

INDIVIDUAL HEALTH INSURANCE PORTABILITY MODEL ACT

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Section 1. Short Title

This Act shall be known and may be cited as the Individual Health Insurance Portability Act.

Section 2. Purpose

The purpose and intent of this Act are to promote the availability of health insurance coverage to recently insured individuals regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to limit the use of preexisting condition exclusions, to provide for development of individual basic and standard health benefit plans, to assure fair access to health plans, and to improve the overall fairness and efficiency of the individual health insurance market.

Drafting Note: This model act assumes that a state has enacted the NAIC Model Health Plan for Uninsurable Individuals Act. States implementing this model without the NAIC Model Health Plan for Uninsurable Individuals Act should be aware that this model addresses portability, renewability, and some rating problems in the individual health insurance market. This model does not address the availability problems of those persons who are uninsurable and do not have a qualifying event or qualifying previous coverage or prior creditable coverage.

Section 3. Definitions

As used in this Act:

- A. “Actuarial certification” means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that an individual carrier is in compliance with the provisions of Section 5 of this Act, based upon the persons examination and including a review of the appropriate records and the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable individual health benefit plans.
- B. “Affiliate” or “affiliated” means an entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
- C. “Affiliation period” means a period of time that must expire before health insurance coverage becomes effective, and during which the carrier is not required to provide benefits.
- D. “Age bracket” means ages of an individual in increments of no less than one year beginning at age nineteen (19). All individuals under age nineteen (19) shall constitute a single age bracket.
- E. “Assessable loss” means the amount calculated pursuant to Section 12K of this Act.
- F. “Association” means the nonprofit corporation established pursuant to Section 12 of this Act.

- G. “Block of business” means a separate grouping of enrollees and dependents as allowed by regulation.
- H. “Carrier” or “health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) uses the term “health insurance issuer” instead of “carrier” or “health carrier.” The definition of “health insurance issuer” contained in HIPAA is consistent with the term “carrier” or “health carrier,” as defined in Section 3H of this Act.

- I. “Church plan” has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974.
- J. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Where the word “commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted. Where jurisdiction of managed care organizations lies with some other state agency, or dual regulation occurs, a state should add additional language referencing that agency to ensure the appropriate coordination of responsibilities.

- K. “Converted policy” means a basic or standard health benefit plan issued pursuant to [insert reference to state law comparable to the Group Health Insurance Mandatory Conversion Privilege Model Act].
- L. (1) “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:
 - (a) A group health benefit plan;
 - (b) A health benefit plan;
 - (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);
 - (e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents (Civilian Health and Medical Program of the Uniformed Services) (CHAMPUS). For purposes of Chapter 55 of Title 10, United States Code, “uniformed services” means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
 - (f) A medical care program of the Indian Health Service or of a tribal organization;
 - (g) A state health benefits risk pool;
 - (h) A health plan offered under Chapter 89 of Title 5, U. S. Code (Federal Employees Health Benefits Program (FEHBP));
 - (i) A public health plan, which for purposes of this act, means a plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan; or
 - (j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
- (2) A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Act, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

Drafting Note: It may be desirable to grant the commissioner rulemaking authority to further define that coverage which falls within the definition above. However, the commissioner's authority is limited by HIPAA with respect to creditable coverage. The commissioner cannot define this term in a manner that would prevent the application of the federal law.

- M. "Dependent" shall be defined in the same manner as in [insert reference to state insurance law defining dependent].

Drafting Note: States without a statutory definition of dependent may wish to use the definition below. If using the suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child below is not intended to be limited to natural children of the enrollee.

"Dependent" means a spouse, an unmarried child under the age of [nineteen (19)] years, an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the enrollee, and an unmarried child of any age who is medically certified as disabled and dependent upon the enrollee.

- N. "Eligible person" means a person who is a resident of this state who is not eligible to be insured under an employer-sponsored group health benefit plan.
- O. "Enrollee" means a person who:
- (1) Is covered by an individual health benefit plan; and
 - (2) Has paid premium for himself or herself and his or her dependents, if any, who are also covered under the individual health benefit plan, and is responsible for continued premium payments under the terms of the individual health benefit plan.
- P. "Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever is earlier.
- Q. "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carriers certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
- R. "Family composition" means:
- (1) Enrollee;
 - (2) Enrollee, spouse and children;
 - (3) Enrollee and spouse;
 - (4) Enrollee and children; or
 - (5) Child only.
- S. "Federally defined eligible individual" means:
- (1) An individual:
 - (a) For whom, as of the date on which the individual seeks coverage under this Act, the aggregate of the periods of creditable coverage, as defined in Subsection L, is eighteen (18) or more months;
 - (b) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan;
 - (c) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or a state plan under Title XIX of the Act, or any successor program, and who does not have other health insurance coverage;

- (d) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; and
 - (e) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, both elected and exhausted such coverage; or
- (2) A child who is covered under any creditable coverage within [thirty (30)] days of birth, adoption, or placement for adoption, provided that the child does not experience a significant break in coverage.

Drafting Note: Under HIPAA, states may establish a special enrollment period longer than 30 days for a child with creditable coverage who satisfies Paragraph (2).

- T. “Genetic information” means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Drafting Note: The definition of “genetic information” is derived from interim federal regulations. Prior to adopting the above definition, states should review final federal regulations to ensure that the language for the definition has not been altered.

- U. “Geographic area” is an area established by the commissioner used for adjusting the rates for a health benefit plan.

- V. “Governmental plan” has the meaning given the term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

- W. (1) “Group health benefit plan” means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in Subsection DD and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

- (2) For purposes of this Act:

- (a) Any plan, fund or program that would not be, but for PHSA Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b), as an employee welfare benefit plan that is a group health benefit plan;
- (b) In the case of a group health benefit plan, the term “employer” also includes the partnership in relation to any partner; and
- (c) In the case of a group health benefit plan, the term “participant” also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual’s beneficiary who is, or may become, eligible to receive a benefit under the plan, if:
 - (i) In connection with a group health benefit plan maintained by a partnership, the individual is a partner in relation to the partnership; or
 - (ii) In connection with a group health benefit plan maintained by a self-employed individual, under which one or more employees are participants, the individual is the self-employed individual.

