

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

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Section 1. Statement of Purpose

This regulation is intended to implement the provisions of the Individual Market Health Insurance Coverage Model Act (“Act”). The purposes of the Act and this regulation are to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the individual market and provide for the establishment of coverage and other benefit requirements in the individual market.

Section 2. Definitions

As used in this Regulation:

- A. “Actuarial Value” or “AV” means the percentage paid by a health benefit plan of the total allowed costs of benefits.
- B. “Annual open enrollment period” means the period each year during which an individual may enroll or change coverage in a health benefit plan.
- C. “Benefit year” means a calendar year for which a health benefit plan provides coverage for health benefits.
- D. “CMS” means the federal Centers for Medicare and Medicaid Services.
- E. (1) “Cost-sharing” means any expenditure required by or on behalf of an enrollee with respect to essential health benefits.
 (2) “Cost-sharing” includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.
- F. “EHB-benchmark plan” means the standardized set of essential health benefits (EHB) that a health carrier must provide as required by the commissioner or Secretary.
- G. “HHS” means the U.S. Department of Health and Human Services.

- H. (1) “Health factor” means, in relation to any individual, any of the following health status-related factors:
- (a) Health status;
 - (b) Medical condition, including both physical and mental illnesses;
 - (c) Claims experience;
 - (d) Receipt of health care services;
 - (e) Medical history;
 - (f) Genetic information;
 - (g) Evidence of insurability, including:
 - (i) Conditions arising out of acts of domestic violence; or
 - (ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or
 - (h) Disability.
- (2) For purposes of this subsection, “health factor” does not include the decision whether to elect individual market health insurance coverage, including the time chosen to enroll, such as under special enrollment or later enrollment.
- I. “Minimum essential coverage” has the meaning stated in Section 5000A(f) of the Internal Revenue Code (Code).
- J. “Percentage of the total allowed costs of benefits” means the anticipated covered medical spending for EHB coverage, as defined in Section 3K of the Act, paid by a health benefit plan for a standard population, computed in accordance with the plan’s cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.
- K. “Plan” means, with respect to a health carrier and a product, the pairing of health insurance coverage benefits under the product with a metal tier level, as described in Section 1302(d) and (e) of the Federal Act, and service area. The product comprises all plans offered within the product, and the combination of all plans offered within a product constitutes the total service area of the product.
- L. “Policy year” means, with respect to:
- (1) Grandfathered health plan coverage providing individual market health insurance coverage and student health insurance coverage, the 12-month period that is designated as the policy year in the policy documents of the health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year; or
 - (2) Non-grandfathered health plan coverage providing individual market health insurance coverage, or a market in which the State has merged has merged the individual and small group market risk pools for coverage issued or renewed beginning Jan. 1, 2014, a calendar year for which health insurance coverage provides coverage for health benefits.
- M. “Product” means a discrete package of health insurance coverage benefits that a health carrier offers using a particular product network type (e.g., HMO, PPO, EPO, POS or indemnity) within a geographic service area.

- N. “Special enrollment period” means a period during which an individual or covered person who experiences certain qualified events may enroll in or change enrollment in a health benefit plan outside of the initial and annual open enrollment periods.

Section 3. Applicability and Scope

Subject to the provisions in Section 4 of the Act and specific provisions in this regulation, this regulation is applicable to health carriers offering health benefit plans providing individual market health insurance coverage in this State.

Section 4. Restrictions Relating to Premium Rates

- A. The premium rate charged by a health carrier offering a health benefit plan providing individual market health insurance coverage may vary only, with respect to the particular coverage involved, on the basis of the following:

- (1) Whether the plan covers an individual or family:
 - (a) For family coverage, the total premium for family coverage must be determined by summing the premiums for each individual family member, except that if there are more than three (3) covered children under the age of twenty-one (21), the total family premium shall include only the premiums for all covered family members over the age of twenty-one (21) and the three (3) oldest children under the age of twenty-one (21); and
 - (b) For family coverage, any rating variation on the basis of age or tobacco use must be applied separately to the portion of the premium attributable to each covered family member;

Drafting Note: As specified in 45 CFR §147.102(c)(2), a state has the option to establish uniform family tiers and uniform rating multipliers for those tiers in lieu of the family rating methodology specified in Paragraph (1), but only if the state does not permit any rating variation for age and tobacco use as described in Paragraphs (3) and (4). If the state does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology in this section under Paragraph (1) will apply in that state.

- (2) (a) (i) Geographic rating area, as established by HHS in accordance with 45 CFR §147.102(b), unless the commissioner establishes alternative geographic rating areas pursuant to Item (ii) of this subparagraph; and
 - (ii) The commissioner may adopt regulations establishing uniform geographic rating areas subject to the provisions of 45 CFR §147.102(b); and

Drafting Note: States choosing to limit the permissible variation based on geographic rating areas, or to establish uniform geographic area multipliers, should consider incorporating those provisions in an additional provision under this subparagraph, such as Item (iii).

Drafting Note: States should be aware that 45 CFR §147.102(b) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish one or more geographic rating areas within that state. If a state does not establish geographic rating areas, or the federal Centers for Medicare and Medicaid Services (CMS) determines that the state’s geographic rating areas are not adequate, the default will be one geographic rating area for each metropolitan statistical area in the state and one geographic rating comprising all non-metropolitan statistical areas in the state, as defined by the Office of Management and Budget (OMB).

