Attachment 1

Date: 2/25/16

Market Conduct Examination Standards (D) Working Group
Conference Call
February 10, 2016

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call Feb. 10, 2016. The following Working Group members participated: Jim Mealer, Vice Chair (MO); Damion Hughes and David Tucker (CO); Kurt Swan (CT); Sharon Shipp (DC); Debra Peirce (GA); Doug Ommen (IA); Russ Hamblen (KY); Richard Bradley (MA); Teresa Fischer and Sherri Mortensen-Brown (MN); Cheryl Allen-Bivens, Jean Holliday and Tracy Biehn (NC); Cindy Williamson (NE); Cliff Day (NJ); Jeremey Gladstone and Peggy Willard-Ross (NV); Sharon Ma and Robert McLaughlin (NY); Angela Dingus (OH); Brian Gabbert (OK); Kelly Krakowski (PA); Julie Fairbanks (VA); Christina Rouleau (VT); Susan Ezalarab, Elena Hafenbredl and Cari Lee (WI); and Mark Hooker (WV).

Mr. Mealer chaired the meeting on behalf of Director Bruce R. Ramge (NE).

1. Adopted its Fall National Meeting Minutes

Mr. Hooker made a motion, seconded by Ms. Rouleau, to adopt the Working Group's Nov. 21 minutes *(see NAIC Proceedings – Fall 2015, Market Regulation and Consumer Affairs (D) Committee, Attachment Six)*. The motion passed unanimously.

2. Discussed Draft Health Reform Market Conduct Examination Standards – Guaranteed Availability, Dec. 29, 2015, Draft, for Inclusion in the *Market Regulation Handbook*

Mr. Mealer said that on the Working Group's Oct. 29 call, it was suggested that the adopted health reform-related guaranteed availability examination standards, adopted by the NAIC in 2014, be reopened and revised to incorporate language addressing special enrollment period provisions.

Mr. Mealer said that at the Working Group Meeting at the Fall National Meeting, comments dated Nov. 16, 2015, were presented by the NAIC consumer representatives. He indicated that the Nov. 16 comments, as well as additional NAIC consumer representatives' comments dated Dec. 8, 2015, were incorporated into the revised draft guaranteed availability examination standards circulated for the call.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) said the language submitted by the NAIC consumer representatives adds wording that identifies special enrollment triggers in exceptional circumstances, without going into specifics in this area, thereby providing a list that is fairly comprehensive, however not likely to change. Ms. Lueck said the comments add language to the examination standards to reflect that, in the small group market, there is an open enrollment period from Nov. 15 to Dec. 15, where a small group employer can obtain coverage, even though it does not meet the minimum participation or contribution levels. Ms. Lueck said the comments also add language to the examination standards describing annual open enrollment periods.

Timothy Stoltzfus Jost (Virginia Organizing) said the NAIC consumer representatives' suggested revisions to the examination standards regarding special enrollment provisions do not need to be revised due to guidance changes issued by the U.S. Department of Health and Human Services (HHS) in January 2016, because the January changes were made to HHS guidance, not HHS regulations regarding special enrollment periods.

Mr. Mealer said the comment period on the draft would be extended until Feb. 29. Ms. Wallace said the draft for the next Working Group call will incorporate all of the comments to date, and any new comments received through Feb. 29 will be shown as redline in the document, for review and discussion at the next Working Group call.

3. Discussed 2016 Working Group Tasks

Mr. Mealer said the Working Group's task for 2016 is to evaluate the need and develop, as necessary, updated market conduct examination-related standards and examination-related procedural sections in the *Market Regulation Handbook*.

Mr. Mealer added that the Working Group will continue to develop draft examination standards to address health reform-related issues, for inclusion in the *Market Regulation Handbook*. Mr. Mealer said that, in 2015, the Working Group reviewed and discussed draft examination standards regarding the nondiscrimination provisions of Section 1557, the civil rights provision of the federal Affordable Care Act (ACA). Mr. Mealer said the Working Group had tabled this item on its Oct. 29, 2015, conference call, because final federal guidance regarding Section 1557 nondiscrimination had, at that time, not yet been issued by HHS. Mr. Mealer said that when final guidance is released by HHS—which is scheduled to occur in June 2016—the Working Group will resume work on the examination standards, which will provide regulators and nonregulators an opportunity to review the final guidance, submit comments and make proposed revisions to the draft standards, as appropriate.

Mr. Mealer said substantial revisions to the *Health Benefit Plan Network Access and Adequacy Model Act* (#74)—previously known as the *Network Adequacy Model Act*—were adopted by the NAIC in 2015. The Working Group will be working on developing corresponding updated network adequacy examination standards.

Mr. Mealer said that with the adoption in 2015 of the *Cybersecurity Bill of Rights* and the adoption of cybersecurity-related revisions to the *Financial Condition Examiners Handbook*, cybersecurity and the *Market Regulation Handbook* is an area that the Working Group will be focusing on in 2016.

Mr. Mealer said the Working Group will be developing a new chapter for inclusion in the *Market Regulation Handbook* that will provide guidance for state insurance regulators regarding closing continuum actions.

Mr. Mealer said the Working Group will not meet at the Spring National Meeting. Mr. Mealer said the next Working Group call is scheduled to occur in March, and advance email notice will be provided by NAIC staff.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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PROVISION TITLE: Guaranteed Availability of Coverage (Individual and Group Market Health Insurance)

CITATION: PHSA §2702

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual or group markets in a state must offer to any individual or employer in the applicable state all products approved for sale in the applicable market, and must accept any eligible individual or employer applying for any of those products.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual and group market in a state must accept for coverage, in the applicable state, every individual and employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law.

