)(i)(C), the coverage must be specifically designed to fill gaps in primary coverage, such as co-insurance or deductibles. As indicated above, we will look closely at any product that, although it is called a supplemental plan, is designed to provide a major portion of the medical benefits to the participants of the primary group health plan, such as a plan that supplements a high deductible group health plan.

- Similar to Medicare Supplemental Insurance or TRICARE -- Value of Coverage. One important factor in determining whether coverage is similar to Medicare supplemental insurance or TRICARE is that the proportion of total benefits that is charged to a policyholder as cost-sharing should be similar to the proportion of total Medicare benefits that is charged to beneficiaries as cost-sharing. According to CMS actuaries, this proportion is currently around 15 percent. We will consider any product that is 15 percent or less to meet this requirement of the regulations. We will look closely at any product that exceeds that percentage. We will consider any reasonable method for calculating the value of the total coverage, but one that we will consider to be acceptable would be to compare the COBRA cost of the supplemental coverage with the COBRA cost of the primary coverage. If this method is used, we believe it is reasonable to use 100 percent of the applicable premium as the COBRA cost (without the 2 percent allowable administrative charge). Some group health plans subject to HIPAA titles I or IV are not subject to the COBRA continuation coverage requirements, such as church plans and plans maintained by an employer with fewer than 20 employees. For these plans it would be reasonable to compute cost as if the plan were subject to COBRA. (To the extent the plan is insured, it would be reasonable to use the premiums for the primary and supplemental insurance coverage as a proxy for COBRA costs).

- Similar to Medicare Supplemental Insurance or TRICARE -- Protection Against Underwriting (Group Market Only). All Medicare beneficiaries are provided an opportunity when they first become eligible for Medicare based upon age to purchase a Medicare supplemental policy without being subject to underwriting based upon health status. Accordingly, to meet the requirement that the coverage be similar to Medicare supplemental insurance, enrollees in group supplemental plans should have similar protections. We will review closely, therefore, supplemental products that differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual.

IV. Conclusion

In considering whether products in the individual and group markets reasonably fit into the excepted benefits category of "similar supplemental coverage provided to coverage under a group health plan," we will consider whether the coverage meets each of the following factors:

(1) Separate Policy, Certificate or Contract of Insurance. Whether a policy, certificate, or contract of insurance is issued by an entity that does not provide the primary coverage under the plan. For this purpose, entities that are part of the same controlled group of corporations or part of the same group of trades or businesses under common control, within the meaning of section 52(a) or (b) of the Code, are considered to be a single entity.

(2) Designed to Fill Gaps in Primary Coverage. Whether the policy, certificate, or contract of insurance is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. This does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination-of-benefits provision.

(3) Similar to Medicare Supplemental Insurance or TRICARE -- Value of Coverage. Whether the cost of coverage under the policy, certificate, or contract of insurance exceeds 15 percent of the cost of primary coverage. For this purpose, the cost of both the supplemental and primary coverage can be determined in the same manner as the applicable premium is calculated under the COBRA continuation provision, less the allowable 2 percent administrative charge.

We will also consider the following additional factor for products in the group market:

(4) Similar to Medicare Supplemental Insurance or TRICARE—Protection Against Underwriting. Whether a policy, certificate, or contract of insurance that is group health insurance coverage differentiates among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

Questions concerning the information contained in this Bulletin may be directed to the PHIG mailbox at phig@cms.hhs.gov.