Drafting Note: Paragraph (1) of the definition of “group health plan” tracks the federal definition of “group health plan” found in PHSa Section 2791(a)(1), as amended by HIPAA. However, the federal law’s definition of “group health plan” also defines “medical care” as part of the definition of “group health plan.” In this model act, the definition of “medical care” is separate from the definition of “group health plan” and is found in Section 3DD below. The definition of “group health plan” in this model also differs from the federal definition in that it contains Paragraph (2), which tracks the language of PHSa Section 2721(e), as amended by HIPAA, addressing the treatment of partnerships.

- X. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: HIPAA uses the term “health insurance coverage.” “Health benefit plan,” as defined in this model act, is intended to be consistent with the definition of “health insurance coverage” contained in HIPAA. Paragraphs (2), (3), (4) and (5) below track the language of HIPAA that addresses “excepted benefits,” i.e., those benefits that are excepted from the requirements of HIPAA.

- (2) “Health benefit plan” shall not include one or more, or any combination of, the following:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (3) “Health benefit plan” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Such other similar, limited benefits as are specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (4) “Health benefit plan” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (5) “Health benefit plan” shall not include the following if offered as a separate policy, certificate or contract of insurance:

- (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
- (b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
- (c) Similar supplemental coverage provided to coverage under a group health plan.

Drafting Note: States should examine the exemptions already provided in this definition before adopting any additional exemptions.

- (6) A carrier offering policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance shall comply with the following:
 - (a) The carrier files on or before March 1 of each year a certification with the commissioner that contains the statement and information described in Subparagraph (b);
 - (b) The certification shall contain the following:
 - (i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance; and
 - (ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for these policies and certificates in this state; and
 - (c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the commissioner the information and statement required in Subparagraph (b) at least thirty (30) days prior to the date the policy or certificate is issued or delivered in this state.

Drafting Note: It may be desirable to provide the commissioner with discretion to implement regulations to delineate the suitability of these products in the health insurance market reformed pursuant to this Act. For example, the commissioner might conclude that the sale of certain specified disease or other policies is inappropriate in the context of a reformed health insurance market. Furthermore, states may wish to consider whether the information filed pursuant to the requirement in paragraph (6) is necessary for effective regulation of those products in light of the market conduct of limited benefit carriers in their states.

- Y. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.
- Z. “Health status-related factor” means any of the following factors:
 - (1) Health status;
 - (2) Medical condition, including both physical and mental illnesses;
 - (3) Claims experience;
 - (4) Receipt of health care;
 - (5) Medical history;
 - (6) Genetic information;

- (7) Evidence of insurability, including conditions arising out of acts of domestic violence; or
- (8) Disability.

Drafting Note: This definition tracks the language contained in PHSA Section 2702(a), as amended by HIPAA.

- AA. “Individual basic or standard health benefit plan” means the core group of health benefits developed pursuant to Section 9 of this Act.
- BB. “Individual carrier” means a carrier that issues or offers for issuance individual health benefit plans covering one or more residents of this state.
- CC. (1) “Individual health benefit plan” means:
 - (a) A health benefit plan other than a converted policy or a professional association plan for individuals and their dependents; and
 - (b) A certificate issued to an enrollee that evidences coverage under a policy or contract issued to a trust or association or other similar grouping of individuals, regardless of the situs of delivery of the policy or contract, if the enrollee pays the premium and is not being covered under the policy or contract pursuant to continuation of benefits provisions applicable under federal or state law.
- (2) “Individual health benefit plan” shall not include a certificate issued to an enrollee that evidences coverage under a professional association plan.

Drafting Note: In reforming the individual health insurance market, it is important that state insurance departments have jurisdiction over policies sold to individuals through trusts or associations situated outside the state. Paragraph (1)(b) clarifies that if the certificate holder lives within the state and pays the premium for the policy, that policy is an individual health benefit plan subject to this Act, even if the policy was marketed or purchased through an out-of-state trust or association. Also, under Section 4D, the commissioner has specific injunctive authority to enforce the provisions of this Act.

- DD. “Medical care” means amounts paid for:
 - (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and
 - (3) Insurance covering medical care referred to in Paragraphs (1) and (2).
- EE. “Network plan” means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.
- FF. (1) “Preexisting condition” means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months preceding the enrollment date of the coverage.
- (2) “Preexisting condition” shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and that was a covered benefit under the plan, provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.
- (3) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information.
- GG. “Premium” means all moneys paid by employers, employees or enrollees as a condition of receiving coverage from a carrier, including any fees or other contributions, associated with a health benefit plan.

HH. “Producer” means [incorporate reference to definition in state’s law for licensing producers].

Drafting Note: States that have not adopted the NAIC Producer Licensing Model Act or similar provision should substitute the term agent or broker for the term producer as appropriate.

II. “Professional association” means an association that meets all of the following criteria:

- (1) Serves a single profession that requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice that profession;
- (2) Has been actively in existence for five (5) years;
- (3) Has a constitution and by-laws or other analogous governing documents;
- (4) Has been formed and maintained in good faith for purposes other than obtaining insurance;
- (5) Is not owned or controlled by a carrier or affiliated with a carrier;
- (6) Does not condition membership in the association on any health status-related factor;
- (7) Has at least 1,000 members if it is a national association; 500 members if it is a state association; or 200 members if it is a local association;
- (8) All members and dependents of members are eligible for coverage regardless of any health status-related factor;
- (9) Does not make health benefit plan offered through the association available other than in connection with a member of the association;
- (10) Is governed by a board of directors and sponsors annual meetings of its members; and
- (11) Producers only market association memberships, accept applications for membership, or sign up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the professional association.