- (b) For purposes of this paragraph, geographic rating area is to be determined in the individual market using the primary policyholder’s address;
- (3) Age:
 - (a) The rate may not vary based on age by more than 3:1 for like individuals of different age who are twenty-one (21) and older, and the variation in rate must be actuarially justified for individuals under age twenty-one (21);
 - (b) The rate for each enrollee must be based on the enrollee’s age as of the date of policy issuance, renewal or addition to the policy;

- (c) Variations in rates based on age must be consistent with the uniform age rating curve established by HHS under 45 CFR §147.102(e), unless the commissioner establishes an alternative age rating curve pursuant to Subparagraph (d) of this paragraph; and
- (d) The commissioner may adopt regulations establishing a uniform age rating curve, subject to the restrictions imposed by 45 CFR §147.102(e). Any uniform age rating curve must be based on the following uniform age bands:
 - (i) A single age band for individuals age 0 through 20;
 - (ii) One-year age bands for individuals age 21 through 63; and
 - (iii) A single age band for individuals age 64 and older; and

Drafting Note: States should be aware that 45 CFR §147.102(e) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish a uniform age rating curve in the individual or small group market, or both markets. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with 45 CFR §147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

- (4) Tobacco use:
 - (a) The rate may not vary by more than 1.5:1 on the basis of tobacco use;
 - (b) A rating surcharge for tobacco use may only be applied to individuals who may legally use tobacco under federal and state law;
 - (c) A rating surcharge for “tobacco use” may only be applied to individuals who have used tobacco on average four (4) or more times per week within the most recent six-month period; and
 - (d) The health carrier may consider the use of any tobacco product for rating purposes, but may not consider religious or ceremonial use of tobacco. Further, the health carrier must consider “tobacco use” in terms of when a tobacco product was last used.

Drafting Note: States may prohibit tobacco use as a rating factor or may impose stronger restrictions on tobacco use rating than the restrictions in this Regulation as provided in Paragraph (4) above.

- B. A premium rate may not vary with respect to a particular coverage by any other factor not described in Subsection A.
- C. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 5. Single Risk Pool

- A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must consider the claims experience of all enrollees in all health benefit plans (other than grandfathered health plan coverage) subject to Section 5 of the Act and offered by the carrier in the individual market in a state, including enrollees who do not enroll in such plans through the exchange, to be members of a single risk pool.

Drafting Note: As specified in 45 CFR §156.80, a state may require the individual and small group health insurance markets within the state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in 45 CFR §147.103.

- B. (1) (a) A health carrier must establish an index rate that is effective January 1 of each calendar year for the individual market, described in Subsection A or, if applicable, a merged market, if the state has required such merger, based on the total combined claims cost for providing essential health benefits within the single risk pool of that state market.

- (b) The index rate must be adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and exchange user fees (expected to be remitted under 45 CFR §156.50(b) or §156.50(c) and (d), as applicable, plus the dollar amount under 45 §156.50(d)(3)(i) and (ii) expected to be credited against user fees payable in that state market).
 - (c) The premium rate for all of the health carrier’s plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to plan-level adjustments permitted in Paragraph (2).
- (2) For policy years beginning on or after January 1, 2014, a health carrier may vary premium rates for a particular health benefit plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:
- (a) The actuarial value and cost-sharing design of the plan;
 - (b) The plan’s provider network, delivery system characteristics and utilization management practices;
 - (c) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits;
 - (d) Administrative costs, excluding exchange user fees; and
 - (e) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.
- (3) A health carrier may not establish an index rate and make the market-wide adjustments pursuant to Paragraph (1), or make the plan-level adjustments pursuant to Paragraph (2), more or less frequently than annually.
- C. This section does not apply to grandfathered health plan coverage in accordance with the provisions of Section 1312(c)(4) of the Federal Act.

Section 6. Guaranteed Availability of Individual Market Health Insurance Coverage; Enrollment Periods

- A. Subject to Section 6 of the Act and Subsections B through D, a health carrier offering a health benefit plan providing individual market health insurance coverage must offer to any individual in the state all products that are approved for sale in the individual market and must accept any individual that applies for coverage under any of those products.

Drafting Note: States should be aware that additional exceptions (*i.e.* exceptions for network plans, limited financial capacity, etc.) to guaranteed availability of coverage can be found in Section 6 of the *Individual Market Health Insurance Coverage Model Act* (#36). Those provisions were not included in this section in order to avoid unnecessary duplication. However, states may choose to include those provisions in this section if they want to do so.

- B. A health carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.
- C. (1) A health carrier must allow an individual to purchase health insurance coverage during an annual open enrollment period established by HHS unless the commissioner establishes a broader open enrollment period than the open enrollment period established by HHS. Coverage must become effective consistent with the dates described in Paragraph (2).
- (2) The health carrier must ensure coverage is effective for an individual who has applied for coverage under the health benefit plan in accordance with requirements established by the commissioner if the commissioner establishes a broader open enrollment period or as established by HHS.

- D. For individuals enrolled in non-calendar year health benefit plans, a health carrier must provide a limited open enrollment period that begins on the date that is thirty (30) calendar days prior to the date the policy year ends in 2014. The effective date of coverage under this subsection must be consistent with the dates described in Subsection E(2)(b).

Drafting Note: States that permitted health carriers to renew non-ACA compliant policies pursuant to the November 2013 “Transitional Policy,” and any extensions of that transitional policy, may need to alert carriers that they must provide a special enrollment period for those covered persons at least 30 calendar days prior to the date the policy ends.