Health carriers are permitted to limit enrollment to designated annual open and special enrollment periods.

This provision applies to all health carriers in the individual market and to group plans. This provision applies to non-grandfathered group health plans. This provision also applies to grandfathered small group health plans, which were already required to comply with guaranteed availability of coverage requirements under HIPAA.

FAQs: See the HHS website for guidance.

NOTES:

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
(INDIVIDUAL MARKET)

Standard 1
A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law.

Apply to: All individual health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificate holders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of individual market health insurance coverage in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to plan applicants in compliance with final regulations established by HHS, the DOL and the Treasury and does not place unallowable conditions on such availability.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods, and coverage issued during an open or special enrollment period must become effective consistent with the dates set forth in federal regulations. Verify that a health carrier has complied with any requirements that would allow for continuous open enrollment based upon certain circumstances of failing to file rates and forms and have them approved prior to open enrollment period.

Individual Health Insurance Coverage – Open Enrollment Period

(NY 3/7/2016 Comments) A health ~~insurance issuer~~ carrier in the individual market must allow an individual to purchase health insurance coverage during the annual open enrollment period described in 45 CFR 155.410(e).

Individual Health Insurance Coverage – Special Enrollment Periods

(NY 3/7/2016 Comments) Verify that a health carrier ~~that restricts enrollment to~~allows enrollment during defined enrollment periods, including open enrollment periods, limited open enrollment periods, and special enrollment periods, and provides those periods pursuant to 45 CFR 147.104 and 155.420 as well as in accordance with state-specific requirements.

Verify that a health carrier provides for a special enrollment period that is not less than sixty calendar days pursuant to 45 CFR 147.104 and 155.420 for qualified individuals (and their dependents, when applicable) in the following circumstances:

- Loss of minimum essential coverage (including employer plans, Medicaid, CHIP, and COBRA coverage as well as loss of coverage due to divorce, legal separation, loss of dependent status, or death of the policyholder);
- Addition of a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care (including gaining a dependent through a child support order or other court order);
- Unintentional, inadvertent, or erroneous enrollment in a plan that results from error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the exchange or HHS or its instrumentalities, or a non-exchange entity (including a health carrier or its representative) that provides enrollment assistance or conducts enrollment activities;
- Health carrier substantially violated a material provision of its contract in relation to the enrollee
- Enrollee or dependent of an enrollee is determined newly eligible or ineligible for an advance premium tax credit or experiences a change in eligibility for cost-sharing reductions;
- A person terminates employer coverage as a result of being determined newly eligible for premium tax credits due to becoming ineligible for qualifying coverage in an eligible employer-sponsored plan;
- A person in a state that has not expanded Medicaid who was previously ineligible for premium tax credits due to having income below the federal poverty line experiences a change in household income that makes the person newly eligible for premium tax credits; or
- Permanent move that results in access to new individual market plans (including release from incarceration.)

Verify that a health carrier that offers qualified health plans through an insurance exchange or marketplace serving the individual insurance market also provides for a special enrollment period that is not less than sixty days for qualified individuals in the following circumstances:

- Gain of status as a citizen, national, or lawfully present individual;
- Status as federally recognized American Indian tribe or Alaska Native; or
- Person demonstrates to the exchange in the state, in accordance with federal guidelines, that the individual meets other exceptional circumstances as the exchange may provide.

Verify that a health carrier provides for a special enrollment period with effective coverage dates that begin the first day of the month following enrollment if the plan is selected between the 1st and 15th of the month or the first day of the second month following enrollment if the plan is selected between the 16th and the last day of the month with the following exceptions:

- In the case of marriage, not later than the first day of the month following plan selection;
- In the case of a dependent's birth, adoption, placement for adoption, or placement in foster care, the date of the birth, adoption, placement for adoption, or placement in foster care; or
- For loss of minimum essential coverage, the first day of the month following the loss of previous coverage if the qualified health plan is selected before or on the day of the loss. If the plan is selected after the date of coverage loss, then coverage is effective the first day of the month following plan selection.

Note: In some circumstances, federal rules permit states or the marketplace in a state to implement alternative coverage effective dates. (NY 3/7/2016 Comments) Examiners should verify that ~~issuers~~ health carriers are complying with any state-specific requirements that may apply.

Note: Examiners need to be aware that a health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required to provide coverage if:

- For any period of time the carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all individuals in the individual market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of an individual and his or her dependents or any health status-related factor relating to such individual and his or her dependents.

With regard to a health carrier denying coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the individual market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Note: Examiners need to be aware that with respect to coverage offered through a network plan, a health carrier is not required to offer individual market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- To an individual, when the individual does not live or reside within the health carrier's established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to any additional individuals because of its obligations to existing enrollees.

Review health carrier underwriting files to verify that a health carrier, that cannot offer coverage for reason of lack of network capacity, does not offer coverage in the individual market in the applicable geographic service to new individuals or to any enrollees until the later of 180 days following each such refusal or the date on which the health carrier notifies the commissioner of the applicable state that it has regained capacity to deliver services.

