

**SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT
(PROSPECTIVE REINSURANCE WITH OR WITHOUT AN OPT-OUT)**

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Section 1. Short Title

This Act shall be known and may be cited as the Small Employer Health Insurance Availability Act.

Section 2. Purpose

The purpose and intent of this Act are to enhance the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to prevent segmentation of the health insurance market based upon health risk, to spread health insurance risk more broadly, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to limit the use of preexisting condition exclusions, to provide for development of “basic” and “standard” health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

This Act is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

Drafting Note: This revised model act provides guidance to states interested in reforming their group health insurance laws, particularly as they affect small employers, in order to promote the availability of health insurance coverage to those employers. It is the intent of the NAIC to consider further amendments of this act to deal with the availability of health insurance for individuals as well. In addition, the NAIC believes that the reform of the individual market is critical to achieving the purpose of this model, which is prevention of the segmentation of the market based on health risk.

Section 3. Definitions

As used in this Act:

- A. “Actuarial certification” means a written statement signed by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 5 of this Act, based upon the person’s examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

- B. “Adjusted community rating” means a method used to develop a carrier’s premium which spreads financial risk across the carrier’s entire small group population in accordance with the requirements in Section 5 of this Act.
- C. “Affiliate” or “affiliated” means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
- D. “Affiliation period” means a period of time that must expire before health insurance coverage provided by a carrier becomes effective, and during which the carrier is not required to provide benefits.
- E. “Basic health benefit plan” means a lower cost health benefit plan developed pursuant to Section 13 of this Act.

Drafting Note: States should consider the level of benefits that are included in the design of the basic benefit plan. Several studies on requirements to offer “bare bones” benefit plans have indicated that these limited benefit polices are not well received by consumers.

- F. “Board” means the board of directors of the program established pursuant to Section 12 of this Act.
- G. “Carrier” or “small employer carrier” means all entities licensed, or required to be licensed, by the Department of Insurance that offer health benefit plans covering eligible employees of one or more small employers pursuant to this Act. For the purposes of this Act, carrier includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Drafting Note: HIPAA uses the term “health insurance issuer” instead of “carrier” or “small employer carrier.” The definition of “health insurance issuer” contained in HIPAA is consistent with the term “carrier” or “small employer carrier,” as defined in Section 3G of this Act.

Drafting Note: The term “multiple employer welfare arrangement” should be added to the list of carriers in those states that have separate certificates of authority for such arrangements. In states that do not have separate licenses for self-funded multiple employer welfare arrangements, such arrangements should be treated as unauthorized insurers. States should enforce their laws against transaction of unauthorized insurance against such unauthorized self-funded multiple employer welfare arrangements. This language does not contain any exemption for health benefit plans covering eligible employees of small employers when these plans are sold through the vehicle of associations and is intended to include such plans. States should examine the definitions in their statutes to determine whether more explicit language is necessary.

- H. “Commissioner” means the insurance commissioner of this state.

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

- I. “Committee” means the health benefit plan committee created pursuant to Section 13 of this Act.
- J. “Control” shall be defined in the same manner as in Section [insert reference to state law corresponding to the National Association of Insurance Commissioners (NAIC) Model Insurance Holding Company System Regulatory Act].
- K. (1) “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:
 - (a) A group health plan;
 - (b) A health benefit plan;
 - (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);

- (e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents. 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);
 - (f) A medical care program of the Indian Health Service or of a tribal organization;
 - (g) A state health benefits risk pool;
 - (h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
 - (i) A public health plan, which for purposes of this act, means a plan established or maintained by a state, 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;
 - (j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or
 - (k) Title XXI of the Social Security Act (State Children’s Health Insurance Program).
- (2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

Drafting Note: States may wish to grant the commissioner rulemaking authority to further define that coverage which falls within the definition above. However, the commissioner’s authority is limited by the requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA) with respect to creditable coverage. The definition of “creditable coverage” is governed by HIPAA’s preemption rule relating to state provisions addressing preexisting conditions, which is more stringent than the general preemption test under HIPAA. State provisions relating to preexisting conditions are preempted if they differ from the requirements of HIPAA, unless the state provision falls into one of seven explicit exceptions. However, one of these seven exceptions is broad and permits a state requirement to stand if the requirement “prohibits the imposition of any preexisting condition exclusion in cases not described in Section 2701(d) or expands the exceptions described in such section.” PHSA Section 2723(b)(2)(v). The language of this section permits states to continue to prohibit preexisting condition exclusions in a number of situations not specifically addressed by HIPAA.

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

Drafting Note: States without a statutory definition of dependent may wish to use the following definition:

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

Drafting Note: If using the suggested definition, states should conform this definition to include those individuals that are defined as a “dependent” under state law. States also should be aware that, when developing a definition of dependent that may include specific ages for a child to be considered a dependent, federal law may define a dependent child with respect to age differently for purposes of a federal income tax deduction. If the state definition differs in this respect, then it could impact the individual filer’s tax liability.

- M. “Eligible employee” means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours under a *bona fide* employer-employee relationship which was not established for the purpose of buying health insurance. At the employer’s sole discretion, the eligibility criterion may be broadened to include part-time employees, as long as a standard of at least seventeen and one-half (17.5) hours per normal work week is applied uniformly among all of the employer’s employees, and the eligibility criterion and the employees’ work schedules are not established or adjusted by the employer because of any health status-related factor. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.
- N. “Enrollment date” means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever is earlier.

Drafting Note: The definition of “enrollment date” above should be interpreted to mean that enrollees and dependents are subject to only one enrollment date and/or waiting period per small employer. If a small employer changes carriers, enrollees and dependents are not subject to a new enrollment date or waiting period.

- O. “Established geographic service area” means a geographic area, as approved by the commissioner and based on the carrier’s certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
- P. “Family composition” means:
 - (1) Enrollee;
 - (2) Enrollee, spouse and children;
 - (3) Enrollee and spouse; or
 - (4) Enrollee and children.

Drafting Note: States may wish to consider permitting carriers to include other adults living in the home of the enrollee to fall within the above definition of family composition.