Drafting Note: This definition of “professional association” is narrower than the definition of “bona fide association” contained in HIPAA because of the requirement of Paragraph (1) above that the professional association serve a single profession. Specifically, HIPAA defines “bona fide association,” with respect to health insurance coverage offered in a state, as an association, which: (1) has been actively in existence for at least 5 years; (2) has been formed and maintained in good faith for purposes other than obtaining insurance; (3) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee); (4) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member); (5) does not make health insurance offered through the association available other than in connection with a member of the association; and (6) meets such additional requirements as may be imposed under state law. Because the definition of “bona fide association” contained in HIPAA explicitly permits states to impose additional requirements, the narrower definition of “professional association” used in this model does not conflict with the federal law. As such, states can elect to adopt either definition, “professional association,” as used in this model or “bona fide association,” as used in HIPAA. States, however, should examine other provisions of this model, particularly its rating provisions, before adopting the “bona fide association” definition because HIPAA does not include any rating provisions.

JJ. “Professional association plan” means a health benefit plan offered through a professional association that covers members of a professional association and their dependents in this state regardless of the situs of delivery of the policy or contract and which meets all the following criteria:

- (1) Conforms with the provisions of Section 5 of this Act concerning rates as they apply to individual carriers and individual health benefit plans. If the health benefit plan offered by the professional association covers at least 2,000 members of the professional association, then that associations experience pool can be the basis for setting rates. If the professional association plan covers fewer than 2,000 members of the professional association, the carrier shall community rate the experience of that professional association with the experience of other professional associations covered by the carrier;

Drafting Note: The purpose of this paragraph is to require a carrier to pool, for rating purposes, the experience of all of the professional association plans it offers, except those plans with 2,000 or more members which a carrier chooses to rate separately based on each plans experience.

- (2) Provides renewability of coverage for the members and dependents of members of the professional association that meets the criteria set forth in Section 6 of this Act;
- (3) Provides availability of professional association plan coverage for the members and dependents of members of the professional association who are eligible persons in conformance with the provisions of Section 7A and B and Section 8 of this Act, except that the professional association shall not be required to offer individual basic or standard health benefit plan coverage;
- (4) Is offered by a carrier that offers health benefit plan coverage to any professional association seeking health benefit plan coverage from the carrier; and
- (5) Conforms with the preexisting condition provisions of all of Section 7 E, F and G and Section 8 of this Act as they apply to individual health benefit plans.

Drafting Note: Subsections CC(1)(a) and JJ of this section exempt professional association plans and the carriers that offer them from certain rating and availability requirements of the model. This exemption was intended to be very narrow in scope to address a limited marketing issue. In considering these provisions, states should be mindful of the risk segmentation consequences.

KK. “Qualifying event” means any of the following:

- (1) Loss or change of dependent status under qualifying previous coverage; or
- (2) The attainment by an individual of the age of majority.

LL. “Qualifying previous coverage” or “qualifying existing coverage” means benefits or coverage provided under any of the following:

- (1) Medicare, Medicaid, Civilian Health and Medical Program for Uniformed Services (CHAMPUS), Indian Health Service program or any other similar publicly sponsored program;
- (2) Any group health insurance, including coverage issued by a health maintenance organization, [insert appropriate reference for a prepaid hospital or medical service plan] or [insert appropriate reference for a fraternal benefit society], that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, provided that the coverage has been in effect for a period of at least one year;
- (3) A self-funded employer sponsored health benefit plan that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, provided that the coverage has been in effect for a period of at least one year if:
 - (a) The employer has elected to voluntarily participate in the Individual Health Benefit Plan Association pursuant to Section 13 of this Act; and
 - (b) The employer has complied with the requirements regarding participation set forth in the plan of operation of the Individual Health Benefit Plan Association.
- (4) An individual health insurance benefit plan or a professional association plan including coverage issued by a health maintenance organization, [insert appropriate reference for a prepaid hospital or medical service plan] or [insert appropriate reference for a fraternal benefit society] that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, if the coverage has been in effect for a period of at least one year; or
- (5) Any state’s coverage provided under a plan similar to the NAIC Model Health Plan for Uninsurable Individuals Act if the coverage has been in effect for a period of at least one year.

Drafting Note: States are strongly encouraged to study their high risk pools by examining the claims costs and history of the individuals residing in the pool. If the results of the study indicate that residence of longer than one year in the high risk pool is necessary to avoid potential negative effects on the private individual market, states should change the one year period in Paragraph (5) above to a longer time period. States may also want to consider a transition period regarding the exit of all people eligible to leave the high risk pool at the end of the first year period, to avoid a large “dump” of potentially high claim cost individuals into the private individual market simultaneously.

- MM. “Rating characteristics” means:
- (1) Family composition;
 - (2) Geographic area;
 - (3) Age bracket; and
 - (4) Other characteristics as allowed by regulation.
- NN. “Rating period” means the calendar period for which premium rates established by a carrier subject to this Act are in effect.
- OO. “Recently insured individual” means an individual who is a resident of this state and who had qualifying previous coverage within the past thirty-one (31) days, or an individual who has had a qualifying event occur within the past thirty-one (31) days.
- PP. “Restricted network provision” means a provision of an individual health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.
- QQ. “Significant break in coverage” means a period of ninety (90) consecutive days during all which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

Section 4. Applicability and Scope

- A. The provisions of this Act concerning individual health benefit plans and the individual carriers that offer them shall apply to:
- (1) An individual health benefit plan offered to eligible persons or that covers enrollees and their dependents who are residents of this state at the time of issue who are not eligible to be insured under an employer-sponsored group health benefit plan;
 - (2) A certificate issued to an enrollee that evidences coverage under a policy or contract issued to a trust or association or other similar grouping of individuals, regardless of the situs of delivery of the policy or contract, if the enrollee pays the premium and is not covered under the policy or contract pursuant to continuation of benefits provisions applicable under federal or state law;
 - (3) Professional association plans as set forth in this Act; and
 - (4) Converted policies as set forth in this Act.
- B. Except as provided in Subsection C, for purposes of this Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this Act shall apply as if all individual health benefit plans delivered or issued for delivery to residents of this state by the affiliated carriers were issued by one carrier.
- C. An affiliated carrier that is a health maintenance organization having a certificate of authority under Section [insert reference to state health maintenance organization licensing act] may be considered to be a separate carrier for the purposes of this Act.
- D. The commissioner shall have authority pursuant to [insert reference to state insurance code or administrative law provisions providing for injunctive enforcement relief] to prosecute violations of this Act.