Review health carrier underwriting files to verify that the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all individuals without regard to the claims experience of those individuals and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- The provisions set forth in the final regulations established by HHS, the DOL and the Treasury should not be construed to require that a health carrier offering group health benefit plans must offer health benefit plans in the individual market;
- A health carrier offering only student health insurance coverage is not required to otherwise offer coverage in the individual market so long as the health carrier is offering student health insurance coverage consistent with the HHS, DOL and the Treasury definition of "student health

insurance coverage." In accordance with 45 CFR 147.145, student health insurance is exempt from the requirement to establish open enrollment periods and coverage effective dates based on a calendar policy year; and

- A health carrier, at the time of renewal, may modify coverage under a health benefit plan offering individual market health insurance coverage so long as such modification is consistent with applicable state statutes, rules and regulations and effective on a uniform basis among all individuals covered under the health benefit plan.

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to eligible plan applicants, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and, if applicable, from the marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

(NY 3/7/2016 Comments) Verify that a health ~~insurance issuer~~carrier and its officials, employees, agents and representatives comply with any applicable statutes, rules and regulations regarding marketing by health ~~insurance issuers~~ carriers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to guaranteed availability of individual market health insurance coverage.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed availability of individual market health insurance coverage.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds. (NY 3/7/2016 Comments) Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment.

Determine if the health carrier monitors producer-generated notices that deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
(GROUP MARKET)

Standard 2
A health carrier offering group market health insurance coverage shall issue any applicable health benefit plan to any employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with state and federal law. ~~\~~

Apply to: All group health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140. However, grandfathered small group health plans were already required to comply with guaranteed availability of coverage requirements under HIPAA

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC References

Small Group Market Health Insurance Coverage Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of group market health insurance coverage in accordance with final regulations provided by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier makes group market health insurance coverage available on a guaranteed availability basis to eligible employers in compliance with final regulations provided by HHS, the DOL and the Treasury and that the carrier does not place unallowable conditions on such availability.

Review health carrier underwriting policies and procedures to verify the health carrier:

- Offers coverage to all eligible employees of the eligible employer, and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan; and
- Does not limit the offer of coverage to only certain individuals or dependents in the group or to only part of the group.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods.

Group Plans – Special Enrollment Periods

Verify that a health carrier offering coverage in the small group market provides for an annual open enrollment period from November 15 through December 15, during which time small employers may enroll in coverage effective January 1 of the subsequent year without meeting any minimum participation or minimum contribution requirements.

Verify that a health carrier offering coverage in the small group market permits small employers to enroll at any time during the year, including outside of the annual small group open enrollment period, and that the carrier does not place any unallowable enrollment restrictions on small employers.

Verify that any enrollment restrictions that may be allowable outside of the annual small group enrollment period (such as minimum participation and minimum contribution requirements) are applied by the carrier in a consistent manner to all small employers seeking coverage.

Note: Different enrollment standards may apply depending on whether small group coverage is being offered within a small group exchange (also known as a SHOP marketplace) or in the small group market outside of an exchange or SHOP. For example, the minimum participation requirement may be calculated differently. Examiners should be aware of such differences and also of whether the carrier being examined is offering coverage within a SHOP, outside the SHOP, or both.

Verify that a health carrier permits an employee, or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of any health benefit package under the plan of the employer during a special enrollment period if:

- The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;
- The employee's or dependent's coverage:
    - Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or
    - Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated, or loss of coverage because an individual no longer resides, lives, or works in the service area of HMO coverage;
- The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time; or
- Under the terms of the health benefit plan, the employee requests enrollment not later than thirty days after the triggering event.

Verify that the health carrier provides a special enrollment period to all covered employees that experience the following qualifying events that result in the loss of coverage of a qualified beneficiary pursuant to 29 U.S.C. 1163:

- The death of the covered employee;
- The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment;
- The divorce or legal separation of the covered employee from the employee's spouse;
- The covered employee becomes entitled to benefits under Title XVIII of the Social Security Act;
- A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; or
- A proceeding in a case under Title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

Verify that if an employee requests enrollment, the health carrier provides for enrollment effective not later than the first day of the first calendar month beginning after the date the health carrier received the completed request for enrollment.

Verify that, with respect to dependents of employees, the health carrier provides for a dependent special enrollment period during which the dependent, and if not otherwise enrolled, the employee, may be enrolled under a health benefit plan, if a person becomes a dependent of the employee/participant through marriage, birth, adoption, or placement for adoption.

Verify that the health carrier's special enrollment period for qualified individuals provides a period of time not less than thirty days from the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available, at least thirty days after the date the plan makes dependent coverage generally available.)

Verify that the health carrier, for an employee who seeks to enroll a dependent during a special enrollment period, provides for the coverage of the dependent effective upon:

- In the case of marriage, not later than the first day of the first month beginning after the health carrier receives the completed request for special enrollment;
- In the case of a dependent's birth, the date of the child's birth; and
- In the case of a dependent's adoption or placement for adoption, not later than the date of the adoption or placement for adoption.

Verify that the health carrier permits an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll in coverage under the terms of the health benefit plan if:

- The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under the plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the plan not later than sixty days after the date of termination of such coverage; or
- The employee or dependent becomes eligible for assistance, with respect to coverage under the plan under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act, including any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the plan not later than sixty days after the employee or dependent is determined to be eligible for such assistance.

Verify that the health carrier provides adequate written notice of special enrollment rights and the requirement furnished to an individual declining coverage (if the plan requires the reason for declining coverage to be in writing). 29 CFR 2590.701-6 includes model language for informing employees of their special enrollment rights.