- Q. “Genetic information” means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.
- R. “Geographic area” is an area, subject to the approval of the commissioner, established by a carrier used for adjusting the rates for a health benefit plan.
- S. “Governmental plan” has the meaning given the term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.
- T. (1) “Group health plan” means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in Subsection Z, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
 - (2) For purposes of this Act:
 - (a) Any plan, fund or program that would not be, but for PHSA Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b) of this paragraph, as an employee welfare benefit plan that is a group health plan;
 - (b) In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner; and
 - (c) In the case of a group health plan, the term “participant” also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual’s beneficiary who is, or may become, eligible to receive a benefit under the plan, if:
 - (i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or

- (ii) In connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the individual is the self-employed individual.

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

- U. (1) “Health benefit plan” means any hospital or medical policy or certificate, major medical expense insurance, [insert reference to subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan], or health maintenance organization subscriber contract. Health benefit plan does include short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

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

- (2) “Health benefit plan” shall not include one or more, or any combination of, the following:
 - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (3) (a) “Health benefit plan” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
 - (i) Limited scope dental or vision benefits;
 - (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
 - (iii) Benefits provided under a health flexible spending arrangement for a class of participants only if:
 - (I) Other coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and
 - (II) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two (2) times the participant’s salary reduction election for the year or, if greater, cannot exceed \$500 plus the amount of the participant’s salary reduction election; or

- (iv) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (b) For purposes of this paragraph, benefits are not an integral part of a plan, whether the benefits are provided through the same plan or a separate plan, only if the two following requirements are satisfied:
 - (i) Participants shall have a right to elect not to receive coverage for the benefits; and
 - (ii) If a participant elect to receive coverage for the benefits, the participant is required to pay an additional premium or contribution for that coverage
- (4) “Health benefit plan” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
 - (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (5) “Health benefit plan” shall not include the following if offered as a separate policy, certificate or contract of insurance:
 - (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (known as TRICARE supplemental programs); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.

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

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

- (c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the commissioner the information and statement required in Subparagraph (b) of this paragraph at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.

Drafting Note: It may be desirable to provide the commissioner with discretion to implement regulations to delineate the suitability of these products in the health insurance market reformed pursuant to this Act. For example, the commissioner might conclude that the sale of certain specified disease or other policies is inappropriate in the context of a reformed health insurance market.

- V. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.
- W. “Health status-related factor” means any of the following factors:
 - (1) Health status;
 - (2) Medical condition, including both physical and mental illnesses;
 - (3) Claims experience;
 - (4) Receipt of health care;
 - (5) Medical history;
 - (6) Genetic information;
 - (7) Evidence of insurability, including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities; or
 - (8) Disability.

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

- X. (1) “Late enrollee” means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days.
- (2) “Late enrollee” shall not mean an eligible employee or dependent:
 - (a) Who meets each of the following:
 - (i) The individual was covered under creditable coverage at the time of the initial enrollment;
 - (ii) The individual lost creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of a spouse, divorce or legal separation; and
 - (iii) The individual requests enrollment within thirty (30) days after termination of the creditable coverage or the change in conditions that gave rise to the termination of coverage;
 - (b) If, where provided for in contract or where otherwise provided in state law, the individual enrolls during the specified bona fide open enrollment period;

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- (c) If the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;
 - (d) If a court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and a request for enrollment is made within thirty (30) days after issuance of the court order;
 - (e) If the individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within thirty (30) days after the change in status;
 - (f) If the individual had coverage under a COBRA continuation provision and the coverage under that provision has been exhausted; or
 - (g) Who meets the requirements for special enrollment pursuant to Section 7C(6) and (7) of this Act.
- Y. "Limited benefit health insurance" means that form of coverage that pays stated predetermined amounts for specific services or treatments or pays a stated predetermined amount per day or confinement for one or more named conditions, named diseases or accidental injury.
- Z. "Medical care" means amounts paid for:
- (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and
 - (3) Insurance covering medical care referred to in Paragraphs (1) and (2).
- AA. "Network plan" means a health benefit plan issued by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.
- BB. "Plan of operation" means the plan of operation of the program established pursuant to Section 12 of this Act.
- CC. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.
- DD. "Plan sponsor" has the meaning given this term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974.
- EE. (1) "Preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition that exists prior to the enrollment date of the coverage.
- (2) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.
- FF. "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.
- GG. "Producer" means [incorporate reference to definition in state's law for licensing producers].

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

- HH. “Program” means the [State] Small Employer Reinsurance Program created by Section 12 of this Act.
- II. “Rating period” means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.
- JJ. “Reinsuring carrier” means a small employer carrier participating in the reinsurance program pursuant to Section 12 of this Act.
- KK. “Restricted network provision” means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.

Drafting Note: States should modify this section to make reference to the types of restricted network arrangements authorized in the state.

- LL. “Risk adjustment mechanism” means the mechanism established pursuant to Section 20 of this Act.
- MM. “Risk-assuming carrier” means a small employer carrier whose application is approved by the commissioner pursuant to Section 10 of this Act.

Drafting Note: Delete Subsections JJ and MM if participation in the reinsurance program is mandatory.

- NN. “Self-employed individual” means an individual or sole proprietor who derives a substantial portion of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.
- OO. “Significant break in coverage” means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

Drafting Note: States should be aware that, for purposes of applying a preexisting condition exclusion, HIPAA permits an individual to have a gap in coverage for a period of no longer than 63 days rather than the longer 90-day period provided in Subsection OO. Under HIPAA’s preemption provisions, states may deviate from the HIPAA requirements for provisions related to preexisting condition exclusion provisions so long as the deviation is more generous to the consumer. Therefore, the NAIC has chosen to retain the longer time frame as provided in this Subsection and throughout this Act.