- E. (1) (a) In addition to the special enrollment periods provided in Section 9B of the Act and qualifying events, as defined under Section 603 of ERISA, a health carrier must provide special enrollment periods for the following triggering events:
- (i) An individual or dependent loses minimum essential coverage;
 - (ii) An individual gains a dependent through marriage, birth, adoption or placement for adoption or placement in foster care;
 - (iii) An individual’s enrollment or non-enrollment in a health benefit plan is unintentional, inadvertent or erroneous and as a result of the error, misrepresentation or inaction of an officer, employee or agent of the health carrier or HHS or its instrumentalities as evaluated and determined by the health carrier. In such cases, the health carrier may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction;
 - (iv) A covered person adequately demonstrates to the health carrier that the health benefit plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the covered person;
 - (v) A covered person is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions. A health carrier must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable, as defined by federal law or regulation, or no longer provide minimum value, as defined by federal law or regulation, for his or her employer’s upcoming plan year, to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; and
 - (vi) An individual or covered person gains access to new health benefit plans as a result of a permanent move.
- (b) These special enrollment periods are in addition to any other special enrollment periods required under state or federal law.

Drafting Note: States should be aware that federal preemption standards allow states to impose stronger consumer protections in state law such as, for example, additional special enrollment periods or open enrollment periods that allow individuals to purchase coverage more frequently than the federal minimum requirements.

- (2) (a) With respect to an election made under Subsection D or Paragraph (1) of this subsection, coverage must become effective consistent with the dates described in Subparagraph (b) of this paragraph.
- (b) Except as provided in Subparagraph (c) of this paragraph, for a health benefit plan selection received by the health carrier from an individual:
- (i) Between the first and fifteenth day of any month, the health carrier must ensure a coverage effective date of the first day of the following month; and

- (ii) Between the sixteenth and the last day of any month, the health carrier must ensure a coverage effective date of the first day of the second following month.
- (c) (i) In the case of birth, adoption or placement for adoption, the health carrier must ensure that coverage is effective regardless of enrollment date in accordance with the provisions of Section 9B of the Act on the date of birth, adoption or placement for adoption.
- (ii) In the case of marriage, or in the case where an individual loses minimum essential coverage, as described in Paragraph (1)(a)(i), the health carrier must ensure coverage is effective on the first day of the following month.

F. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 7. Guaranteed Renewability of Individual Market Health Insurance Coverage

A. As provided in Section 7 of the Act and this section, subject to Subsection B, a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must renew or continue in force the coverage at the option of the individual.

Drafting Note: States should be aware that additional exceptions (*i.e.* exceptions for product discontinuation and market exit, etc.) to guaranteed renewability of coverage can be found in Section 7 of the *Individual Market Health Insurance Coverage Model Act* (#36). Those provisions were not included in this section in order to avoid unnecessary duplication. However, states may choose to include those provisions in this section if they want to do so.

B. A health carrier may nonrenew or discontinue health insurance coverage based only on one or more of the following:

- (1) The individual has failed to pay premiums in accordance with the terms of the health insurance coverage, including any timeliness requirements;
- (2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;
- (3) The carrier is ceasing to offer coverage in the market in accordance with Section 7C (discontinuing a particular product) or Section 7D (discontinuing all coverage) of the Act and applicable state law;
- (4) For network plans, there is no longer any covered person who lives, resides or works in the service area of the carrier (or the area for which the carrier is authorized to do business); or
- (5) For coverage made available in the individual market only through one or more bona fide associations, the individual’s membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered persons.

C. (1) At the time of coverage renewal only, a health carrier may modify the health insurance coverage for a product offered in the individual market if the modification is consistent with federal or state law and is effective uniformly among all policyholders with that product.

- (2) For purposes of Paragraph (1), a modification made uniformly and solely pursuant to applicable federal or state requirements is considered a uniform modification of coverage if:
 - (a) The modification is made within a reasonable time period after the imposition or modification of the federal or state requirement; and
 - (b) The modification is directly related to the imposition or modification of the federal or state requirement.

(3) Other types of modifications made uniformly are considered a uniform modification of coverage if the individual market health insurance coverage for the product meets all of the following criteria:

- (a) The product is offered by the same health carrier, as that term is defined in Section 3B of the Act;
- (b) The product is offered as the same product network type;
- (c) The product continues to cover at least a majority of the same service area;
- (d) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of health care services, or to maintain the same metal tier level described in Section 1302(d) and (e) of the Federal Act; and
- (e) The product provides the same covered benefits, except any changes in benefits that cumulatively impact the plan-adjusted index rate, as described in Section 5B of this regulation, for any plan within the product within an allowable variation of +/- two (2) percentage points, not including changes pursuant to applicable federal or state requirements.

Drafting Note: States should be aware that 45 CFR §147.106(e)(4) permits a state to broaden the standards described in Paragraph (3)(c) and (d) above.

- D. If a health carrier is renewing non-grandfathered individual market health insurance coverage as described in Subsection A, or uniformly modifying non-grandfathered individual market health insurance coverage as described in Subsection C, the health carrier must provide to each individual written notice of the renewal before the date of the first day of the next open enrollment period in a form and manner specified by the Secretary.
- E.
 - (1) Nothing in this section should be construed to require a health carrier to renew or continue in force individual market health insurance coverage for which continued eligibility would otherwise be prohibited under applicable federal law.
 - (2) Medicare eligibility or entitlement to such benefits is not a basis for non-renewal or termination of an individual's health insurance coverage in the individual market.
- F. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed renewability provisions under Section 2742 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of the Federal Act.

Section 8. Prohibition of Preexisting Condition Exclusions

- A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not impose any preexisting condition exclusions as provided in Section 9A of the Act.
- B. As described in Section 4 of the Act, grandfathered health plan coverage that is individual health insurance coverage is not required to comply with this section.