Section 5. Restrictions Relating to Premium Rates

- A. The premium rates for an individual health benefit plan shall be subject to the following provisions:
- (1) The individual carrier shall develop its rates based on rating characteristics. After adjustment for allowed rating characteristics and benefit design, the rate for any block of individual health benefit plan business written on or after [insert effective date of this Act] by a carrier subject to this Act shall not exceed the rate for any other block of individual health benefit plan business by more than 100 percent. Any differences in rating factors across blocks of business must be recognized in applying this test. A block of business shall have a single uniform rate that is adjusted for individuals within the block only by factors based on allowed rating characteristics. Rating characteristics shall not include durational or tier rating, or changes in health status or claim experience after issue.
 - (2) Individual carriers may charge the lowest allowable adult rate for child only coverage.
- B. The annualized amount of rate change applied to a single block of business shall not exceed the annualized amount of rate change applied to any other block of business by more than fifteen percent (15%) due to the claim experience or health status of that block of business after adjustment for allowed rating characteristics and benefit design.
- C. For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar benefit design to a health benefit plan that does not contain such a provision if the restriction of benefits to network providers results in substantial differences in claim costs.
- D. Rates for individual basic and standard coverages as provided in this Act shall be determined by each carrier as the average of the lowest rate available for issuance by that carrier adjusted for rating characteristics other than health status or claims experience and benefits and the maximum rate allowable by law after adjustments for rate characteristics other than health status or claims experience and benefits.
- E. A carrier shall not transfer an enrollee with an individual health benefit plan or the enrollee's dependent involuntarily into or out of a block business.
- F. The single uniform rate pursuant to Subsection A(1) of this section for a health benefit plan may not be changed more frequently than annually. The premium charged to an enrollee may not be changed more frequently than once in twelve (12) months except to reflect:
- (1) Changes to the family composition of the enrollee; or
 - (2) Changes to the health benefit plan requested by the enrollee.
- G. If a carrier adjusts premiums for a block of business to a higher level than permitted by loss ratio requirements in order to comply with this section, the carrier must meet those loss ratio requirements on its entire individual health benefit plan business.

Drafting Note: States should be mindful of the desirability of having consistent rating schemes in the small group and individual markets. Whatever the rating rules are for small employer health benefit plans in a state, they should be consistent with individual health benefit plans.

- H. The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by individual carriers are consistent with the purposes of this Act, including regulations that prescribe the manner in which geographic territories are designated by all individual carriers.

Drafting Note: This section is designed to prohibit segmentation of certain geographic areas and avoid risk selection through territorial rating. Rating areas vary widely across the country and states are encouraged to set the geographic region at no less than a county or three-digit ZIP code area, whichever is greater. States may also wish to use the Metropolitan Statistical Service Area that is established by the U.S. Census Bureau as the minimum geographical area for carriers to differentiate rating areas. Further, in establishing these rating territories, consideration should be given to: existing rating and service areas of carriers; natural provider distribution and health care referral patterns; purchase alliance areas, if any; the potential or need for cross subsidies within the area; and the potential for unfair risk selection by plans whose service areas or provider networks serve only selected portions of the geographic rating area.

- I. In connection with the offering for sale of an individual health benefit plan to an individual, a carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:
- (1) The extent to which premium rates for an individual and dependents are established or adjusted based upon rating characteristics;
 - (2) The carrier's right to change premium rates, and the factors, other than claim experience, that affect changes in premium rates;
 - (3) The provisions relating to renewability of policies and contracts;
 - (4) Any provisions relating to any preexisting condition provision; and
 - (5) All individual health benefit plans offered by the carrier, the prices of the plans if available to the eligible person, and the availability of the plans to the individual.
- J. A carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.
- K. A carrier shall file with the commissioner annually on or before [insert date], an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner, and shall contain information, as specified by the commissioner. A copy of the certification shall be retained by the carrier at its principal place of business.
- L. A carrier shall make the information and documentation maintained pursuant to Subsection J of this section available to the commissioner upon request. Except in cases of violations of this Act, the information and documentation shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the [insert appropriate reference to department of insurance] except as agreed to by the carrier or as ordered by a court of competent jurisdiction. Notwithstanding the provisions of this section, premium rates charged by a carrier are not considered proprietary.

Section 6. Renewability of Coverage

- A. An individual health benefit plan shall be renewable with respect to an enrollee or dependents at the option of the enrollee, except in any of the following cases:
- (1) The enrollee has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;
 - (2) The enrollee or the enrollee's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;
 - (3) The carrier elects to discontinue offering all of its individual health benefit plans delivered or issued for delivery in the state if the carrier :
 - (a) Provides advance notice of its decision to the commissioner in each state in which it is licensed to sell health benefit plans; and
 - (b) Provides notice of the decision to all enrollees and to the commissioner in each state in which an enrollee is known to reside at least ninety (90) days prior to the nonrenewal of the health benefit plan by the carrier, provided the notice to the commissioner is sent at least three (3) working days prior to the date the notice is sent to enrollees.