- PP. (1) “Small employer” means any person, firm, corporation, partnership, association, political subdivision that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed at least two (2) no more than [fifty (50)] eligible employees. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this Act that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term small employer includes a self-employed individual with at least one employee.
- (2) “Small employer” includes any person, firm, corporation, partnership, association or political subdivision that is actively engaged in business that on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed a combination of no more than [fifty (50)] eligible employees and part-time employees.
- (3) If a small employer has employees in more than one state, the provisions of this Act shall apply to a health benefit plan issued to the small employer if:
 - (a) The majority of eligible employees of the small employer are employed within this state;
or

- (b) If no state contains a majority of eligible employees of the small employer, the primary business location of the small employer in this state.

Drafting Note: HIPAA defines “small employer” as those employers with between two (2) and fifty (50) employees with the ability of states to include groups of one (i.e., self-employed individuals with no other employees). Paragraph (1) represents the most restrictive definition of “small employer” that states may use under HIPAA. States may wish to consider eliminating the two-employee threshold to include self-employed individuals with no employees or raising the maximum numbers of employees for the purposes of defining “small employer,” depending on the underwriting and marketing practices in the state and other relevant factors. In an effort to promote continuity of coverage, states should also consider the adoption of more liberal standards for retaining eligibility for a small group market product, regardless of size-related eligibility standards, or consider extending the employer’s right to renew to the date of the plan’s second anniversary following the date on which the small employer no longer meets the size requirements.

- QQ. “Standard health benefit plan” means a health benefit plan developed pursuant to Section 13 of this Act.
- RR. “Waiting period” means, with respect to a health benefit plan and an individual, who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to Subsection K(2), a waiting period shall not be considered a gap in coverage.

Section 4. Applicability and Scope

This Act shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

- A. Any portion of the premium or benefits is paid by or on behalf of the small employer;
- B. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;
- C. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code; or
- D. The health benefit plan is marketed to individual employees through an employer.

Drafting Note: In some cases, individual health benefit plans could be subject both to the provisions of this Act and to the provisions of the state’s laws for individual health insurance. A state should consider whether inconsistencies in regulatory standards would result, especially in the provisions relating to premium rates. A state may wish to consider exempting individual health benefit plans covered by this Act from the rating provisions of existing state statutes.

- E. (1) Except as provided in Paragraph (2), for the purposes of this Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this Act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.
- (2) An affiliated carrier that is a health maintenance organization having a certificate of authority under Section [insert reference to state health maintenance organization licensing act] may be considered to be a separate carrier for the purposes of this Act.
- (3) Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. [The provisions of {insert applicable reference to state law on assumption reinsurance} shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.]

Drafting Note: The language in brackets should be included in states that have enacted laws regulating assumption reinsurance.

Section 5. Restrictions Relating to Premium Rates

- A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:
- (1) The small employer carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:
 - (a) Geographic area;
 - (b) Family composition; and
 - (c) Age.
 - (2) The adjustment for age in Paragraph(1)(c) may not use age brackets smaller than five-year increments and these shall begin with age thirty (30) and end with age sixty-five (65).
 - (3) The small employer carriers shall be permitted to develop separate rates for individuals age sixty-five (65) or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.
 - (4) The adjustments to the rates for a health benefit plan permitted in Paragraph(1)(c) shall not result in a rate per enrollee for the health benefit plan of more than 200 percent of the lowest rate for all age groups effective five (5) years after enactment of this Act. During the first two (2) years after enactment of this Act the permitted rates for any age group shall be no more than 400 percent of the lowest rate for all age groups and two (2) years after enactment of this Act the permitted rates for any age group shall be no more than 300 percent of the lowest rate for all age groups.
- Drafting Note:** The limitations on premium rate variations contained above represent one of several viable approaches that might be considered by a state and should be viewed in that way rather than as a recommended approach. The state may wish to include a provision for a recommendation to postpone the subsequent steps if a study determines the rate compression is producing unanticipated effects. In particular, there is a potential for adverse results from timing issues relative to implementing these rate limitations prior to the inclusion of individual insurance.
- B. The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect:
- (1) Changes to the enrollment of the small employer;
 - (2) Changes to the family composition of the employee; or
 - (3) Changes to the health benefit plan requested by the small employer.
- C. Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to Section 12 of this Act.
- D. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.
- E. For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.
- F. The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this Act, including regulations that:

- (1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design or coverage (not including differences due to the nature of the groups assumed to select particular health benefit plans or separate claim experience for individual health benefit plans); and
- (2) Prescribe the manner in which geographic territories are designated by all small employer carriers.

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

- G. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:
- (1) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;
 - (2) The provisions relating to renewability of policies and contracts;
 - (3) The provisions relating to any preexisting condition provision; and
 - (4) A listing of and descriptive information, including benefits and premiums, about all benefit plans for which the small employer is qualified.
- H. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.
- (2) Each small employer carrier shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the small employer carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.
- (3) A small employer carrier shall make the information and documentation described in Subsection E(1) available to the commissioner upon request. Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.
- I. The requirements of this section shall apply to all health benefit plans issued or renewed on or after the effective date of this Act.

Drafting Note: States may want to consider adding a section that allows the commissioner to modify the requirements of this section for business that is assumed from a company that elects to leave the small employer market or business assumed through an insolvent carrier.

Section 6. Renewability of Coverage

Drafting Note: States that already have adopted the NAIC Model Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Employers Model Act will have provisions that substantially duplicate the provisions of this section. Some of the provisions in this model, however, are more favorable to policyholders and states may wish to modify their laws to conform to the provisions in this section.