Verify that the health carrier does not treat special enrollees as late enrollees and offers the same benefit package as is offered to similarly situated individuals who enroll when first eligible. Any differences in benefits or cost-sharing requirements for different individuals constitute a different benefit package, and a special enrollee cannot be required to pay more for coverage or to enroll in different coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

Verify that the health carrier is in compliance with 45 CFR 147.108 and 45 CFR 146.111, including the examples identified in federal regulations.

Review health carrier underwriting policies and procedures to verify the health carrier does not apply any waiting period (consistent with the HHS, DOL and Treasury definition of "waiting period") that exceeds 90 days.

Review the health carrier's underwriting files to verify the requirements used by a health carrier in determining whether to provide coverage to an employer are applied uniformly among all employers applying for coverage or receiving coverage from the health carrier.

(NY 3/8/2016 Comments) In states that have adopted the NAIC *Small Group Market Health Insurance Coverage Model Act* (#106), ~~R~~review health carrier underwriting files to verify that any minimum participation level that a health carrier establishes for small employers applying for coverage outside of the Nov. 15 to Dec. 15 small group open enrollment period is not greater than:

- 100% of eligible employees working for groups of three or fewer employees; and
- 75% of eligible employees working for groups with more than three employees.

(NY 3/7/2016 Comments) Minimum participation requirements are permitted outside the annual enrollment period from Nov. 15-Dec. 15 to the extent permitted by state law. Examiners should review health carrier underwriting files to verify that any minimum participation rules applied by the health carrier comply with any state-specific requirements.

(NY 3/8/2016 Comments) In states that have adopted the NAIC *Small Group Market Health Insurance Coverage Model Act* (#106), r~~R~~eview health carrier underwriting files to verify the health carrier, in applying minimum participation requirements with respect to a small employer, that applies for coverage outside of the November 15 to December 15 time period, does not consider employees or dependents of employees who have creditable coverage in determining whether the applicable percentage of participation is met. ~~Examiners need to be aware that HHS guidance regarding the applicability of group participation rules provides for different ways in which a state and/or health carrier may calculate minimum participation requirements, and such variations are deemed permissible by HHS.~~

(NY 3/7/2016 Comments) "Creditable coverage" is defined in the *Small Group Market Health Insurance Coverage Model Act* (#106) as follows:

"Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(1) A group health plan;
(2) A health benefit plan;
(3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(4) 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);
(5) 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. For purposes of Title 10, U.S.C. Chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);

(6) A medical care program of the Indian Health Service or of a tribal organization;
(7) A state health benefits risk pool;
(8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
(9) A public health plan, which for purposes of this act, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan;
(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or
(11) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(NY 3/8/2016 Comments) In states that have not adopted the NAIC *Small Group Market Health Insurance Coverage Model Act* (#106), examiners need to be aware that HHS guidance regarding the applicability of group participation rules provide for different ways in which the state and/or health carrier may calculate minimum participation requirements, as such variations are deemed permissible by HHS.

In applying minimum participation requirements with respect to a small employer, review health carrier underwriting files to verify the health carrier does not consider individuals eligible for coverage under a COBRA continuation provision as eligible employees in determining whether the applicable percentage of participation is met.

Review health carrier underwriting files to verify the health carrier does not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(NY 3/7/2016 Comments) Examiners should verify that ~~issuers~~ health carriers are complying with any state-specific requirements that may apply.

Note: Examiners need to be aware that a health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required to provide coverage if:

- For any period of time the health carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all employers in the group market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of an employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

With regard to a health carrier that denies coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the group market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Note: Examiners need to be aware that with respect to coverage offered through a network plan, a health carrier is not required to offer group market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- In an area outside of the health carrier's established geographic service area for such network plan;
- To an employee when the employee does not live, work or reside within the health carrier's established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group certificateholders and covered persons.

Review health carrier underwriting files to verify that a health carrier that cannot offer coverage for reason of lack of network capacity does not offer coverage in the group market in the applicable geographic service area to new cases of employer groups or to any employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services.

Review health carrier underwriting files to verify the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all employers without regard to the claims experience of the employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- A health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required by such regulations to provide small group market health insurance coverage if the health carrier elects not to offer new coverage to small employers in the applicable state;
- A health carrier that elects not to offer new coverage may be allowed, as determined by the commissioner, to maintain its existing policies in the applicable state; and
- A health carrier that elects not to offer new coverage to small employers in the applicable state has provided notice of its election to the commissioner and does not write new business in the small group market in the applicable state for a period of 5 years beginning on the date the carrier ceased offering new coverage in the applicable state.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to an eligible employer, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible employer that was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and, if applicable, from the marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of group market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of group market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to guaranteed availability of group market health insurance coverage.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed availability of group market health insurance coverage.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds. NY 3/7/2016 Comments) Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment.

Determine if the health carrier monitors producer-generated notices that deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

NEW YORK STATE
DEPARTMENT*of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Maria T. Vullo
Acting Superintendent

March 7, 2016

Director Bruce R. Ramge
Market Conduct Examination Standards (D) Working Group
National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Dear Director Ramge:

Subject: Draft Market Conduct Examination Standards – Guaranteed Availability Coverage

Below are comments from the NYS Department of Financial Services ("DFS") regarding suggested revisions to the draft market conduct examination standards relative to Guaranteed Availability of Coverage.

