

## GROUP HEALTH INSURANCE STANDARDS MODEL ACT

### Table of Contents

Section 1.	Short Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Permitted Groups
Section 5.	Policies Issued Out of State or to Groups Not Meeting the Requirements of Section 4
Section 6.	Notice of Compensation
Section 7.	Dependent Group Health Insurance
Section 8.	Group Health Insurance Standard Provisions
Section 9.	Regulations

### Section 1. Short Title

This Act shall be known and may be cited as the Group Health Insurance Standards Act.

### Section 2. Purpose

This Act lists the permissible groups that may be issued a policy of group health insurance coverage in this state. This Act lists the circumstances under which a group health insurance policy that is issued in another state may be offered to residents of this state. This Act describes the circumstances under which dependent coverage is permitted or required to be included in a group health insurance policy. This Act also lists the standard provisions that must be included in a policy of group health insurance.

### Section 3. Definitions

For purposes of this Act:

- A. “Commissioner” means the commissioner of insurance.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

- B. “Evidence of individual insurability” means medical information, or other information that indicates health status, used to determine whether coverage of an individual within the group is to be limited or excluded.

### Section 4. Permitted Groups

Except as provided in Section 5, an insurer shall not deliver a group health insurance policy in this state unless it conforms to one of the following descriptions:

- A. A policy issued to an employer, or to the trustees of a fund established by an employer and maintained, directly or indirectly, by the participating employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:
- (1) (a) The employees eligible for coverage under the policy shall be all of the employees of the employer, or all of any class or classes thereof.
  - (b) The policy may define “employees” to include:
    - (i) The employees of one or more subsidiary corporations;

- (ii) The employees, individual proprietors and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;
  - (iii) The retired employees, former employees and directors of a corporate employer; and
  - (iv) For a policy issued to insure the employees of a public body, elected or appointed officials.
- (2) The premium for the policy shall be paid either from the employer's fund or from funds contributed by the insured employees, or from both.
  - (3) Except as provided in Paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject coverage in writing.
  - (4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

**Drafting Note:** Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

B. A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness, subject to the following requirements:

- (1) The debtors eligible for coverage under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof.
- (2) The policy may define "debtors" to include:
  - (a) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;
  - (b) The debtors of one or more subsidiary corporations; and
  - (c) The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control.
- (3) The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both.
- (4) Except as provided in Paragraph (5), a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.
- (5) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

- (6) The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.
  - (7) The insurance may be payable to the creditor or any successor to the right, title and interest of the creditor. The payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each payment and any excess of the insurance shall be payable to the insured or the estate of the insured.
  - (8) Notwithstanding the preceding provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.
- C. A policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members or employees of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:
- (1) The members or employees eligible for coverage under the policy shall be all of the members or employees of the union or organization, or all of any class or classes thereof.
  - (2) The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members or employees specifically for their insurance, or from both.
  - (3) Except as provided in Paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured members or employees specifically for their insurance must insure all eligible members or employees, except those who reject coverage in writing.
  - (4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

**Drafting Note:** Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

- D. A policy issued to a trust, or to the trustees of a fund, established by two (2) or more employers and maintained, directly or indirectly, by those participating employers, or by one or more labor unions of similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:
- (1) (a) The persons eligible for coverage shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof.
  - (b) The policy may define “employee” to include:
    - (i) The employees of one or more subsidiary corporations;
    - (ii) The employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;

- (iii) Retired employees, former employees and directors of a corporate employer; and
  - (iv) The trustees or their employees, or both, if their duties are principally connected with the trusteeship.
- (2) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations.
- (3) Except as provided in Paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing.
- (4) An insurer may exclude or limit the coverage under the policy on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

**Drafting Note:** Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

- E.
  - (1) A policy issued to an association or to a trust or to the trustees of a fund established by an association or associations otherwise eligible for issuance of a policy under this subsection and maintained, directly or indirectly, by the association or associations for the benefit of members of one or more associations.
    - (2)
      - (a) An association shall not be controlled by an insurer as evidenced by the operation of the association.
      - (b) The following factors may be used as evidence to determine whether an association is an insurer-operated association; however, the presence of these factors shall not serve to limit or be dispositive of such a determination:
        - (i) Common board members, officers, executives or employees;
        - (ii) Common ownership of the insurer and the association or other eligible group; or
        - (iii) Common use of the same office space or equipment utilized by the insurer to transact insurance.
    - (3) An association may use the solicitation of insurance as one of its methods to obtain new members.
    - (4) The association or associations shall:
      - (a) Have at the outset a minimum of 100 persons;
      - (b) Have a shared or common purpose that is not primarily a business or customer relationship;
      - (c) Have been organized and maintained in good faith primarily for purposes other than that of obtaining insurance;
      - (d) Have been in active existence for at least one year; and