- (4) The commissioner:
 - (a) Finds that the continuation of the coverage would not be in the best interests of the enrollees or would impair the carrier's ability to meet its contractual obligations; and
 - (b) Assists enrollees in finding replacement coverage;
 - (5) The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the state's individual insurance market if the carrier:
 - (a) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed to sell health benefit plans;
 - (b) Provides notice of the decision not to renew coverage to at least 180 days prior to the nonrenewal of any health benefit plans to:
 - (i) All enrollees; and
 - (ii) The commissioner in each state in which an enrollee is known to reside, provided the notice to the commissioner is sent at least three (3) working days prior to the date the notice is sent to enrollees;
 - (c) Offers to each enrollee provided that particular type of health benefit plan (obsolete product form) the option to purchase all other health benefit plans currently being offered by the carrier to individuals in the state; and
 - (d) In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to Subparagraph (c), acts uniformly without regard to the claims experience of any enrollee or any health status-related factor relating to any enrollee or beneficiaries who may become eligible for the coverage;
 - (6) In the case of health benefit plans that are made available in the individual market only through one or more professional associations, the membership of an individual in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any enrollee; or
 - (7) In the case of health benefit plans that are made available in the individual market through a network plan, the enrollee no longer resides, lives or works in the carrier's established geographic service area, provided coverage is terminated under this paragraph without regard to any health status-related factor relating to any enrollee.
- B.
- (1) An individual carrier that elects to discontinue offering health benefit plans under Subsection A(3) shall be prohibited from writing new business in the individual market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in the state.
 - (2) In the case of an individual carrier that ceases offering new coverage under Paragraph (1), the individual carrier, as determined by the commissioner, may renew its existing business in the individual market in this state or may be required to nonrenew its business in the individual market in this state.
- C.
- In the case of an individual carrier doing business in one established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in that service area.

Drafting Note: HIPAA does not contain an exception to guaranteed renewability in the case of an enrollee's attaining eligibility for Medicare. The preamble to the interim final federal regulations for the individual insurance market states: "Becoming eligible for Medicare by reason of age or otherwise is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market, because it is not included in the statute's specifically defined list of permissible reasons for nonrenewal. If permitted by state law, however, policies that are sold to individuals before they attain Medicare eligibility may contain coordination of benefit clauses that exclude payment under the policy to the extent that Medicare pays." 62 *Fed. Reg.* at 16989 (April 8, 1997).

Section 7. Availability of Coverage

- A.
- (1) An individual carrier shall, as a condition of transacting business in this state, make available the choice of an individual basic or standard health benefit plan to a recently insured individual who applies for an individual health benefit plan and agrees to make the required premium payments and to satisfy other reasonable provisions of the individual basic or standard health benefit plan.
 - (2) If a recently insured individual had qualifying previous coverage with benefits that are not comparable to or do not exceed the individual standard health benefit plan, a carrier may make available only the individual basic health benefit plan to that recently insured individual.
 - (3) A carrier is not required to issue an individual basic or standard health benefit plan to a recently insured individual who meets any of the following criteria:
 - (a) Who does not apply for an individual basic or standard health benefit plan within thirty one (31) days of a qualifying event or within thirty one (31) days after becoming ineligible for qualifying existing coverage;
 - (b) Who is covered, or is eligible for coverage through, a benefit plan that provides health care coverage that is provided by the recently insured individual's employer. A converted policy is not considered a benefit plan provided by an employer for purposes of this paragraph;
 - (c) Who is covered, or is eligible for coverage, through a benefit plan that provides health care coverage in which the individual's spouse, parent or guardian is enrolled or eligible to be enrolled;
 - (d) Who has coverage under an individual health benefit plan and does not terminate coverage under the prior health benefit plan by the effective date of the newly issued coverage;
 - (e) Who is covered, or is eligible for coverage, under any other private or public health benefits arrangements, including a Medicare supplement policy or the Medicare program established under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or any other act of Congress or law of any state, except for a Medicare-eligible individual who is eligible for Medicare for reasons other than age; or
 - (f) Who is covered, or is eligible for any continued group coverage under Section 4980b of the Internal Revenue Code, sections 601 through 608 of the federal Employee Retirement Income Security Act of 1974, Section 2201 through 2208 of the federal Public Health Service Act as amended, or any state required continued group coverage. For purposes of this subsection, an individual who would have been eligible for continuation coverage, but is not eligible solely because the individual or other responsible party failed to make the required coverage election during the applicable time period, shall be deemed to be eligible for group coverage until the date on which the individuals continuing group coverage would have expired had an election been made.

Drafting Note: States may wish to consider the implications of possible duplicate coverages of public programs, such as Medicare, including risk contracts, Medicaid and CHAMPUS, and the Federal Employee Health Benefits Program, and authorize the commissioner to promulgate regulations to preclude undesired duplication or the prospect of unintended dumping. States may also wish to add a provision allowing the commissioner to authorize exemptions from the guaranteed issue requirement for certain specific plans, such as student medical policies, in narrowly circumscribed circumstances. However, these exceptions shall not apply with respect to federally defined eligible individuals.

- B. Upon a carrier notifying an enrollee, who is a resident of this state, of a premium rate increase on the enrollee's individual health benefit plan, any carrier shall issue an individual basic or standard health benefit plan at the option of the enrollee, if the option is exercised within thirty-one (31) days of receiving the notification and the enrollee terminates the existing coverage.
- C. A carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the individual basic and standard health benefit plans. An individual basic and standard health benefit plan filed pursuant to this subsection may be used by a carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.
- D. After providing notice and an opportunity for a hearing to the carrier, the commissioner at any time may disapprove the continued use by a carrier of an individual basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this Act.
- E. The individual basic or standard health benefit plan shall not deny, exclude or limit benefits for a covered person for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition.
- F.
 - (1) An individual carrier that does not use preexisting condition limits in any of its health benefit plans in this state may impose or apply one or more of the following terms or conditions.
 - (2) However, if more than one term or condition is used, the combination of terms or conditions may not exceed the actuarial value of the twelve-month preexisting condition limit permitted by this section:
 - (a) A rating surcharge not to exceed fifty percent (50%) of the best new business rate for a period not to exceed twelve (12) months; or
 - (b) An affiliation period that:
 - (i) Does not exceed ninety (90) days; and
 - (ii) During which no premiums are charged and the coverage issued is not effective.
 - (3) An affiliation period shall be waived for the period of time an individual was covered by qualifying previous coverage, provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of new coverage.
- G.
 - (1) A carrier shall waive a rating surcharge, an affiliation period, or time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time an individual was covered by qualifying previous coverage that provided benefits with respect to those services, provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage. The length of the period following the termination of qualifying previous coverage shall not include any waiting period for the enrollment date of the new coverage applied by the carrier or for the normal application and enrollment process.
 - (2) A carrier shall not impose a surcharge as otherwise allowed in Subsection F of this section if an individual was covered by qualifying previous coverage that was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage. The length of the period following the termination of qualifying previous coverage shall not include any waiting period for the enrollment date of the new coverage applied by the carrier or for the normal application and enrollment process.
- H. A carrier is not required to offer coverage or accept applications pursuant to Subsection A of this section from an eligible person not residing in the carrier's established geographic service area.