(1) Individual Health Insurance Coverage- Special Enrollment Periods, page 3. DFS suggests revision to the first review standard thereunder so that it begins as follows: "Verify that a health carrier allows enrollment during defined enrollment periods, including open enrollment periods,…"

(2) On pages 6 and 14, the proposed examination standards include the following review standard: "Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regards to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds." DFS suggests insertion of the following additional sentence to the review standard: "Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment." We note that on a recent NAIC CCIIO Oversight call, CCIIO indicated that guidance will be forthcoming in the "near future" on the relationship between guaranteed availability and broker commissions.

(3) Review standards for special enrollment periods (SEPs) in the group market are set forth on pages 9-11 but there is no reference to state specific enrollment periods. DFS suggests that insertion of wording in the group

market review standards similar to that already included in the individual market review standards such as: "Examiners should verify that health carriers are complying with any state-specific requirements that may apply."

(4) Minimum Participation Requirements, Page 12. The proposed review standards reference minimum participation standards of 100% for groups of three or fewer employees and 75% of eligible employees with more than three employees. 45 C.F.R. 147.104(b)(1)(B) states that that minimum participation requirements are permitted in the small group market outside of the annual enrollment period **to the extent permitted by state law** (emphasis added). DFS suggests that a note be added to these review standards to state that minimum participation requirements are permitted outside the annual enrollment period from November 15th to December 15th to the extent permitted by state law. Examiners should review health carrier underwriting files to verify that any minimum participation rules applied by the carrier comply with any state-specific requirements.

(5) Minimum Participation Requirements and Counting of Employees with Other Coverage. On page 12, the proposed review standards state: "Review health carrier underwriting files to verify the health carrier, in applying minimum participation requirements with respect to a small employer that applied for coverage outside of the November 15 to December 15 time period, does not consider employees or dependents of employees who have creditable coverage in determining whether the applicable percentage of participation is met."

A. We note that the ACA, PHSA and HHS regulations do not dictate how insurers are to count employees with other coverage when determining whether minimum participation requirements are satisfied. HHS guidance[1] states that there are different ways that a state and/or insurer may calculate minimum participation requirements and that such variations are permissible. DFS suggests revision of the proposed examination standards to reflect the HHS guidance.

B. Additionally, we note that the term "creditable coverage" is undefined in the proposed examination standards. It is also unclear as to whether such "creditable coverage" must be in effect, whether all forms of "creditable coverage" must be considered and whether

[1] See pages 3-6 of HHS Guidance titled "Guaranteed Availability Under Title XXVII of the Public Health Service Act-Applicability of Group Participation Rules" available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_00_05_508.pdf.)

the source of such "creditable coverage" is relevant (e.g. employee covered under his or her spouse's employer plan). DFS suggests that this review standard be revised to more fully explain what is meant and its application.

(6) Consistent Terminology. "Health carrier" appears to be the term most commonly used throughout the document; however, in a few places, the term "issuer" or "health insurance issuer" is used. Unless there is a reason to use different terminology, DFS suggests use of a single term throughout the document.

Thank you for the opportunity to provide the above suggested input to the draft market conduct examination standards.

Very Truly Yours,

Robert W. McLaughlin, CIE, CFE
Supervising Insurance Examiner
Health Bureau
New York State Department of
Financial Services

CC: Jim Mealer, Vice Chair, Market Conduct Exam Standards (D) Working Group, NAIC
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PROVISION TITLE: Guaranteed Availability of Coverage (Individual and Group Market Health Insurance)

CITATION: PHSA §2702

EFFECTIVE DATE: Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

PROVISION: The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual or group markets in a state must offer to any individual or employer in the applicable state all products approved for sale in the applicable market, and must accept any eligible individual or employer applying for any of those products.

BACKGROUND: Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual and group market in a state must accept for coverage, in the applicable state, every individual and employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law.

Health carriers are permitted to limit enrollment to designated annual open and special enrollment periods.

This provision applies to all health carriers in the individual market and to group plans. This provision applies to non-grandfathered group health plans. This provision also applies to grandfathered small group health plans, which were already required to comply with guaranteed availability of coverage requirements under HIPAA.

FAQs: See the HHS website for guidance.

NOTES:

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
(INDIVIDUAL MARKET)

Standard 1
A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with federal and state law.

Apply to: All individual health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificate holders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC References

Individual Market Health Insurance Coverage Model Regulation (#26)
Individual Market Health Insurance Coverage Model Act (#36)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of individual market health insurance coverage in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to plan applicants in compliance with final regulations established by HHS, the DOL and the Treasury and does not place unallowable conditions on such availability.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods, and coverage issued during an open or special enrollment period must become effective consistent with the dates set forth in federal regulations. Verify that a health carrier has complied with any requirements that would allow for continuous open enrollment based upon certain circumstances of failing to file rates and forms and have them approved prior to open enrollment period.

Individual Health Insurance Coverage – Open Enrollment Period
(NY 3/7/2016 Comments) A health ~~insurance issuer~~ carrier in the individual market must allow an individual to purchase health insurance coverage during the annual open enrollment period described in 45 CFR 155.410(e).

Individual Health Insurance Coverage – Special Enrollment Periods
(NY 3/7/2016 Comments) Verify that a health carrier ~~that restricts enrollment to~~allows enrollment during defined enrollment periods, including open enrollment periods, limited open enrollment periods, and special enrollment periods, and provides those periods pursuant to 45 CFR 147.104 and 155.420 as well as in accordance with state-specific requirements.