Section 9. Prohibition on Discrimination Based on Health Factors

Drafting Note: For purposes of this *Individual Market Health Insurance Coverage Model Regulation* (#TBD), states should be aware that Section 2705 of the PHSA extends the HIPAA nondiscrimination prohibitions to the individual market. However, Section 2705 of the PHSA does not extend the wellness program exception to the prohibition on discrimination to coverage in the individual market. In addition, states should be aware that in the Incentives for Nondiscriminatory Wellness Programs in Group Health Plans; Final Rule (78 Fed. Reg. 33158) published in the *Federal Register* June 3, 2013, the preamble of that final rule (78 Fed. Reg. 33167) states that “[c]ommenters requested that the wellness provisions be extended to the individual market or that states be allowed to authorize participatory programs in the individual market. Although the proposed rule addressing the individual market is being finalized without change, it is HHS’s belief that participatory wellness programs in the individual market do not violate the nondiscrimination provisions provided that such programs are consistent with State law and available to all similarly situated individuals enrolled in the individual health insurance coverage. This is because participatory wellness programs do not base rewards on achieving a standard related to a health factor, and thus do not discriminate based upon health status.”

- A.
 - (1) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not establish a rule for eligibility, including continued eligibility, of an individual to enroll for benefits under the plan that discriminates based on any health factor that relates to the individual or dependent of the individual.
 - (2) For purposes of this section, a rule of eligibility includes a rule relating to:
 - (a) Enrollment;
 - (b) The effective date of coverage;
 - (c) Waiting or affiliation periods;
 - (d) Late and special enrollment;
 - (e) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;
 - (f) Benefits, including a rule relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Subsection C(1) and (2);
 - (g) Continued eligibility; and
 - (h) Terminating coverage, including disenrollment, of an individual under the plan.
 - (3) Nothing in this section prohibits a health carrier from establishing more favorable rules of eligibility for individuals with an adverse health factor, such as a disability, than for individuals without the adverse health factor.
- B.
 - (1) Subject to federal or state law or regulations and Paragraph (2), Subsection A does not require a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act to provide coverage for any particular benefit to similarly situated individuals.
 - (2)
 - (a) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act shall make the benefits provided under a plan available uniformly to all individuals.
 - (b) For any restriction on a benefit or benefits provided under a plan, the health carrier:
 - (i) Shall apply the restriction uniformly; and
 - (ii) May not direct the restriction, as determined based on all of the relevant facts and circumstances, at any individual or dependents of an individual based on any health factor of the individual or a dependent of the individual.
 - (c) The health carrier may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the cost-sharing requirement:
 - (i) Applies uniformly;
 - (ii) Is not directed at any individual or dependents of an individual based on any health factor of the individual or dependent of an individual; and
 - (iii) Does not apply to preventive benefits specified in Section 2713 of the Public Health Service Act (PHSA).

- (d) For purposes of this paragraph, a plan amendment applicable to all individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual or dependent of an individual.
- (3) If the health carrier generally provides benefits for a type of injury, the health carrier may not deny any individual or dependent of an individual benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition. This provision applies to an injury resulting from a medical condition even if the medical condition is not diagnosed before the injury.
- C. In accordance with Subsection A, a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act may not establish a rule of eligibility or set an individual policyholder's premium or contribution rate based on:
 - (1) Whether the policyholder is confined in a hospital or other health care institution; or
 - (2) The policyholder's ability to engage in normal life activities.

Section 10. Essential Health Benefits Package

- A. To meet the requirements of Section 13 of the Act, provision of essential health benefits means that a health benefit plan provides health benefits that:
 - (1) Are substantially equal to the EHB-benchmark plan including:
 - (a) Covered benefits;
 - (b) Limitations on coverage including coverage of benefit amount, duration and scope; and
 - (c) Prescription drug benefits that meet the requirements of Section 12 of this Regulation;
 - (2) With the exception of the essential health benefits category of coverage for pediatric services, do not exclude an enrollee from coverage in an essential health benefits category;
 - (3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of 45 CFR §146.136 related to parity in mental health and substance use disorder benefits;
 - (4) Include preventive health services, as provided in Section 14 of the Act;
 - (5) If the EHB-benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:
 - (a) Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services;
 - (b) Is determined by the health carrier and reported to HHS; or
 - (c) As determined by the state as provided in 45 CFR §156.110(f).
- B. A health carrier offering a health benefit plan in the individual market providing essential health benefits may substitute benefits if the carrier meets the following conditions:

Drafting Note: States should be aware that they may adopt more restrictive requirements related to health carriers substituting benefits, including not permitting the practice.

- (1) Substitutes a benefit that:
 - (a) Is actuarially equivalent to the benefit that is being replaced as determined in Paragraph (2);
 - (b) Is made only within the same essential health benefit category; and
 - (c) Is not a prescription drug benefit; and
- (2) Submits evidence of actuarial equivalence that is:
 - (a) Certified by a member of the American Academy of Actuaries;
 - (b) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
 - (c) Based on a standardized plan population; and
 - (d) Determined regardless of cost-sharing.
- C. A health benefit plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).
- D. A health carrier offering a health benefit plan in the individual market providing essential health benefits may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits or non-medically necessary orthodontia as essential health benefits.