- I. A carrier shall not modify an individual basic or standard health benefit plan with respect to an enrollee or dependent through riders, endorsements, rating surcharges based on health status or claim experience or otherwise restrict or exclude coverage or benefits for specific diseases, medical services or conditions otherwise covered by the health benefit plan.

Section 8. Availability of Coverage—Federally Defined Eligible Individuals

- A. Notwithstanding Section 7 of this Act and subject to Subsection B, if an eligible person who is a federally defined eligible individual, applies for coverage under an individual health benefit plan within ninety (90) days of termination of prior creditable coverage, the individual carrier may not:
 - (1) Decline to offer coverage to, or deny enrollment of, the individual; or
 - (2) Impose any exclusion because of a preexisting condition, as that term is defined in Section 3FF of this Act, with respect to the coverage.
- B. (1) An individual carrier may elect to limit the coverage offered under Subsection A if it chooses to offer at least two (2) different policy forms, both of which:
 - (a) Are designed for, made generally available to, and actively marketed to, and enroll both federally defined eligible individuals and other individuals; and
 - (b) Meet the requirements of Subsection C, as elected by the carrier.
 - (2) For purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.
- C. (1) An individual carrier meets the requirements of Subsection B(1)(b) if:
 - (a) The carrier elects to offer policy forms with the largest, and next to largest, premium volume of the policy forms offered by the carrier in the individual market in the state; or
 - (b) The carrier elects to offer a high level and a low level policy form, each of which:
 - (i) Includes benefits substantially similar to other individual health benefit plans offered by the carrier in the state; and
 - (ii) Is covered under a mechanism described in Paragraph (4), relating to risk adjustment, risk spreading or financial subsidization.
 - (2) For purposes of Paragraph (1)(b), a policy form shall be considered:
 - (a) A low level policy form if the actuarial value of its benefits under the coverage is at least eighty-five percent (85%), but not greater than 100 percent of a weighted average; and
 - (b) A high level policy form if:
 - (i) The actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of the coverage described in Subparagraph (a) offered by the carrier in the state; and
 - (ii) The actuarial value of the benefits under the coverage is at least 100 percent, but not greater than 120 percent of a weighted average.
 - (3) (a) For purposes of Paragraph (2), the weighted average is the average actuarial value of the benefits provided, as elected by the carrier:
 - (i) By all of the health benefit plans issued by the carrier in the individual market during the previous year, weighted by enrollment for the different coverages; or

- (ii) By all carriers in the state in the individual market during the previous year, weighted by enrollment for the different coverages.
 - (b) The weighted average calculated under Subparagraph (a) shall not include coverages issued under this section.
 - (4) A mechanism meets the requirements of Paragraph (1)(b)(ii) if:
 - (a) It provides for risk adjustment, risk spreading or a risk spreading mechanism or otherwise provides for some financial subsidization for federally defined eligible individuals, including through assistance to participating carriers; or
 - (b) It is a mechanism under which each federally defined eligible individual is provided a choice of coverage under all individual health benefit plans the carrier otherwise has available.
 - (5) (a) An election made under this subsection shall:
 - (i) Apply uniformly to all federally defined eligible individuals in the state for that individual carrier; and
 - (ii) Is effective for policies offered during a period of at least two (2) years following the date of election.
 - (b) After expiration of the initial election period, and for the expiration of each subsequent election period, pursuant to Subparagraph (a)(ii), the carrier shall again make the elections in accordance with this subsection.
 - (6) For purposes of Paragraph (2), the actuarial value of benefits provided under individual market coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.
- D. (1) An individual carrier that offers coverage in the individual market through a network plan may:
- (a) Limit the individuals who may be enrolled under such coverage to those who live, reside or work within the established geographic service area of the network plan; and
 - (b) Within the established geographic service area of the network plan, deny coverage to individuals who live, reside or work with the established geographic service area, if the carrier demonstrates to the satisfaction of the commissioner, that:
 - (i) It will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group or individual policyholders and individual enrollees; and
 - (ii) It is applying this paragraph uniformly to all individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are federally defined eligible individuals.
- (2) An individual carrier that cannot offer coverage pursuant to Paragraph (1)(b) may not offer coverage in the individual market within the established geographic service area until the later of:
- (a) A period of 180 days after the date of each coverage denial; or
 - (b) The date on which the carrier notifies the commissioner that it has regained capacity to deliver services to individuals in the individual market.
- E. (1) An individual carrier shall not be required to provide coverage to federally defined eligible individuals under this section if:

- (a) For any period of time the commissioner determines, the individual carrier does not have the financial reserves necessary to underwrite additional coverage; and
 - (b) The individual carrier is applying this subsection uniformly to all individuals in the individual market in this state consistent with applicable state law and without regard to any health status-related factor relating to any individual and without regard to whether an individual is a federally defined eligible individual.
- (2) An individual carrier that denies coverage in accordance with Paragraph (1) may not offer coverage in the individual market for the later of:
- (a) A period of 180 days after the date the coverage is denied; or
 - (b) Until the individual carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Drafting Note: Under HIPAA, states may apply the provisions of Paragraph (2) on a service-area-specific basis.

- F. This section shall not be construed to require that a health carrier offering health benefit plans only in connection with group health plans or through one or more professional associations, or both, offer coverage in the individual market.