Verify that a health carrier provides for a special enrollment period that is not less than sixty calendar days pursuant to 45 CFR 147.104 and 155.420 for qualified individuals (and their dependents, when applicable) in the following circumstances:

- Loss of minimum essential coverage (including employer plans, Medicaid, CHIP, and COBRA coverage as well as loss of coverage due to divorce, legal separation, loss of dependent status, or death of the policyholder);

- Addition of a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care (including gaining a dependent through a child support order or other court order);
- Unintentional, inadvertent, or erroneous enrollment in a plan that results from error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the exchange or HHS or its instrumentalities, or a non-exchange entity (including a health carrier or its representative) that provides enrollment assistance or conducts enrollment activities;
- Health carrier substantially violated a material provision of its contract in relation to the enrollee
- Enrollee or dependent of an enrollee is determined newly eligible or ineligible for an advance premium tax credit or experiences a change in eligibility for cost-sharing reductions;
- A person terminates employer coverage as a result of being determined newly eligible for premium tax credits due to becoming ineligible for qualifying coverage in an eligible employer-sponsored plan;
- A person in a state that has not expanded Medicaid who was previously ineligible for premium tax credits due to having income below the federal poverty line experiences a change in household income that makes the person newly eligible for premium tax credits; or
- Permanent move that results in access to new individual market plans (including release from incarceration.)

Verify that a health carrier that offers qualified health plans through an insurance exchange or marketplace serving the individual insurance market also provides for a special enrollment period that is not less than sixty days for qualified individuals in the following circumstances:

- Gain of status as a citizen, national, or lawfully present individual;
- Status as federally recognized American Indian tribe or Alaska Native; or
- Person demonstrates to the exchange in the state, in accordance with federal guidelines, that the individual meets other exceptional circumstances as the exchange may provide.

Verify that a health carrier provides for a special enrollment period with effective coverage dates that begin the first day of the month following enrollment if the plan is selected between the 1st and 15th of the month or the first day of the second month following enrollment if the plan is selected between the 16th and the last day of the month with the following exceptions:

- In the case of marriage, not later than the first day of the month following plan selection;
- In the case of a dependent's birth, adoption, placement for adoption, or placement in foster care, the date of the birth, adoption, placement for adoption, or placement in foster care; or
- For loss of minimum essential coverage, the first day of the month following the loss of previous coverage if the qualified health plan is selected before or on the day of the loss. If the plan is selected after the date of coverage loss, then coverage is effective the first day of the month following plan selection.

Note: In some circumstances, federal rules permit states or the marketplace in a state to implement alternative coverage effective dates. (NY 3/7/2016 Comments) Examiners should verify that ~~issuers~~ health carriers are complying with any state-specific requirements that may apply.

Note: Examiners need to be aware that a health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required to provide coverage if:

- For any period of time the carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and

- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all individuals in the individual market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of an individual and his or her dependents or any health status-related factor relating to such individual and his or her dependents.

With regard to a health carrier denying coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the individual market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Note: Examiners need to be aware that with respect to coverage offered through a network plan, a health carrier is not required to offer individual market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- To an individual, when the individual does not live or reside within the health carrier's established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to any additional individuals because of its obligations to existing enrollees.

Review health carrier underwriting files to verify that a health carrier, that cannot offer coverage for reason of lack of network capacity, does not offer coverage in the individual market in the applicable geographic service to new individuals or to any enrollees until the later of 180 days following each such refusal or the date on which the health carrier notifies the commissioner of the applicable state that it has regained capacity to deliver services.

Review health carrier underwriting files to verify that the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all individuals without regard to the claims experience of those individuals and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- The provisions set forth in the final regulations established by HHS, the DOL and the Treasury should not be construed to require that a health carrier offering group health benefit plans must offer health benefit plans in the individual market;
- A health carrier offering only student health insurance coverage is not required to otherwise offer coverage in the individual market so long as the health carrier is offering student health insurance coverage consistent with the HHS, DOL and the Treasury definition of "student health insurance coverage." In accordance with 45 CFR 147.145, student health insurance is exempt from the requirement to establish open enrollment periods and coverage effective dates based on a calendar policy year; and
- A health carrier, at the time of renewal, may modify coverage under a health benefit plan offering individual market health insurance coverage so long as such modification is consistent with applicable state statutes, rules and regulations and effective on a uniform basis among all individuals covered under the health benefit plan.

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to eligible plan applicants, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and, if applicable, from the marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

(NY 3/7/2016 Comments) Verify that a health ~~insurance issuer~~carrier and its officials, employees, agents and representatives comply with any applicable statutes, rules and regulations regarding marketing by health ~~insurance issuers~~ carriers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of individual market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to guaranteed availability of individual market health insurance coverage.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed availability of individual market health insurance coverage.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds. (NY 3/7/2016 Comments) Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment.

Determine if the health carrier monitors producer-generated notices that deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
(GROUP MARKET)

Standard 2
**A health carrier offering group market health insurance coverage shall issue any applicable health benefit plan to any employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with state and federal law. **

Apply to: All group health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140. However, grandfathered small group health plans were already required to comply with guaranteed availability of coverage requirements under HIPAA

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

_____ Health carrier underwriting policies and procedures related to guaranteed availability of coverage

_____ Underwriting files and supporting documentation regarding guaranteed availability of coverage, including letters, notices, telephone scripts, etc.