Drafting Note: States should be aware that in the preamble of the final regulations published in the *Federal Register* Feb. 25, 2013 (78 FR 12866), there is commentary related to a provision in the ACA and implementing regulations that provides that if an exchange offers a standalone dental plan offering a pediatric dental EHB benefit, medical insurance plans are not required to offer a pediatric dental plan on that exchange. HHS was encouraged by commenters on the proposed regulation to extend into the non-exchange market (outside market) the ability of a medical insurance plan to not offer the pediatric dental EHB in cases where a standalone dental plan that meets the standards to cover the pediatric dental EHB is offered. In its response to the comments, HHS notes that the ACA does not provide for the same exclusion of a pediatric dental EHB outside of the exchange as it does in Section 1304(b)(4) of the ACA for exchanges. Therefore, individuals enrolling in health insurance coverage in the outside market must be offered the full ten EHB categories, including the pediatric dental benefit. HHS notes, however, that in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an exchange-certified stand-alone dental plan off the exchange, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. As such, when an issuer is reasonably assured that an individual has obtained such coverage through an exchange-certified stand-alone dental plan offered outside an exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the exchange-certified stand-alone dental plan, ensures full coverage of EHB. HHS also notes that this alternative method of compliance is at the option of the medical insurance plan issuer, and would only apply with respect to individuals for whom the medical insurance plan issuer is reasonably assured have obtained pediatric dental coverage through an exchange-certified stand-alone dental plan. In addition, this option is only available for pediatric dental EHB, and not for any other EHB. States should be aware that because this alternative option is included in the final regulation’s preamble, but not in the text of the final regulation, states may be taking a different approach to address this issue.

- E. A health carrier offering health benefit plan in the individual market providing essential health benefits may not impose annual and lifetime dollar limits on essential health benefits in accordance with 45 CFR §147.126.

Section 11. Parity in Mental Health and Substance Use Disorder Benefits

- A. (1) The provisions of 45 CFR §146.136 apply to a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act in the same manner and to the same extent as such provisions apply to health insurance coverage offered in connection with a group health insurance plan in the large group market.
- (2) For purposes of this subsection, “large group market” has the meaning stated in 45 CFR §144.103.
- B. This section applies to non-grandfathered health plan coverage and grandfathered health plan coverage.

Section 12. Prescription Drug Benefits

- A. A health benefit plan does not provide essential health benefits unless it:
 - (1) Except as provided in Subsection B, covers at least the greater of:
 - (a) One drug in every United States Pharmacopeia (USP) category and class; or
 - (b) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and
 - (2) Submits its drug list to the state.
- B. A health benefit plan does not fail to provide essential health benefits prescription drug benefits solely because it does not offer drugs approved by the U.S. Food and Drug Administration as a service described in 45 CFR §156.280(d).
- C.
 - (1) A health benefit plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health benefit plan.
 - (2)
 - (a) The procedures must include a process for an enrollee, the enrollee’s designee or the enrollee’s prescribing physician or other prescriber to request an expedited review based on exigent circumstances.
 - (b) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.
 - (c) A health benefit plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee’s designee and the prescribing physician or other prescriber, as appropriate, of its coverage determination no later than twenty-four (24) hours after it receives the request.
 - (d) A health benefit plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Drafting Note: The provisions of Subsection C above reference health benefit plans having procedures, including an expedited review process as part of those procedures, in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health benefit plan. In considering what procedures, if any, states may want to require health carriers to have in place for their health benefit plans to carry out the provisions of Subsection C, states may want to review procedures in the NAIC models concerning internal and external review. In addition, states may want to review the provisions of the NAIC *Health Carrier Prescription Drug Benefit Management Model Act* (#22), particularly Section 7—Medical Exceptions Approval Process Requirements and Procedures.

Section 13. Prohibition on Discrimination in Providing Essential Health Benefits

- A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions.
- B. A health carrier must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection B above and, if necessary, revise the language in Subsection B.

- C. Nothing in this section shall be construed to prevent a health carrier from appropriately utilizing reasonable medical management techniques.

Section 14. Cost-Sharing Requirements

- A. (1) For a policy year beginning in calendar year 2014, cost-sharing may not exceed the following:
 - (a) For self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended; or
 - (b) For non-self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended.
- (2) For a policy year beginning in a calendar year after 2014, cost-sharing may not exceed the following:
 - (a) For self-only coverage, the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in Subsection E; or
 - (b) For non-self-only coverage, twice the dollar limit for self-only coverage described in Subparagraph (a) of this paragraph.
- B. In the case of a plan using a network of providers, the annual limitation on cost-sharing, as defined in Subsection A does not apply to benefits provided out-of-network, other than benefits provided on an appeal or exceptions basis because medically necessary services were not reasonably accessible within the network.

Drafting Note: Subject to state or federal law or regulations, nothing in this section would prohibit a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in Subsection A or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network. Federal law does not prevent a state from establishing lower cost-sharing limits, or establishing limits that apply to out-of-network benefits.

- C. For a policy year beginning in a calendar year after 2014, any increase in the annual dollar limits described in Subsection A that does not result in a multiple of 50 dollars will be rounded down, to the next lowest multiple of 50 dollars.
- D. The premium adjustment percentage is the percentage, if any, by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance coverage for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.
- E. Nothing in this section is in derogation of the requirements of Section 14 of the Act.
- F. Emergency department services must be provided as follows:
 - (1) Without imposing any requirement under the health benefit plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and
 - (2) If such services are provided out of network, cost-sharing must be limited as provided in [insert reference to state law or regulation equivalent to Section 11C of the *Utilization Review and Benefit Determination Model Act*].