- A. A health benefit plan subject to this Act shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

- (1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the carrier has not received timely premium payments;
- (2) The plan sponsor or, with respect to coverage of individual insureds under the health benefit plan, the insured or the insured's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;
- (3) Noncompliance with the carrier's minimum participation requirements;
- (4) Noncompliance with the carrier's employer contribution requirements;
- (5) The small employer carrier elects to discontinue offering all of its health benefit plans delivered or issued for delivery to small employers in this state if the carrier :
 - (a) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and
 - (b) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
 - (i) All affected small employers and enrollees and their dependents; and
 - (ii) The commissioner in each state in which an affected insured individual is known to reside, provided the notice to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;
- (6) The commissioner:
 - (a) Finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations; and
 - (b) Assists affected small employers in finding replacement coverage;
- (7) The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the small employer carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the state's small employer market if the carrier:
 - (a) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed;
 - (b) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
 - (i) All affected small employers and enrollees and their dependents; and
 - (ii) The commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;
 - (c) Offers to each small employer issued that particular type of health benefit plan (obsolete product form) the option to purchase all other health benefit plans currently being offered by the carrier to small employers in the state; and

- (d) In exercising this option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to Subparagraph (c) of this paragraph acts uniformly without regard to the claims experience of those small employers or any health status-related factor relating to any enrollee or dependent of an enrollee or enrollees and their dependents covered or new enrollees and their dependents who may become eligible for coverage; or
- (8) In the case of health benefit plans that are made available in the small group market through a network plan, there is no longer an employee of the small employer living, working or residing within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to Section 7D(1)(b) of this Act.
- B.
 - (1) A small employer carrier that elects not to renew health benefit plan coverage pursuant to Subsection A(2) because of the small employer's fraud or intentional misrepresentation of material fact under the terms of coverage may choose not to issue a health benefit plan to that small employer for one (1) year after the date of nonrenewal.
 - (2) This paragraph shall not be construed to affect the requirements of Section 7 of this Act as to other small employer carriers to issue any health benefit plan to the small employer.
- C.
 - (1) A small employer carrier that elects to discontinue offering health benefit plans under Subsection A(5) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.
 - (2) In the case of a small employer carrier that ceases offering new coverage in this state pursuant to Subsection A(5), the small employer carrier, as determined by the commissioner, may renew its existing business in the small employer market in the state or may be required to non-renew all of its existing business in the small employer market in the state.
- D. In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in that service area.

Drafting Note: A state that has not enacted the NAIC's Group Coverage Discontinuance and Replacement Model Regulation and the Coordination of Benefits Model Regulation should do so as part of these reforms. The Discontinuance and Replacement Model Regulation seeks to assure that all carriers are assuming a fair share of liability for transfers of business and to assure employees that they have full coverage during transfers of business.

Section 7. Availability of Coverage

- A.
 - (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state including at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan from such small employer carrier.
 - (2) Subject to Paragraph (1), a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act.

Drafting Note: States may also want to consider the implications of possible duplicate coverages of public programs, such as Medicare and Medicaid, and authorize the commissioner to promulgate regulations to preclude undesired duplication or the prospect of unintended dumping.

- (3) (a) Subject to Subparagraph (b) of this paragraph, the provisions of this subsection shall be effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to Section 13 of this Act.

- (b) If the Small Employer Health Reinsurance Program created pursuant to Section 12 of this Act is not yet operative on the date provided in Subparagraph (a) of this paragraph, the provisions of this paragraph shall be effective on the date that the program begins operation.
- B.
 - (1) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.
 - (2) The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this Act.
- C. Health benefit plans covering small employers shall comply with the following provisions:
 - (1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than six (6) months following the enrollment date of the individual's coverage due to a preexisting condition, or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more broadly than a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately before the individual's enrollment date.
 - (2)
 - (a) Except as provided in Paragraph (3), a small employer carrier shall reduce the period of any preexisting condition exclusion without regard to the specific benefits covered during the period of creditable coverage, provided that the last period of creditable coverage ended on a date not more than ninety (90) days prior to the enrollment date of new coverage.
 - (b) The aggregate period of creditable coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier, or for the normal application and enrollment process following employment or other triggering event for eligibility.
 - (c) A carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period that:
 - (i) Does not exceed sixty (60) days for new entrants and not to exceed ninety (90) days for late enrollees;
 - (ii) During which the carrier charges no premiums and the coverage issued is not effective; and
 - (iii) Is applied uniformly, without regard to any health status-related factor.
 - (d) This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.
 - (3)
 - (a) Instead of as provided in Paragraph (2)(a), a small employer carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations.
 - (b) A small employer electing to reduce the period of any preexisting condition exclusion using the alternative method described in Subparagraph (a) of this paragraph shall:
 - (i) Make the election on a uniform basis for all enrollees; and

- (ii) Count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.
- (c) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described under Subparagraph (a) of this paragraph shall:
 - (i) Prominently state that the election has been made in any disclosure statements concerning coverage under the health benefit plan to each enrollee at the time of enrollment under the plan and to each small employer at the time of the offer or sale of the coverage; and
 - (ii) Include in the disclosure statements the effect of the election.
- (4) (a) A health benefit plan shall accept late enrollees, but may exclude coverage for late enrollees for preexisting conditions for a period not to exceed twelve (12) months.
- (b) A small employer carrier shall reduce the period of any preexisting condition exclusion pursuant to Paragraph (2) or Paragraph (3).
- (5) A small employer carrier shall not impose a preexisting condition exclusion:
 - (a) Relating to pregnancy as a preexisting condition; or
 - (b) With regard to a child who is covered under any creditable coverage within [thirty (30)] days of birth, adoption or placement for adoption, provided that the child does not experience a significant break in coverage, and provided that the child was adopted or placed for adoption before attaining eighteen (18) years of age.

Drafting Note: Under HIPAA, states may establish a special enrollment period longer than 30 days under Section 7C(7)(b) for a child with creditable coverage who satisfies the Paragraph (5)(b).