- (e) Have a constitution and by-laws that provide that:
  - (i) The association or associations hold regular meetings not less than annually to further the purposes of the members;
  - (ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and
  - (iii) Association members have voting privileges and representation on the governing board and committees.
- (5) The policy shall be subject to the following requirements:
  - (a) The policy may insure members of the association or associations, employees of the association or associations or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.
  - (b) The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations or employer members.
  - (c) Except as provided in Subparagraph (d) of this paragraph, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing.
  - (d) An insurer may exclude or limit the coverage on any individual as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

**Drafting Note:** Under HIPAA, insurers that issue or offer to issue a health benefit plan through a bona fide association may not exclude or limit coverage to an individual or a dependent based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

- (6) (a) In determining whether an association meets the standards set forth in this subsection, the commissioner shall consider whether the association's primary method of obtaining new members is not through, or in conjunction with, the solicitation of insurance.
- (b) If the commissioner determines that an association uses the solicitation of insurance as its primary method of obtaining new members, the commissioner shall not use this determination as the sole criterion for the disapproval of a group under this subsection.
- (7) The provisions of Paragraphs (4)(b) and (c) and (6)(a) shall not apply to any association that made available group health insurance to any of its members prior to [insert effective date for the revisions to Paragraphs (4)(b) and (c) and (6)(a)]. However, for any such association policy that would not otherwise be eligible for issuance under this subsection, the insurer shall disclose its compensation, as required by Section 6 of this Act and shall disclose the following:
  - (a) All costs related to joining and maintaining membership in the association, such as the membership processing fees, the initial association membership fee and the amount of the annual association dues;
  - (b) That membership fees or dues are in addition to the policy premium;

- (c) That the association holds the master contract;
  - (d) That the premium charged and the terms and conditions of coverage are determined between the association and the insurer; and
  - (e) That the premium and the terms and conditions of coverage may be changed by agreement of the association group policyholder and the insurer, without the consent of the individual certificate holder.
- (8) If an insurer collects membership fees or dues on behalf of an association, the insurer shall disclose to the members of the association that the insurer is billing and collecting membership fees and dues on behalf of the association.

**Drafting Note:** Any state adopting this Act that has relaxed rate or form requirements for association group policies and such policies have been or are expected to be a significant portion of the state's health insurance market may wish to consider evening the playing field for insurers writing in the individual market by, for example, similarly relaxing the requirements for individual policies.

- F. A policy issued to a credit union or to a trustee or trustees or agent designated by two (2) or more credit unions, which credit union, trustee, trustees, or agent shall be deemed the policyholder, to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:
- (1) The members eligible for coverage shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.
  - (2) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in Paragraph (3), must insure all eligible members.
  - (3) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.
- G. A policy issued to cover persons in a group where that group is specifically described by a law of this state as a group that may be covered for group life insurance. The provisions of the law relating to eligibility and evidence of individual insurability shall apply.

#### **Section 5. Policies Issued Out of State or to Groups Not Meeting the Requirements of Section 4**

Group health insurance coverage offered to a resident of this state or in connection with employment within this state under a group health insurance policy issued to a group other than a group described in Section 4 shall be subject to the following requirements:

- A. For any such coverage to be delivered in this state the commissioner must find that:
- (1) The issuance of the policy is not contrary to the best interest of the public;
  - (2) The issuance of the policy would result in economies of acquisition or administration; and
  - (3) The benefits are reasonable in relation to the premiums charged.
- B. For any such coverage that is being offered in this state by an insurer under a policy issued in another state, the commissioner in this state or the state in which the policy is issued, having requirements substantially similar to those contained in Subsection A, must make a determination that the requirements of Subsection A have been met.

**Drafting Note:** Alternative language to Subsection B:

Alternative 1. This alternative consists of Subsection B above and Subsection C below.

- B. (1) The insurer shall file with the commissioner for information purposes:
- (a) A copy of the group master contract;
  - (b) A copy of the statute of the state where the policy is issued, authorizing the issuance of the policy under the same or similar statute;
  - (c) Evidence of approval in the state where the policy is issued; and
  - (d) Copies of all supportive material used by the insurer to secure approval of the policy in that state including the documentation in Subsection A.
- (2) The commissioner, at any time subsequent to receipt of the information required under Paragraph (1), after finding that the requirements of Subsection A have not been met, may order the insurer to stop marketing the coverage in this state.