Section 15. Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage

- A. Subject to Subsection B, a health carrier must use the AV Calculator developed and made available by HHS to calculate the AV of a health benefit plan.
- B. If a health benefit plan’s design is not compatible with the AV Calculator, the health carrier must meet the following:

- (1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in Subparagraphs (a) and (b) of this paragraph:
 - (a) Calculate the plan's AV by:
 - (i) Estimating the fit of its plan design into the parameters of the AV calculator; and
 - (ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or
 - (b) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries, calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator; and
 - (2) The calculation methods described in Paragraph (1)(a) and (b) may include in-network cost-sharing, including multi-tier networks.
- C.
- (1) Beginning in 2015, if submitted by the state and approved by HHS, a state-specific data set, in a format specified by HHS that can support the use of the AV Calculator as described in Subsection A, will be used as the standard population to calculate AV in accordance with Subsection A.
 - (2) The AV will be calculated using the default standard population described in Paragraph (3), unless a data set in a format specified by HHS that can support the use of the AV Calculator, as described in Subsection A, is submitted by a state and approved by HHS consistent with the requirements of 45 CFR §156.135(d) by a state specified by HHS.
 - (3) The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in Subsection A.
- D.
- (1) The AV, calculated as described in Subsections A through C, and within a de minimis variation as defined in Paragraph (3), determines whether a health benefit plan offers a bronze, silver, gold or platinum level of coverage.
 - (2) The levels of coverage are:
 - (a) A bronze plan is a health benefit plan that has an AV of 60%.
 - (b) A silver plan is a health benefit plan that has an AV of 70%.
 - (c) A gold plan is a health benefit plan that has an AV of 80%.
 - (d) A platinum plan is a health benefit plan that has an AV of 90%.
 - (3) The allowable variation in the AV of a health benefit plan that does not result in a material difference in the true dollar value of the health benefit plan is +/-2 percentage points.

Section 16. Enrollment in Catastrophic Plans

- A. A health benefit plan is a catastrophic plan if it meets the following conditions:
- (1) Meets all of the applicable requirements for individual market health insurance coverage and is offered only in the individual market;

- (2) Does not provide a bronze, silver, gold or platinum level of coverage described in Section 1302(d) of the Federal Act;
 - (3) Provides coverage of essential health benefits under Section 1302(b) of the Federal Act once the annual limitation on cost-sharing in Section 1302(c)(1) of the Federal Act is reached and, except as provided in Paragraph (4) and Subsection B, provides no benefits for any policy year until such limitation on cost-sharing is reached;
 - (4) Provides coverage for at least three (3) primary care visits per year before reaching the deductible; and
 - (5) Covers only individuals who meet either of the following conditions:
 - (a) Have not attained the age of thirty (30) years prior to the first day of the policy year; or
 - (b) Have received a certificate of exemption for reasons identified in Section 1302(e)(2)(B)(i) or (ii) of the Federal Act.
- B. A catastrophic plan may not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, for preventive services, in accordance with Section 2713 of the Public Health Service Act (PHSA).
- C. For other than self-only coverage, each individual enrolled must meet the requirements of Subsection A(5).

Section 17. Provision of Summary of Benefits and Coverage; Uniform Glossary

Drafting Note: States should be aware that in addition to the provisions of 45 CFR §147.200, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, have issued extensive sub-regulatory guidance in the form of frequently asked questions (FAQs) and enforcement safe harbors for issuers subject to Section 2715 of the PHSA and the implementing federal regulations. The drafting note below details this sub-regulatory guidance and issuer enforcement safe harbors.

Drafting Note: The Departments have maintained their intent to continue the safe harbors and other enforcement relief provided to issuers for the first year of applicability related to the requirement to provide a Summary of Benefits and Coverage (SBC) and a uniform glossary during subsequent years of applicability. The Departments confirmed their intent in the Affordable Care Act Implementation FAQs Part XIX, Q8 issued May 2, 2014, “in recognition of and to ensure a smooth transition to new market changes in 2014,” to extend the following previously-issued enforcement and transition relief guidance until further guidance is issued:

- Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the federal agencies’ basic approach to implementation of the SBC requirements during the first year of applicability);
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);
- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);
- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator); and related information related to use of the coverage examples calculator;
- Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer’s obligation to provide an SBC with respect to benefits it does not insure);
- Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);
- Affordable Care Act Implementation FAQs Part XIV, Q2 (regarding providing information about MEC (minimum essential coverage) and MV (minimum value) without changing the SBC template);
- Affordable Care Act Implementation FAQs Part XIV, Q3 (removal of the row on the SBC template related to annual limits information);
- Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding carve-out arrangements);
- Affordable Care Act Implementation FAQs Part XIV, Q7 (regarding anti-duplication rule for student health insurance coverage);
- The Special Rule contained in the Instruction Guides for Group and Individual Coverage;
- Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage); and
- Affordable Care Act Implementation FAQs Part XIV, Q6 (an enforcement safe harbor related to closed blocks of business).

The May 2, 2014 guidance also noted that “[t]his guidance supersedes any previous sub-regulatory guidance, including FAQs, stating that certain enforcement relief for the SBC and uniform glossary requirements is limited to the first or second year of applicability.”

- A. A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must provide a summary of benefits and coverage (SBC) for each benefit package without charge to the individuals described in this section and in accordance with this section.

Drafting Note: States should be aware that, as enacted, the Federal Act retained, with amendment, what was Section 2713 of the PHSA, now Section 2709 of the PHSA (Disclosure of Information), which requires health carriers to disclose information to individuals concerning the carrier’s right to change premium rates and the factors that may affect changes in premium rates and the benefits and premiums available under all health insurance coverage for which the individual is qualified. The provisions of this section do not include these required disclosure requirements.