_____ Complaint register/logs/files

_____ Health carrier complaint records concerning guaranteed availability of coverage (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Health carrier form approvals (policy language, enrollment materials and advertising materials, as required under state statutes, rules and regulations)

_____ Health carrier marketing and sales policies and procedures' references to guaranteed availability of coverage

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

_____ _____

_____ _____

NAIC References

Small Group Market Health Insurance Model Act (#106)
Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

_____ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of group market health insurance coverage in accordance with final regulations provided by HHS, the DOL and the Treasury.

Review health carrier underwriting policies and procedures related to guaranteed availability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier makes group market health insurance coverage available on a guaranteed availability basis to eligible employers in compliance with final regulations provided by HHS, the DOL and the Treasury and that the carrier does not place unallowable conditions on such availability.

Review health carrier underwriting policies and procedures to verify the health carrier:

- Offers coverage to all eligible employees of the eligible employer, and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan; and
- Does not limit the offer of coverage to only certain individuals or dependents in the group or to only part of the group.

A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods.

<u>Group Plans – Special Enrollment Periods</u>
Verify that a health carrier offering coverage in the small group market provides for an annual open enrollment period from November 15 through December 15, during which time small employers may enroll in coverage effective January 1 of the subsequent year without meeting any minimum participation or minimum contribution requirements.

Verify that a health carrier offering coverage in the small group market permits small employers to enroll at any time during the year, including outside of the annual small group open enrollment period, and that the carrier does not place any unallowable enrollment restrictions on small employers.

Verify that any enrollment restrictions that may be allowable outside of the annual small group enrollment period (such as minimum participation and minimum contribution requirements) are applied by the carrier in a consistent manner to all small employers seeking coverage.

Note: Different enrollment standards may apply depending on whether small group coverage is being offered within a small group exchange (also known as a SHOP marketplace) or in the small group market outside of an exchange or SHOP. For example, the minimum participation requirement may be calculated differently. Examiners should be aware of such differences and also of whether the carrier being examined is offering coverage within a SHOP, outside the SHOP, or both.

Verify that a health carrier permits an employee, or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of any health benefit package under the plan of the employer during a special enrollment period if:

- The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;
- The employee's or dependent's coverage:
    - Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or
    - Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated, or loss of coverage because an individual no longer resides, lives, or works in the service area of HMO coverage;
- The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time; or
- Under the terms of the health benefit plan, the employee requests enrollment not later than thirty days after the triggering event.

Verify that the health carrier provides a special enrollment period to all covered employees that experience the following qualifying events that result in the loss of coverage of a qualified beneficiary pursuant to 29 U.S.C. 1163:

- The death of the covered employee;
- The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment;
- The divorce or legal separation of the covered employee from the employee's spouse;
- The covered employee becomes entitled to benefits under Title XVIII of the Social Security Act;
- A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; or
- A proceeding in a case under Title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

Verify that if an employee requests enrollment, the health carrier provides for enrollment effective not later than the first day of the first calendar month beginning after the date the health carrier received the completed request for enrollment.

Verify that, with respect to dependents of employees, the health carrier provides for a dependent special enrollment period during which the dependent, and if not otherwise enrolled, the employee, may be enrolled under a health benefit plan, if a person becomes a dependent of the employee/participant through marriage, birth, adoption, or placement for adoption.

Verify that the health carrier's special enrollment period for qualified individuals provides a period of time not less than thirty days from the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available, at least thirty days after the date the plan makes dependent coverage generally available.)

Verify that the health carrier, for an employee who seeks to enroll a dependent during a special enrollment period, provides for the coverage of the dependent effective upon:

- In the case of marriage, not later than the first day of the first month beginning after the health carrier receives the completed request for special enrollment;
- In the case of a dependent's birth, the date of the child's birth; and
- In the case of a dependent's adoption or placement for adoption, not later than the date of the adoption or placement for adoption.

Verify that the health carrier permits an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll in coverage under the terms of the health benefit plan if:

- The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under the plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the plan not later than sixty days after the date of termination of such coverage; or
- The employee or dependent becomes eligible for assistance, with respect to coverage under the plan under a Medicaid plan under Title XIX of the Social Security Act or under the state child health plan under Title XXI of the Social Security Act, including any waiver or demonstration project conducted under or in relation to such a plan, if the employee requests coverage under the plan not later than sixty days after the employee or dependent is determined to be eligible for such assistance.

Verify that the health carrier provides adequate written notice of special enrollment rights and the requirement furnished to an individual declining coverage (if the plan requires the reason for declining coverage to be in writing). 29 CFR 2590.701-6 includes model language for informing employees of their special enrollment rights.

Verify that the health carrier does not treat special enrollees as late enrollees and offers the same benefit package as is offered to similarly situated individuals who enroll when first eligible. Any differences in benefits or cost-sharing requirements for different individuals constitute a different benefit package, and a special enrollee cannot be required to pay more for coverage or to enroll in different coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

Verify that the health carrier is in compliance with 45 CFR 147.108 and 45 CFR 146.111, including the examples identified in federal regulations.

Review health carrier underwriting policies and procedures to verify the health carrier does not apply any waiting period (consistent with the HHS, DOL and Treasury definition of "waiting period") that exceeds 90 days.

Review the health carrier's underwriting files to verify the requirements used by a health carrier in determining whether to provide coverage to an employer are applied uniformly among all employers applying for coverage or receiving coverage from the health carrier.