Section 9. Health Benefit Plan Standards

The commissioner shall adopt by rule the form and level of coverage of the basic health benefit plan and the standard health benefit plan for the individual market that shall provide benefits substantially similar to those under the [insert reference to law corresponding to the NAIC Small Employer Health Insurance Availability Model Act] with respect to small employer coverage, but which shall be appropriately adjusted to reflect the individual market.

Section 10. Certification of Creditable Coverage

- A. Individual carriers shall provide written certification of creditable coverage to individuals in accordance with Subsection B.
- B. The certification of creditable coverage shall be provided:
- (1) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;
 - (2) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and
 - (3) At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Paragraph (1) or (2), whichever is later.
- C. Individual carriers may provide the certification of creditable coverage required under Subsection B(1) at a time consistent with notices required under any applicable COBRA continuation provision.
- D. The certificate of creditable coverage required to be provided pursuant to Subsection A shall contain:
- (1) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and
 - (2) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

- E. (1) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage and the individual provides a certificate of coverage that was provided to the individual pursuant to Subsection B, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.
- (2) The entity providing the information pursuant to Paragraph (1) may charge the requesting group health plan the reasonable cost of disclosing the information.

Drafting Note: Federal regulations to be issued pursuant to PHSA Section 2701(e) will establish rules to prevent an entity's failure to provide the information under this Section 10 with respect to previous creditable coverage of an individual from adversely affecting any subsequent coverage of the individual under another health benefit plan. In addition, federal regulations to be issued pursuant to PHSA Section 2701(c)(3)(B) will provide further clarification on the operation of the alternative method for counting creditable coverage.

Section 11. Standards to Assure Fair Marketing

- A. (1) If a carrier denies individual health benefit plan coverage to a recently insured individual who is an eligible person on the basis of the health status or claims experience of the recently insured individual, or the individual's dependents, the carrier shall offer the recently insured individual the opportunity to purchase an individual basic or standard health benefit plan.
- (2) Unless permitted under Section 8 of this Act, notwithstanding Paragraph (1), an individual carrier may not deny coverage to an applicant who is a federally defined eligible individual.
- B. Except as provided in Subsection C, no carrier or producer shall, directly or indirectly, engage in the following activities:
 - (1) Encourage or direct individuals to refrain from filing an application for coverage with the carrier because of the health status, claims experience, industry, occupation or geographic location of the individual; or
 - (2) Encourage or direct individuals to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the individual.
- C. The provisions of Subsection B(1) shall not apply with respect to information provided by a carrier or producer to an individual regarding the established geographic service area of the carrier or the restricted network provision of the carrier.
- D. Except as provided in Subsection E of this section, no carrier shall, directly or indirectly, enter into a contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of an individual basic or standard health benefit plan to be varied because of the health status or permitted rating characteristics of the individual or the individual's dependents.
- E. Subsection D shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of the health status or other permitted rating characteristics of the individual or the individual's dependents.
- F. Denial by a carrier of an application for coverage from an individual shall be in writing and shall state the reason or reasons for the denial.
- G. A violation of this section by a carrier or producer shall be an unfair trade practice under [insert reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].
- H. If a carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of individual health benefit plans in this state, the third-party administrator is subject to this section as if it were a carrier.

Section 12. Individual Health Benefit Plan Association

- A. (1) A nonprofit corporation is established to be known as the Individual Health Benefit Plan Association. All health carriers in this state shall be members of this association.
- (2) The association shall be incorporated under state law, shall operate under a plan of operation, and shall exercise its powers through a board of directors established under this section.
- B. The initial board of directors of the association shall consist of seven (7) members appointed by the commissioner as follows:
 - (1) Four (4) members shall be representatives of the four (4) largest domestic carriers based on individual health benefit premiums in the state as of the calendar year ending December 31, 20[].

Drafting Note: The requirement for four (4) representatives may need to be adjusted by the state to reflect the state's actual experience regarding the number of domestic carriers offering individual health benefit plans.

- (2) Three (3) members shall be representatives of the three (3) largest carriers of health insurance in the state, excluding Medicare supplement coverage premiums, which are not otherwise represented. In the event a carrier to be represented pursuant to this paragraph does not appoint a representative, the board member shall be a representative of the next largest carrier that satisfies the criteria.
- (3) The commissioner shall sit on the board as an ex-officio member.
- C. After the initial term, board members shall be nominated and elected by the members of the association.
- D. Members of the board may be reimbursed from the funds of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.
- E. (1) The association shall submit to the commissioner a plan of operation for the association and any amendments to the association's articles of incorporation necessary and appropriate to assure the fair, reasonable, and equitable administration of the association.
- (2) The plan shall provide for the sharing of losses related to individual basic or standard plans, if any, on an equitable and proportional basis among the members of the association.
- (3) (a) If the association fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, the commissioner shall adopt rules necessary to implement this section.
- (b) The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
- (4) In addition to other requirements, the plan of operation shall provide for all of the following:
 - (a) The handling and accounting of assets and funds of the association;
 - (b) The amount of and method for reimbursing the expenses of board members;
 - (c) Regular times and places for meetings of the board of directors;
 - (d) Records to be kept relating to all financial transactions, and annual fiscal reporting to the commissioner;
 - (e) Procedures for selecting the board of directors; and
 - (f) Additional provisions necessary or proper for the execution of the powers and duties of the association.