- B. (1) A health carrier must provide an SBC to an individual covered under the health benefit plan, including every dependent, upon receiving an application for any plan, as soon as practicable following receipt of the application, but in no event later than seven (7) business days following receipt of the application.
- (2) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the individual no later than the first day of coverage.
- (3) (a) A health carrier must provide the SBC to policyholders annually at renewal in accordance with Subparagraph (b) of this paragraph. The SBC must reflect any modified plan terms that would be effective on the first day of the new policy year.
- (b) The SBC must be provided as follows:
- (i) If written application is required in either paper or electronic form for renewal or reissuance, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or
- (ii) If renewal or reissuance is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new policy year; however, if the policy, certificate or contract of insurance has not been issued or renewed before such 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issuance of the new policy, certificate or contract of insurance or the receipt of the written confirmation of intent to renew, whichever is earlier.
- (4) (a) A health carrier must provide an SBC to any individual or dependent anytime the individual or dependent requests an SBC or summary information about a health insurance product as soon as practicable, but in no event later than seven (7) business days following receipt of the request.
- (b) For purposes of this subsection, a request for an SBC or summary information about a health insurance product includes a request made both before and after an individual submits an application for coverage.
- (5) If a health carrier provides a single SBC to an individual and any dependents at the individual’s last known address, then the carrier’s requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent’s last known address is different than the individual’s last known address, the carrier must provide a separate SBC to the dependent at the dependent’s last known address.

- C. (1) Subject to Paragraph (3), an SBC provided under this section must include the following:
- (a) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of, or exceptions to, their coverage, in accordance with guidance as specified by the Secretary;
 - (b) A description of the coverage, including cost-sharing, for each category of benefits identified by the Secretary in guidance;
 - (c) The exceptions, reductions and limitations of coverage;
 - (d) The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;
 - (e) The renewability and continuation of coverage provisions;
 - (f) Coverage examples in accordance with Paragraph (2);
 - (g) A statement about whether the coverage provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code of 1986, as amended and whether the coverage's share of the total allowed costs of benefits provided under the coverage meets applicable requirements;
 - (h) A statement that the SBC is only a summary and that the policy, certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;
 - (i) Contact information for questions and obtaining a copy of the insurance policy, certificate or contract of insurance, such as a telephone number for customer service and a publicly accessible Internet address where a copy of the plan document or the insurance policy, certificate or contract of insurance can be reviewed and obtained;
 - (j) For carriers that maintain one or more provider networks, an Internet address, or similar contact information, for obtaining a list of network providers;
 - (k) For carriers that use a formulary in providing prescription drug coverage, an Internet address, or similar contact information, for obtaining information on prescription drug coverage; and
 - (l) An Internet address for obtaining the uniform glossary, as described in Subsection H, as well as a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.
- (2) (a) The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the coverage for common benefit scenarios, including pregnancy and serious or chronic medical conditions in accordance with this paragraph. The Secretary may identify up to six (6) coverage examples that may be required in an SBC.
- (b) For purposes of this paragraph, a benefit scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specified period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality.

Drafting Note: The HHS Secretary of will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

- (c) (i) For purposes of this paragraph, to illustrate benefits provided under the coverage for a particular benefits scenario, a carrier simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the policy or benefit package.
 - (ii) The illustration of benefits provided will take into account any cost-sharing, excluded benefits and other limitations on coverage as specified by the Secretary in guidance.
- (3) (a) In lieu of summarizing coverage for items and services provided outside of the United States, a carrier may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States.

Drafting Note: In Frequently Asked Questions (FAQs), the federal agencies charged with implementing the ACA provide that expatriate coverage is not subject to the ACA requirements for plan years ending before Dec. 15, 2015, including the requirements to provide an SBC with respect to expatriate coverage during the first year of applicability. States should refer to the Drafting Note at the beginning of this section for additional information regarding this enforcement safe harbor.

- (b) In any case, the carrier must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the coverage within the United States.
- D. (1) A carrier must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in regulations and applicable guidance.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the safe harbor for plans and issuers provided in the Special Rule in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition) for completing the SBC. As stated in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition), the Special Rule provides: “To the extent a plan’s terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program.”

- (2) The SBC must be provided in a uniform format, use terminology understandable by the average individual covered under the policy, not exceed four (4) double-sided pages in length and not include print smaller than 12-point font.
 - (3) The carrier must provide the SBC as a stand-alone document.
- E. (1) A carrier must provide an SBC in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the circumstances in which a SBC may be provided electronically consistent with the safe harbor provided by the federal agencies.

- (2) A carrier satisfies the requirements of this subsection if the carrier:
 - (a) Hand-delivers a printed copy of the SBC to the individual or dependent;
 - (b) Mails a printed copy of the SBC to the mailing address provided to the carrier by the individual or dependent;
 - (c) Provides the SBC by email after obtaining the individual’s or dependent’s agreement to receive the SBC or other electronic disclosures by email;
 - (d) Posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with Subparagraphs (a) through (c) of this paragraph, that the SBC is available on the Internet and includes the applicable Internet address; or