(NY 3/8/2016 Comments) In states that have adopted the NAIC *Small Group Market Health Insurance Coverage Model Act* (#106),~~R~~review health carrier underwriting files to verify that any minimum participation level that a health carrier establishes for small employers applying for coverage outside of the Nov. 15 to Dec. 15 small group open enrollment period is not greater than:

- 100% of eligible employees working for groups of three or fewer employees; and
- 75% of eligible employees working for groups with more than three employees.

(NY 3/7/2016 Comments) Minimum participation requirements are permitted outside the annual enrollment period from Nov. 15-Dec. 15 to the extent permitted by state law. Examiners should review health carrier underwriting files to verify that any minimum participation rules applied by the health carrier comply with any state-specific requirements.

(NY 3/8/2016 Comments) In states that have adopted the NAIC *Small Group Market Health Insurance Coverage Model Act* (#106),~~R~~review health carrier underwriting files to verify the health carrier, in applying minimum participation requirements with respect to a small employer, that applies for coverage outside of the November 15 to December 15 time period, does not consider employees or dependents of employees who have creditable coverage in determining whether the applicable percentage of participation is met. ~~(NY 3/7/2016 Comments) Examiners need to be aware that HHS guidance regarding the applicability of group participation rules provides for different ways in which a state and/or health carrier may calculate minimum participation requirements, and such variations are deemed permissible by HHS.~~

(NY 3/7/2016 Comments) "Creditable coverage" is defined in the *Small Group Market Health Insurance Coverage Model Act* (#106) as follows:

"Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

(1) A group health plan;
(2) A health benefit plan;
(3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(4) 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);
(5) 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. For purposes of Title 10, U.S.C. Chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
(6) A medical care program of the Indian Health Service or of a tribal organization;
(7) A state health benefits risk pool;
(8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
(9) A public health plan, which for purposes of this act, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan;

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(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or
(11) Title XXI of the Social Security Act (State Children's Health Insurance Program).

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(NY 3/8/2016 Comments) In states that have not adopted the NAIC *Small Group Market Health Insurance Model Act* (#106), examiners need to be aware that HHS guidance regarding the applicability of group participation rules provide for different ways in which state and/or health carrier may calculate minimum participation requirements, as such variations are deemed permissible by HHS.

In applying minimum participation requirements with respect to a small employer, review health carrier underwriting files to verify the health carrier does not consider individuals eligible for coverage under a COBRA continuation provision as eligible employees in determining whether the applicable percentage of participation is met.

Review health carrier underwriting files to verify the health carrier does not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(NY 3/7/2016 Comments) Examiners should verify that ~~issuers~~ health carriers are complying with any state-specific requirements that may apply.

Note: Examiners need to be aware that a health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required to provide coverage if:

- For any period of time the health carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all employers in the group market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of an employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

With regard to a health carrier that denies coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the group market in the applicable state until the later of:

- A period of 180 days after the date the coverage is denied; or
- Until the health carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Network Plans

Note: Examiners need to be aware that with respect to coverage offered through a network plan, a health carrier is not required to offer group market health insurance coverage under that plan or accept applications for that plan in the case of the following:

- In an area outside of the health carrier's established geographic service area for such network plan;

- To an employee when the employee does not live, work or reside within the health carrier's established geographic service area for such network plan; or
- Within the geographic service area for such network plan where the health carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group certificateholders and covered persons.

Review health carrier underwriting files to verify that a health carrier that cannot offer coverage for reason of lack of network capacity does not offer coverage in the group market in the applicable geographic service area to new cases of employer groups or to any employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services.

Review health carrier underwriting files to verify the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all employers without regard to the claims experience of the employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- A health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required by such regulations to provide small group market health insurance coverage if the health carrier elects not to offer new coverage to small employers in the applicable state;
- A health carrier that elects not to offer new coverage may be allowed, as determined by the commissioner, to maintain its existing policies in the applicable state; and
- A health carrier that elects not to offer new coverage to small employers in the applicable state has provided notice of its election to the commissioner and does not write new business in the small group market in the applicable state for a period of 5 years beginning on the date the carrier ceased offering new coverage in the applicable state.

General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to restriction of guaranteed availability of coverage.

Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to an eligible employer, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible employer that was not offered health insurance coverage on a guaranteed availability basis.

Review policy form files to ensure approval(s) from the applicable state and, if applicable, from the marketplace.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of group market health insurance coverage.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of group market health insurance coverage.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to guaranteed availability of group market health insurance coverage.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed availability of group market health insurance coverage.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds. NY 3/7/2016 Comments) Review commission schedules and related commission filing information to verify that commissions do not have the effect of discouraging enrollment.

Determine if the health carrier monitors producer-generated notices that deny or restrict coverage. Review producer records of such notices for compliance with the guaranteed availability provisions in final regulations established by HHS, the DOL and the Treasury.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

Conference Call

STANDARDIZED DATA REQUEST (D) SUBGROUP
February 24, 2016
Summary Report

The Standardized Data Request (D) Subgroup met via conference call Feb. 24, 2016, in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance, including, but not limited to, Annual and Quarterly Statement Blanks and Instructions, the *Accounting Practices and Procedures Manual*, and similar materials) of the NAIC Policy Statement on Open Meetings. During this meeting, the Subgroup:

1. Discussed plans to review three NAIC standardized data requests (producer, commission and complaint, P/C personal lines, and life and annuity) and provide recommended changes to the Market Conduct Examination Standards (D) Working Group.

2. Began its work to update the producer, commission and complaint standardized data request. The Subgroup established a conference call schedule and will next meet in March.

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