Alternative 2. Under this alternative the language in this Subsection B below may be used as a substitute for the language in Subsection B above.

- B. (1) For any such coverage that is being offered in this state by an insurer under a policy issued in another state, the commissioner must make a determination that the requirements of Subsection A have been met.
- (2) The insurer shall file with the commissioner:
- (a) A copy of the group master contract;
  - (b) A copy of the statute of the state where the policy is issued, authorizing the issuance of the group policy under the same or similar statute;
  - (c) Evidence of approval in the state where the policy is issued; and
  - (d) Copies of all supportive material used by the insurer to secure approval of the policy in that state including the documentation required in Subsection A.
- (3) If the commissioner has not made a determination within thirty (30) days of filing by the insurer, the requirements shall be deemed to have been met.
- (4) The commissioner, at any time subsequent to receipt of the information required under Paragraph (2), after finding that the requirements of Subsection A have not been met, may order the insurer to stop marketing the coverage in this state.

**Drafting Note:** States should adopt Subsections C and D below regardless of which alternative a state chooses to adopt for Subsection B above.

- C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.
- D. An insurer may exclude or limit the coverage under the policy on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

**Drafting Note:** Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

**Section 6. Notice of Compensation**

- A. (1) With respect to an individual, blanket or franchise policy which, if issued through or in conjunction with a sponsoring or endorsing entity, would not qualify under Section 4A, B, C, D, E or F of this Act, the insurer shall distribute a written notice of compensation to prospective insureds if the insurer will or may pay compensation to a sponsoring or endorsing entity.
- (2) (a) With respect to a policy issued on a group basis to a group in compliance with Section 4E of this Act, the insurer shall distribute a written notice of compensation to prospective insureds if the insurer will or may pay compensation to a policyholder or sponsoring or endorsing entity in the case of a group policy.
- (b) If the compensation is solely for services performed and is not directly or indirectly for sponsoring or endorsing the insurer or any of the insurer's products, written notice of compensation is not required for:

Group Health Insurance Standards Model Act

- (i) Any compensation to the insurer for services provided to the policyholder or the sponsoring or endorsing entity; or
  - (ii) Any compensation to the policyholder or sponsoring or endorsing entity.
- B. The notice required under Subsection A shall be placed on or accompany any application or enrollment form provided to prospective insureds.
  - C. The notice shall be provided, whether:
    - (1) The compensation is direct or indirect; or
    - (2) The compensation is paid to or retained by:
      - (a) The policyholder or sponsoring or endorsing entity; or
      - (b) A third party at the direction of the policyholder or sponsoring or endorsing entity, or an entity affiliated by way of ownership, contract or employment.
  - D. For purposes of this section, "sponsoring or endorsing entity" means an organization that has arranged for the offering of a plan of insurance in a manner that communicates that eligibility for participation in the plan is dependent upon affiliation with the organization or that it encourages participation in the plan.

**Section 7. Dependent Group Health Insurance**

- A. Except for a policy issued under Section 4B of this Act, a group health insurance policy may be extended to insure the family members and dependents of the employees or members, or any class or classes thereof, if:
  - (1) The premium for the insurance is paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued, or from funds contributed by the covered persons, or from both.
  - (2) Except as provided in Subsection B, a policy on which no part of the premium for the family members or dependents coverage is to be derived from funds contributed by the covered persons shall insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof.

- B. An insurer may exclude or limit the coverage under the policy on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

**Drafting Note:** Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

## **Section 8. Group Health Insurance Standard Provisions**

- A. A group health insurance policy shall not be delivered in this state unless it contains in substance the provisions of this section, or provisions that, in the opinion of the commissioner, are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder, provided that:
- (1) Subsections F and H shall not apply to policies insuring debtors;
  - (2) The standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and
  - (3) If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.
- B. A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first. During the grace period the policy shall continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.
- C. A provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue. Absent a showing of intentional fraud, no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime nor unless the statement is contained in a written instrument signed by the person making the statement. However, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy.
- D. A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.
- E. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

- F. (1) Except as provided in Paragraph (2), a provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, that existed prior to the effective date of the person's coverage under the policy. Except for disability income policies, any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve (12) months prior to the effective date of the person's coverage. In no event shall the exclusion or limitation apply to loss incurred commencing after the earlier of (a) the end of a continuous period of twelve (12) months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; and (b) the end of the two-year period commencing on the effective date of the person's coverage. For disability income policies, any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twenty-four (24) months prior to the effective date of the person's coverage. In no event shall the exclusion or limitation apply to a disability commencing after the end of the two-year period starting on the effective date of the person's coverage.
- (2) A policy that is subject to the preexisting condition exclusion requirements in Section 2701 of the Public Health Service Act, as added by Pub. L. No. 104-191, shall have a provision specifying any preexisting condition exclusions or limitations consistent with those requirements except as otherwise provided by state law.