- (6) (a) A small employer carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group health plan of the small employer during a special enrollment period if:
 - (i) 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;
 - (ii) 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;
 - (iii) The employee's or dependent's coverage described under Item (i):
 - (I) Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or
 - (II) 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, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated; and

- (iv) Under terms of the health benefit plan, the employee requests enrollment not later than thirty (30) days after the date of exhaustion of coverage described in Item (iii)(I) or termination of coverage or employer contribution described in Item (iii)(II).
 - (b) If an employee requests enrollment pursuant to Item (iv), the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.
- (7) (a) A small employer carrier that makes coverage available under a health benefit plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in Subparagraph (b) of this paragraph during which the dependent and, if not otherwise enrolled, the individual may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage if:
- (i) The individual is a participant under the health benefit plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan; and
 - (ii) A person becomes a dependent of the individual through marriage, birth or adoption or placement for adoption.
- (b) The special enrollment period for individuals that meet the provisions of Subparagraph (a) of this paragraph shall be a period of not less than thirty (30) days and begins on the later of:
- (i) The date dependent coverage is made available; or
 - (ii) The date of the marriage, birth or adoption or placement for adoption described in Subparagraph (a)(ii).
- (c) If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under Subparagraph (b) of this paragraph, the coverage of the dependent shall be effective:
- (i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
 - (ii) In the case of a dependent's birth, as of the date of birth; and
 - (iii) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
- (8) (a) Except as provided in this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier.
- (b) A small employer carrier shall not require a minimum participation level greater than:
- (i) One hundred percent (100%) of eligible employees working for groups of three (3) or less employees; and
 - (ii) Seventy-five percent (75%) of eligible employees working for groups with more than three (3) employees.

- (c) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met.
 - (d) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider individuals covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 as eligible employees, as that term is defined in Section 3M of this Act, in determining whether the applicable percentage of participation is met.
 - (e) A small employer carrier shall 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.
- (9)
- (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small 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. A small employer carrier shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.
 - (b) A small employer carrier shall not place any restriction in regard to any health status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.
 - (c) Except as permitted under Paragraphs (1) and (4) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.
- D.
- (1) Subject to Paragraph (3), a small employer carrier shall not be required to offer coverage or accept applications pursuant to Subsection A in the case of the following:
 - (a) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;
 - (b) To an employee, when the employee does not live, work or reside within the carrier's established geographic service area; or
 - (c) Within an area where the small employer 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 policyholders and enrollees.
 - (2) A small employer carrier that cannot offer coverage pursuant to Paragraph (1)(c) may not offer coverage in the applicable area to new cases of employer groups with more than [insert the size of employer to correspond with the definition of small employer in Section 3 of this Act] eligible employees or to any small 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 to small employer groups.
 - (3) A small employer carrier shall apply the provisions of this subsection uniformly to all small employers without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

- E. (1) A small employer carrier shall not be required to provide coverage to small employers pursuant to Subsection A if:
 - (a) For any period of time the commissioner determines, the small employer carrier does not have the financial reserves necessary to underwrite additional coverage; and
 - (b) The small employer carrier is applying this subsection uniformly to all small employers in the small group market in this state consistent with applicable state law and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.
- (2) A small employer carrier that denies coverage in accordance with Paragraph (1) may not offer coverage in the small group market for the later of:
 - (a) A period of 180 days after the date the coverage is denied; or
 - (b) Until the small employer has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

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

- F. (1) A small employer carrier shall not be required to provide coverage to small employers pursuant to Subsection A if the small employer carrier elects not to offer new coverage to small employers in this state.
- (2) A small employer carrier that elects not to offer new coverage to small employers under this subsection may be allowed, as determined by the commissioner, to maintain its existing policies in this state.
- (3) A small employer carrier that elects not to offer new coverage to small employers under Paragraph (1) shall provide notice of its election to the commissioner and shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

Section 8. Certification of Creditable Coverage

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

- (2) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

Drafting Note: Federal regulations issued pursuant to PHSA Section 2701(e) include additional information that must be included in a certificate of creditable coverage. This additional information can be found in Section 8 of the NAIC Model Regulation to Implement the Small Employer Health Insurance Availability Model Act.

- E. To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under Subsection A if the carrier offering the coverage provides for certification in accordance with Subsection B.
- F.
 - (1) If an individual enrolls in a health benefit plan that uses the alternative method of counting creditable coverage pursuant to Section 7C(3) of this Act and the individual provides a certificate of coverage that was provided to the individual pursuant to Subsection B, on request of the health benefit plan, the entity that issued the certification to the individual promptly shall disclose to the health benefit plan information on the classes and categories of health benefits available under the entity's health benefit plan.
 - (2) The entity providing the information pursuant to Paragraph (1) may charge the requesting health benefit plan the reasonable cost of disclosing the information.

Section 9. Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier

- A.
 - (1) Within thirty (30) days after the plan of operation is approved by the commissioner under Section 12 of this Act, each small employer carrier shall notify the commissioner of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 10 of this Act.
 - (2) The decision shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The commissioner may permit a carrier to modify its decision at any time for good cause shown.
 - (3) The commissioner shall establish an application process for small employer carrier seeking to change their status under this subsection. In the case of a small employer carrier that has been acquired by another such carrier, the commissioner may waive or modify the time periods established in Paragraph (2).
- B. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

Drafting Note: Delete this section if participation in the reinsurance program is mandatory.

Section 10. Application to Become a Risk-Assuming Carrier

- A. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.
- B. The commissioner shall consider the following factors in evaluating an application filed under Subsection A:
 - (1) The carrier's financial condition;
 - (2) The carrier's history of rating and underwriting small employer groups;
 - (3) The carrier's commitment to market fairly to all small employers in the state or its established geographic service area, as applicable; and

- (4) The carrier's experience with managing the risk of small employer groups.
- C. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the commissioner, the carrier may request a hearing.
- D. The commissioner may rescind the approval granted to a risk-assuming carrier under this section if the commissioner finds that:
 - (1) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with Section 9 of this Act without the protection afforded by the program;
 - (2) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or
 - (3) The carrier has failed to provide coverage to eligible small employers as required in Section 7 of this Act.
- E. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of Section 12 of this Act.

Drafting Note: States should consider establishing special rules for carriers whose charter and bylaws place limits on the types or kinds of individuals that can be insured by the carrier. Such carriers should be permitted to operate as risk-assuming carriers, provided that they accept all eligible small employers, regardless of the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents, that would be eligible for coverage pursuant to the charter and bylaws of the carrier.

Drafting Note: Delete this section if participation in the reinsurance program is mandatory.

Section 11. Prohibited Activities

The commissioner may by regulation prescribe standards for determining whether a policy issued as a stop loss policy is a health benefit plan for the purposes of this Act.