- F. The plan of operation may provide that the powers and duties of the association may be delegated to a person who will perform functions similar to those of the association. A delegation under this subsection takes effect only upon the approval of the board of directors.
- G. (1) The association has the general powers and authority enumerated by this section and executed in accordance with the plan of operation approved by the commissioner under Subsection E of this section.
- (2) In addition to the general powers and authority enumerated by this section and executed in accordance with the plan of operation pursuant to Subsection E, the association may do any of the following:
- (a) Enter into contracts as necessary or proper to administer this Act;
 - (b) Sue or be sued, including taking any legal action necessary or proper for recovery of any assessments for, on behalf of, or against members of the association or other participating persons;
 - (c) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, including the hiring of independent consultants as necessary; and
 - (d) Perform any other functions within the authority of the association.
- H. Following the close of each calendar year, the association, in conjunction with the commissioner, shall require each carrier to report the amount of earned premiums and the associated paid losses for all individual basic and standard plans issued by the carrier. The reporting of these amounts shall be certified by an officer of the carrier.
- I. The board shall develop procedures and make assessments and distributions as required so that each carrier issuing individual basic and standard health benefit plans receives the same ratio of paid claims to earned premiums on its individual basic and standard health benefit plans as the aggregate of all individual basic and standard plans insured by all carriers in the state.
- J. If the statewide aggregate ratio of paid claims to earned premiums is greater than ninety percent (90%), the dollar difference between ninety percent (90%) of earned premiums and the paid claims shall represent an assessable loss.

Drafting Note: The 90% figure used here assumes no premium taxes will be paid on individual basic and standard health benefit plan premiums. The 90% figure should be adjusted if these premiums are not exempt from premium taxation.

- K. (1) The assessable loss plus necessary operating expenses for the association, plus any additional expenses as provided by law, shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in the state during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year, or on any other equitable basis as provided in the plan of operation. In sharing losses, the association may abate or defer any part of the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for an initial or interim assessment against the members of the association to meet the operating expenses of the association until the next calendar year is complete.
- (2) Health insurance premiums or payments for subscriber contracts as used in Paragraph (1) means those premiums or payments related to health benefit plans.

Drafting Note: States may wish to consider expanding the assessment base to health carriers that issue coverages not included in the definition of health benefit plan in order to spread the potential losses of the guaranteed issue basic and standard health benefit plans across a broader health insurance market.

Drafting Note: The United States Supreme Court, in the *New York State Conference of Blue Cross & Blue Shield Plans et al. v. Travelers Insurance Co. et al.* decision, specifically approved an assessment relating to hospital services. States may wish to consider a broader category as an assessment base. For example, assessments could be charged to patients on a per visit or per stay basis or to providers based on collections. However, case law has made it clear that states may not assess self-funded health plans or third party administrators based on claim volume.

Drafting Note: An assessment paid pursuant to this subsection should be allowed as a claims cost by the carrier in computing its loss ratio.

- L. The board shall ensure that procedures for collecting and distributing assessments are as efficient as possible for carriers. The board may establish procedures that combine or offset the assessment from, and the distribution due to, a carrier.
- M. A carrier may petition the association board to seek remedy from writing a significantly disproportionate share of individual basic or standard policies in relation to total premiums written in this state for health benefit plans. Upon a finding that a carrier has written a significantly disproportionate share, the board may agree to compensate the carrier either by paying to the carrier an additional fee not to exceed two percent (2%) of earned premiums from individual basic or standard policies for that carrier or by petitioning the commissioner for remedy.
- N. The commissioner, upon a finding that the acceptance of the offer of individual basic or standard health benefit plan coverage by the individuals pursuant to this Act would place the carrier in a financially impaired condition, shall not require the carrier to offer coverage or accept applications for any period of time the financial impairment is deemed to exist. The commissioner by regulation shall establish the definition of significantly disproportionate share.

Section 13. Self-Funded Employer-Sponsored Health Benefit Plan Participation

A self-funded employer-sponsored health benefit plan qualified under the federal Employee Retirement Income Security Act of 1994 may voluntarily elect to participate in the Individual Health Benefit Plan Association established in Section 12 of this Act in accordance with the plan of operation and subject to the terms and conditions adopted by the board of the association to provide portability and continuity to its covered employees and their covered dependents subject to the same terms and conditions as a participating carrier.

Section 14. Special Rules Relating to Converted Policies

- A. After approval of the basic and standard health benefit plans pursuant to Section 9 of this Act, all carriers that are required to offer a converted policy to a person pursuant to [insert reference to the state law equivalent to the Group Health Insurance Mandatory Conversion Privilege Model Act] may offer as a converted policy a choice of the individual basic and standard health benefit plans only.
- B. If a carrier offers a choice of the individual basic and standard health benefit plans as conversion coverage pursuant to Subsection A, then the carrier shall be eligible to receive distributions under the Individual Health Benefit Plan Association for its individual basic and standard converted policies pursuant to Section 12 of this Act.
- C. If a carrier offers a choice of the individual basic and standard health benefit plans as conversion coverage pursuant to Subsection A, then persons with a converted policy issued prior to the effective date of the requirement contained in Subsection A above shall have the right at each annual renewal of the converted policy to elect an individual basic or a standard health benefit plan as a substitute converted policy, except that at the carrier's option if the person has not made an election within three (3) years after the effective date of this Act, the carrier may require the person to make an election. Once a person has elected either the basic or the standard health benefit plan as a substitute converted policy, that person may not elect another converted policy.
- D. (1) For rating purposes only, all converted policies shall be rated pursuant to this Act as if they were individual basic or standard health benefit plans.

- (2) Carriers that do not write in the individual market:
 - (a) Shall set premiums for converted policies that provide coverage similar to or exceeding that of an individual standard health benefit plan at the average premium charged by the five (5) largest individual carriers (as measured by their premium volume) for their individual standard health benefit plans; and
 - (b) Shall set premiums for all other converted policies at the average premium charged by the five (5) largest individual carriers (as measured by their premium volume) for their individual basic health benefit plans.
 - (3) The averages in Paragraph (2) shall be calculated each year by the commissioner.
 - (4) New and renewal rates for persons with the same converted policies who have the same rating characteristics shall be the same.
- E. The commissioner shall develop regulations for the implementation of this section.

Drafting Note: States may need to include conforming amendments to their existing conversion coverage statutes and regulations, especially with respect to the types of converted policies a carrier may offer and the rating of such policies.

Section 15. Separability

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

Section 16. Effective Date

The Act shall be effective on [insert date].

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

1996 Proc. 1st Quarter 29-32, 125, 625, 639, 641-652 (adopted).

2000 Proc. 3rd Quarter 13, 14, 163, 200, 258-276 (amended and reprinted).