- (e) Provides the SBC by any other method that can reasonably be expected to provide actual notice.
 - (3) An SBC may not be provided electronically unless:
 - (a) The format is reasonably accessible;
 - (b) The SBC is placed in a location that is prominent and readily accessible;
 - (c) The SBC is provided in an electronic form which can be electronically retained and printed;
 - (d) The SBC is consistent with the appearance, content and language requirements of this section; and
 - (e) The carrier notifies the individual or dependent that the SBC is available in paper form without charge upon request and provides it upon request.
 - (4) A carrier that provides the content required under Subsection C, as specified in guidance published by the Secretary, to the federal health reform Web portal described in 45 CFR 159.120 will be deemed to satisfy the requirements of Subsection B(4) with respect to a request for summary information about a health insurance product made prior to an application for coverage. However, nothing in this paragraph should be construed as otherwise limiting the carrier's obligations under this section.
- F. A health carrier must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this section, a carrier is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR §147.136(e) are met as applied to the SBC.
- G.
 - (1) If a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act makes any material modification, as defined under Section 102 of ERISA, in any terms of the coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with renewal or reissuance of coverage, the health carrier must provide notice of the modification to an individual covered under a health benefit plan not later than sixty (60) days prior to the date on which the modification will become effective.
 - (2) The health carrier must provide the notice of modification in a form that is consistent with Subsection E.
- H.
 - (1) A health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act must make available to applicants, policyholders and covered dependents, the uniform glossary described in Paragraph (2) of this subsection in accordance with the appearance and form and manner requirements of Paragraphs (3) and (4).
 - (2) The uniform glossary must provide uniform definitions, specified by the Secretary in guidance of the following health-coverage-related terms and medical terms:
 - (a) Allowed amount; appeal; balance billing; co-insurance; complications of pregnancy; co-payment; deductible; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitative services; health insurance; home health care; hospice services; hospitalization; hospital out-patient care; in-network co-insurance; in-network co-payment; medically necessary; network; non-preferred provider; out-of-network co-insurance; out-of-network co-payment; out-of-pocket limit; physician services; plan; preauthorization; preferred provider; premium; prescription drug coverage; prescription drugs; primary care physician; primary care provider; provider; reconstructive surgery; rehabilitation services; skilled nursing care; specialist; usual customary and reasonable (UCR); and urgent care;

- (b) Such other terms as the Secretary determines are important to define so that individuals may compare and understand the terms of coverage and medical benefits, including any exceptions to those benefits, as specified in guidance.
- (3) A carrier must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable to the average individual covered under a health insurance policy.
- (4) A carrier must make the uniform glossary described in this subsection available upon request, in either paper or electronic form (as requested), within seven (7) business days after receipt of the request.

Drafting Note: States should be aware that consumers may review and obtain the uniform glossary at several websites, including www.healthcare.gov (Centers for Medicare and Medicaid Services (CMS)), www.cciio.cms.gov (Center for Consumer Information and Insurance Oversight (CCIIO)), and www.dol.gov/ebsa/healthreform (U.S. Department of Labor (DOL), Employee Benefits Security Administration (EBSA)).

Section 18. Certification and Disclosure of Prior Creditable Coverage

Drafting Note: The federal agencies charged with implementing the provisions of the ACA published a final rule (79 FR 30341) in the *Federal Register* May 27, 2014, amending 45 CFR §148.124 to eliminate the requirement in the individual market to provide certificates of credible coverage and to demonstrate creditable coverage. The language in this section is consistent with the language from the final rule.

- A. The federal rules for providing certificates of creditable coverage and demonstrating creditable coverage under 45 CFR §148.124 have been superseded by the prohibition on preexisting condition exclusions in accordance with Section 2704 of the Public Health Service Act.
- B. The provisions of this section apply beginning December 31, 2014.

Section 19. Rules Related to Fair Marketing

- A. A health carrier offering health benefit plans providing individual market health insurance coverage subject to the Act must actively market each of its health benefit plans to individuals in this state, except that for health benefit plans providing individual market health insurance coverage not subject to Section 6 of the Act, a health carrier must offer coverage upon request and is not required to actively market such coverage.

Drafting Note: This regulation requires the active marketing of all individual market health benefit plans offered by a carrier. This requirement is present to prevent targeted marketing by a carrier or producer. Marketing materials should make clear, however, that not all individuals may be eligible for all individual market health benefit plans issued by the carrier. Those materials should also make clear that some individual market health benefit plans may only be available in certain geographic areas and based on certain eligibility criteria (e.g. catastrophic plans).

- B. The health carrier shall maintain a toll-free telephone service that answers its telephone calls in a timely manner to provide information to individuals regarding the availability of individual market health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and telephone numbers of producers located geographically proximate to the caller or other information reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

Drafting Note: Some states with smaller populations may determine that this provision is not necessary to assure fair marketing of individual market health benefit plans in their state. For those states that determine this provision is necessary, it is imperative that the toll-free number be accessible.

- C. The health carrier may not require an individual to join or contribute to an association or group as a condition of being accepted for coverage by the carrier.
- D. The health carrier may not require, as a condition to the offer or sale of a health benefit plan to an individual that the individual purchase or qualify for any other insurance product or service.
- E. (1) A health carrier must file annually the following information with the commissioner related to individual market health benefit plans issued by the carrier to individuals in this state:

- (a) The number of individuals that were issued, or received renewals of, individual market health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);
- (b) The number of individual market health benefit plans in force in the state as of December 31 of the previous calendar year;

Drafting Note: Instead of requesting information on the number of individual health benefit plans in force in the state, as provided in Subparagraph (b) above, a state may decide it is more appropriate to request such information by county, three-digit zip code or metropolitan statistical area and non-metropolitan statistical area geographic divisions.

- (c) The number of individual market health benefit plans that were voluntarily not renewed by individuals in the previous calendar year; and
- (d) The number of individual market health benefit plans that were terminated or not renewed and reasons (other than nonpayment of premium) for the termination or nonrenewal by the carrier in the previous calendar year.

(2) The information described in Paragraph (1) shall be filed no later than March 15 of each year.

- F. A health carrier may not create financial incentives or disincentives for producers to sell or to not sell any of its individual market health benefit plans. The commissioner shall have authority to review a carrier's commission structure to ensure no financial incentives or disincentives to sell or to not sell any of its individual market health benefit plans are created by the structure.
- G. A health carrier may not employ marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection G above and, if necessary, revise the language in Subsection G.

Section 20. Rules Related to Quality of Care Reporting

To be completed at a later date.

Section 21. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of its provisions to other persons or circumstances shall not be affected thereby.

Section 22. Effective Date

This regulation shall be effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2014 Proc. 3rd Quarter Vol. I 122-125, 137, 256, 266 (adopted).