Section 12. Small Employer Carrier Reinsurance Program

- A. A reinsuring carrier shall be subject to the provisions of this section.

Drafting Note: Delete Subsection A if participation in the reinsurance program is mandatory.

- B. There is hereby created a nonprofit entity to be known as the [insert name of state] Small Employer Health Reinsurance Program.
- C.
 - (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of Paragraph (2), the board shall consist of [eight] members appointed by the commissioner plus the commissioner or his or her designated representative, who shall serve as an ex officio member of the board.
 - (2)
 - (a) In selecting the members of the board, the commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the commissioner. At least five (5) members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the commissioner.

Drafting Note: The commissioner should consider the appropriateness of appointing risk-assuming carriers to the board of the reinsurance program. The potential for conflict of interest as well as the type and scope of powers given to the board should be considered.

- (b) In the event that the program becomes eligible for additional financing pursuant to Subsection L(4), the board shall be expanded to include two (2) additional members who shall be appointed by the commissioner. In selecting the additional members of the board, the commissioner shall choose individuals who represent [include reference to representatives of sources for additional financing identified in Subsection L(4)(d)(ii)]. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing under Subsection L(4).
 - (3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.
 - (4) A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.
- D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.
- E. Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the commissioner.
- F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.
- G. The plan of operation shall:
- (1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;
 - (2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;
 - (3) Establish procedures for reinsuring risks in accordance with the provisions of this section;
 - (4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;
 - (5) Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers through capitation or salary; and
 - (6) Provide for any additional matters necessary for the implementation and administration of the program.
- H. (1) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals.

- (2) In addition to Paragraph (1), the program shall have the specific authority to:
- (a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;
 - (b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;
 - (c) Take any legal action necessary to avoid the payment of improper claims against the program;
 - (d) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act;
 - (e) Establish rules, conditions and procedures for reinsuring risks under the program;
 - (f) Establish actuarial functions as appropriate for the operation of the program;
 - (g) Assess reinsuring carriers in accordance with the provisions of Subsection L, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;
 - (h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and
 - (i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

I. A reinsuring carrier may reinsure with the program as provided for in this subsection:

- (1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.
- (2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.
- (3) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.
- (4) (a) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next \$50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carriers' liability under this subparagraph shall not exceed a maximum limit of \$10,000 in any one calendar year with respect to any reinsured individual.

- (b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the “Consumer Price Index for All Urban Consumers” of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the commissioner approves a lower adjustment factor.
- (5) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.
- [(6) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in Paragraph (4), shall be reduced to reflect that portion of the risk above the amount set forth in Paragraph (4) that may not be ceded to the program, if any.]

Drafting Note: Federal law prohibits federally-qualified health maintenance organizations from reinsuring the first \$5,000 of covered benefits. States that adopt an initial retention level of less than \$5,000 under Paragraph (4) should include the above language.

- (7) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.
- J.
- (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in Paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan (adjusted to reflect retention levels required under this Act).
 - (2) Premiums for the program shall be as follows:
 - (a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this paragraph.
 - (b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph.
 - (3) The board periodically shall review the methodology established under Paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.
 - (4) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.
- K. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 5 of this Act.

- L. (1) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.
- (2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.
- (3) (a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers.
- (b) The assessment formula shall be based on:
- (i) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and
- (ii) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.
- (c) The formula established pursuant to Subparagraph (b) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150 percent of an amount which is based on the proportion of (i) the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (ii) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.
- (d) The board may, with approval of the commissioner, change the assessment formula established pursuant to Subparagraph (b) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.
- (e) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations, which are federally qualified under 42 U.S.C. Sec. 300, *et seq.*, to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.
- (4) (a) Prior to March 1 of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.
- (b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in Subparagraph (c), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety (90) days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.
- (c) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

- (d) (i) If assessments in each of two (2) consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Item (ii).
- (ii) The additional funding provided for in Item (i) shall be obtained from [the state should specify one or more sources of additional revenue to fund the program. States may wish to consider the alternative revenue sources provided in the NAIC Model Health Plan for Uninsurable Individuals Model Act]. The amount of additional financing to be provided to the program shall be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five percent (5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two (2) previous calendar years pursuant to this subparagraph, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose of the calculation in the previous sentence.
- (iii) Additional financing received by the program pursuant to this subparagraph shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two (2) calendar years.

Drafting Note: The purpose of the 5% limitation is to prevent the program from placing too heavy of a burden on the small employer marketplace.

- (5) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, “future losses” includes reserves for incurred but not reported claims.
 - (6) Each reinsuring carrier’s proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.
 - (7) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.
 - (8) A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.
- M. Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.
 - N. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.
 - O. The program shall be exempt from any and all taxes.

Section 13. Health Benefit Plan Committee

- A. The [commissioner or governor] shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, small employers and employees, health care providers and producers.

Drafting Note: A state may wish to add a representative of third-party administrators to the committee membership.

- B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Section 7 of this Act.
- C. (1) The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan.
- (2) The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.
- (3) The plans recommended by the committee may include cost containment features such as:
- (a) Utilization review of health care services, including review of medical necessity of hospital and physician services;
 - (b) Case management;
 - (c) Selective contracting with hospitals, physicians and other health care providers;
 - (d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and
 - (e) Other managed care provisions.
- (4) The committee shall submit the health benefit plans described in Paragraph (3) to the commissioner for approval within 180 days after the appointment of the committee.

Section 14. Periodic Market Evaluation

The board, in consultation with members of the committee, shall study and report at least every three (3) years to the commissioner on the effectiveness of this Act. The report shall analyze the effectiveness of the Act in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group health insurance marketplace. The report shall address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the Act. The report may contain recommendations for market conduct or other regulatory standards or action.

Section 15. Waiver of Certain State Laws

No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to this Act.

Drafting Note: States should carefully examine how broadly or narrowly they allow the mandate preemption to apply. Specifically, several mandates (e.g., newborn coverage, adoptive children coverage, and conversion requirements) may reinforce the goals of access and continuity of coverage and hence should be maintained. States that have overly burdensome benefit mandates may want to consider their exclusion from other health benefit plans.