**Drafting Note:** HIPAA imposes limitations on the ability of insurers offering coverage in the group market to impose preexisting condition exclusions on plan participants and beneficiaries. Language has been added to Subsection F to carve out those group policies that are subject to those restrictions under HIPAA and any provisions of state law that may be more stringent than HIPAA with respect to preexisting condition exclusion and limitation requirements.

- G. If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated. The provision shall contain a clear statement of the method of adjustment to be used.
- H. A provision that the insurer will issue to the master policyholder in electronic or paper form in accordance with any communications preferences of the master policyholder for delivery to each person insured in the group an individual certificate setting forth a statement as to the insurance coverage to which that person is entitled, to whom the insurance benefits are payable, and a statement as to a family member's or dependent's coverage. If family members or dependents are included in the coverage, the insurer need only issue one certificate to each family unit.
- I. If the insurer requires prior notice of a claim, a provision that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within that time shall not invalidate nor reduce any claim if it can be shown not to have been reasonably possible to give notice and that notice was given as soon as was reasonably possible. Any notices that may be required to be provided under this subsection may be provided in electronic or paper form in accordance with any communications preferences of the person making the claim. If the person making the claim has not made any communications preferences, then any required notices shall be provided in paper form to the person's last known address.
- J. If the insurer requires prior notice of a claim, a provision that the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person, such forms as are usually furnished by it for filing proof of loss. If the forms are not furnished before the expiration of fifteen (15) days after the insurer received notice of a claim under the policy, the person making the claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. Any forms that may be required to be furnished under this subsection may be in electronic or paper form in accordance with any communications preferences of the person making the claim or the policyholder. If the person making the claim has not made any communications preferences, then any required notices shall be provided in paper form to the person's last known address.

- K. A provision that, in the case of a claim for loss of time for disability, written proof of loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that, in the case of claim for any other loss, written proof of loss must be furnished to the insurer within ninety (90) days after the date of loss. Failure to furnish proof within that time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Any forms that may be required to be furnished under this subsection may be in electronic or paper form in accordance with any communications preferences of the person making the claim. If the person making the claim has not made any communications preferences, then any required notices shall be provided in paper form to the person's last known address.
- L. A provision that all benefits payable under the policy, other than benefits for loss of time, will be payable not more than sixty (60) days after receipt of proof, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of the period will be paid as soon as possible after receipt of proof.
- M. A provision that the insurer at its own expense shall have the right and opportunity to:
- (1) Examine the person of the individual for whom claim is made when and as often as it may reasonably require during the pendency of claim under the policy; and
  - (2) Make an autopsy in case of death where it is not prohibited by law.
- N. A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirement of the policy and that no action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the policy.
- O. In the case of a policy insuring debtors, a provision that the insurer will furnish the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness.

## Section 9. Regulations

The commissioner may adopt regulations related to enrollment or eligibility for coverage under a group policy to be issued under Section 4A, C, D or E of this Act, Section 5 of this Act or Section 7 this Act with respect to an individual or dependent of an individual based on the individual's or dependent's evidence of individual insurability. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

**Drafting Note:** Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), insurers that issue or offer to issue certain policies of health insurance coverage in the group market, including bona fide associations, may not exclude or limit eligibility for coverage to individuals or their dependents based on a health status-related factor. A health status-related factor, as defined under HIPAA, includes evidence of individual insurability. This section provides authority for the commissioner to adopt regulations consistent with HIPAA. The commissioner may adopt the provisions of the NAIC Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation.

---

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

1983 Proc. I 6, 35, 447, 667, 670-676 (adopted).

1984 Proc. I 6, 32, 528, 529 (amended).

1985 Proc. I 19, 38, 571, 599-604 (amended and reprinted).

1989 Proc. I 9, 24-25, 704, 839, 842-843 (amended).

2007 Proc. 1<sup>st</sup> Quarter 72-87 (amended and reprinted).