Section 16. Administrative Procedures

The commissioner shall issue regulations in accordance with [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable] for the implementation and administration of the Small Employer Health Coverage Reform Act.

Section 17. Standards to Assure Fair Marketing

- A. Subject to Section 7A(1) of this Act, each small employer carrier shall actively market all health benefit plans sold by the carrier to eligible small employers in the state.
- B. (1) Except as provided in Paragraph (2), no small employer carrier or producer shall, directly or indirectly, engage in the following activities:
 - (a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the any health status-related factor, industry, occupation or geographic location of the small employer;
 - (b) Encouraging or directing small employers to seek coverage from another carrier because of the any health status-related factor, industry, occupation or geographic location of the small employer.
- (2) The provisions of Paragraph (1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.
- C. (1) Except as provided in Paragraph (2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of any initial or renewal health status-related factor, industry, occupation or geographic location of the small employer.
- (2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of any health status-related factor, industry, occupation or geographic area of the small employer.
- D. No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to any initial or renewal health status-related factor, occupation or geographic location of the small employers placed by the producer with the small employer carrier.
- E. A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee or dependent from health coverage or benefits provided in connection with the employee's employment.
- F. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.
- G. The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.
- H. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

- (2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Section 18. Separability

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

Section 19. Restoration of Terminated Coverage

The commissioner may promulgate regulations to require small employer carriers, as a condition of transacting business with small employers in this state after the effective date of this Act, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after [insert date 6 months prior to the date of enactment]. The commissioner may prescribe such terms for the reissue of coverage as the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

Section 20. Risk Adjustment Mechanism

The commissioner may establish a payment mechanism to adjust for the amount of risk covered by each small employer carrier. The commissioner may appoint an advisory committee composed of individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.

Drafting Note: Upon satisfactory development of a risk adjustment mechanism, states should consider phasing out the use of the reinsurance pool established in Section 12 of this Act.

Section 21. Effective Date

The Act shall be effective on [insert date].

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

1992 Proc. 186, 94-95, 912-913, 921, 937-951 (adopted).
1993 Proc. 18, 136, 819, 909, 912-914 (amended).
1994 Proc. 4th Quarter 17, 30, 763, 835-849 (amended and most of model reprinted).
2000 Proc. 3rd Quarter 13, 14, 163, 200, 235-257 (amended and reprinted).
2007 Proc. 1st Quarter 127-149 (amended).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. ADMIN. CODE r. 482-1-116 (1997/2001); BULLETIN 4-17-2014 (2014).
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-2301 to 20-2352 (1993/2009).
Arkansas		ARK. CODE ANN. §§ 23-86-201 to 23-86-209 (1991/1997).
California		CAL. INS. CODE §§ 10700 to 10749 (1992/2010); §§ 10760 to 10764 (2004); BULLETIN 93-3A (1993).
Colorado	COLO. REV. STAT. §§ 10-16-105 to 10-16-108.5 (1992/2013) (portions of model).	B-4.65 (2013).
Connecticut		CONN. GEN. STAT. §§ 38a-564 to 38a-573 (1990/2014); BULLETIN HC-88 (2011); BULLETIN HC-90 (2012).
Delaware	DEL. CODE ANN. tit. 18, §§ 7201 to 7218 (1993/2013).	
District of Columbia		D.C. CODE § 31-4712 (2011).
Florida	FLA. STAT. § 627.6699 (1992/2015).	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Georgia		GA. CODE ANN. § 33-30-12 (1990/1997); §§ 33-59-1 to 33-59-6 (2005) (May offer plans with limited mandated benefits); GA. COMP. R. & REGS. 120-2-10-.12 (1990/2009); GA. CODE ANN; Directive 12-EX-1 (2012).
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho	IDAHO CODE ANN. §§ 41-4701 to 41-4718 (1993/2004).	
Illinois		215 ILL. COMP. STAT. 93/1 to 93/99 (2000); ILL. ADMIN. CODE tit. 50, §§ 5101.10 to 5101.60 (2000).
Indiana		IND. CODE §§ 27-8-15-1 to 27-8-15-26 (1992); §§ 27-8-15.5-1 to 27-8-15.5-30 (1996).
Iowa	IOWA CODE §§ 513B.1 to 513B.18 (1991/2011).	
Kansas	KAN. STAT. ANN. §§ 2209b to 2209p (1992/2000).	
Kentucky	NO CURRENT ACTIVITY	
Louisiana		LA. REV. STAT. ANN. §§ 22:228.1 to 22:228.6 (1991/2004); LA. ADMIN. CODE tit. 37, §§ XIII.2901 to XIII.2909 (Regulation 52) (1994).
Maine		ME. REV. STAT. ANN. tit. 24-A , § 2808-B (1991/2012); BULLETIN 221 (1993).
Maryland		MD. CODE ANN., INS. §§ 15-1201 to 15-1225 (1994/2014); BULLETIN 2009-26 (2009).
Massachusetts		MASS. GEN. LAWS ch. 176J, §§ 1 to 16 (1991/2013).
Michigan		MICH. COMP. LAWS §§ 500.3701 to 500:3723 (2003).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Minnesota		MINN. STAT. §§ 62L.01 to 62L.22 (1992/2013); § 62L.056 (2005) (Basic plan for small groups).
Mississippi		MISS. CODE ANN. §§ 83-63-1 to 83-63-11 (1994/1997).
Missouri	MO. REV. STAT. §§ 379.930 to 379.952 (1992/1995).	
Montana	MONT. CODE ANN. §§ 33-22-1801 to 33-22-1822 (1993/2013).	
Nebraska	NEB. REV. STAT. §§ 44-5223 to 44-5267 (1995/2009).	
Nevada		NEV. REV. STAT. §§ 689C.015 to 689C.355 (1995/2006).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-G:1 to 420-G:16 (1998/2013); §§ 420-K:1 to 420-K:7 (2005).
New Jersey		N.J. STAT. ANN. §§ 17B:27A-17 to 17B:27A-46 (1992/2005); BULLETIN 6-1-2010 (2010).
New Mexico		N.M. STAT. ANN. §§ 59A-23C-1 to 59A-23C-9 (1991/1997).
New York		N.Y. INS. LAW §§ 3231 to 3233 (1992/2013); §§ 4317 to 4318 (1992/2006); N.Y. COMP. CODES R. & REGS. tit. 11, § 52.40 (Regulation 62) (1991/1997).
North Carolina		N.C. GEN. STAT. §§ 58-50-100 to 58-50-150 (1991/2013).
North Dakota	N.D. CENT. CODE §§ 26.1-36.3-01 to 26.1-36.3-12 (1993/2013).	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 3924.01 to 3924.14 (1993/1998); portions suspended 1-1-2014 thru 1-1-2018 – see S.B. 9 (2013)).
Oklahoma	OKLA. STAT. tit. 36, §§ 6511 to 6529 (1992/2013).	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Oregon		OR. REV. STAT. §§ 743.730 to 743.745 (1992/2013).
Pennsylvania	NO CURRENT ACTIVITY	
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island	R.I. GEN. LAWS §§ 27-50-1 to 27-50-16 (2000/2009) (portions of model).	
South Carolina	S.C. CODE ANN. §§ 38-71-910 to 38-71-990 (1992/1997).	BULLETIN 11-2011 (2011).
South Dakota	S.D. CODIFIED LAWS §§ 58-18B-1 to 58-18B-57 (1992/2013).	BULLETIN 2011-7 (2011).
Tennessee	TENN. CODE ANN. §§ 56-7-2201 to 56-7-2221 (1992/1996).	
Texas		TEX. INS. CODE ANN. §§ 26.01 to 26.78 (1993/2012).
Utah		UTAH CODE ANN. §§ 31A-30-101 to 31A-30-112 (1994/2014).
Vermont		VT. STAT. ANN. tit. 8, § 4080a (1991/1997); INS ORDER 3-13-2013 (DOCKET 13-002-I) (2013).
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		VA. CODE ANN. §§ 38.2-3430 to 38.2-3437 (1992/2013).
Washington		WASH. REV. CODE ANN. § 48.21.045 (1990/2004) (Group); §§ 48.44.023 to 48.44.024 (1990/2004) (Health care services); §§ 48.46.066 to 48.46.068 (1990/2004) (HMOs).
West Virginia		W. VA. CODE §§ 33-16D-1 to 33-16D-16 (1991/2004).
Wisconsin		WIS. STAT. §§ 635.01 to 635.31 (1991/2013).
Wyoming	WYO. STAT. ANN. §§ 26-19-301 to 26-19-310 (1992/2003).	

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Proceedings Citations

Cited to the Proceedings of the NAIC

As a drafting committee began its deliberations, the working group chair reviewed the scope of the problem. He stated that some 30 to 31 million people were uninsured, with about two-thirds having an employment connection. Most worked for small employers. One survey indicated that about 14 percent of employers without coverage stated they could not get insurance because the group was uninsurable. The chair cautioned the drafting group not to lose sight of the problem of health care costs; in another survey of small employers, 83 percent of those who did not offer insurance said the reason was cost. He underscored that as regulators try to “fix” problems to promote more coverage availability, costs will probably go up. **1991 Proc. IB 644-645.**

One regulator asked why all the options being considered were based solely on private market options. The working group chair responded that NAIC models are generally limited to subjects that are within the purview of state insurance departments. **1991 Proc. IIB 744.**

By mid-1991 the working group had prepared two exposure drafts to address small employer health coverage reform. The two availability approaches were prospective reinsurance and allocation. All commissioners, superintendents, and directors were encouraged to comment on the drafts. One regulator asked whether the working group would select one of the drafts as its final product, and was told that the current consensus was that both models would likely be recommended for adoption so that states might choose the approach that would best accommodate their needs. **1991 Proc. IIB 717.**

At the time the two health care access models were adopted, the working group prepared a report for the Accident and Health Insurance (B) Committee that summarized some of the problems existing in financing health care for Americans, and detailing some of the areas where state insurance laws on small group coverage could and could not help. **1992 Proc. IB 951-953.**

The two models were the result of a concerted effort by dozens of experts within the regulatory community and the industry, with substantial comments and input having been sought from the consumer, small business, business producer and health care provider communities. These reform models sailed on largely uncharted waters. The proposed solutions, while theoretically sound, were just now being implemented. Many questions as to interpretations and applications remained. While not precisely measurable, it should be recognized that the rating reform component of both models would have a noticeable cost redistribution effect. The result is that a larger amount of small employer groups could see some rate increases than those who could see decreases. In addition, the guaranteed issue component was anticipated to have an additional cost impact on small groups. **1992 Proc. IB 952-953.**

In 1993 federal efforts in health care reform resulted in the formation of an NAIC working group to develop standards for health insurance purchasing groups. The group drafting this model recognized that before its implementation, changes to the small employer health insurance model would be needed. **1993 Proc. 4th Quarter 726, 743-745.**

In March 2004, the NAIC voted to delete the model with the allocation approach from the official set of NAIC *Model Laws, Regulations and Guidelines*. Only one state had adopted it and the NAIC no longer supported the model and its class of business provisions. **2003 Proc. 4th Quarter 508.**

Section 1. Short Title

Section 2. Purpose

Interested parties suggested a number of approaches to the problem of small employer health insurance availability. They described prospective reinsurance with opt-out in a report to the working group. All carriers writing coverage in the small employer market would be required to accept all small employers applying for coverage, regardless of the health condition of their employees. Therefore, carriers could not use medical underwriting to deny coverage. Carriers would be required to offer every small employer at least a basic health care plan and standard health care plan. Both benefit plans would be free of state mandated benefits. A committee appointed by the commissioner would develop the basic and standard plans, subject to

Section 2 (cont.)

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the approval of the commissioner. Small employers would either assume the full risk of covering high-risk individuals and small employers on their own or participate in a voluntary reinsurance program that would permit carriers to reinsure those high risks. Carriers utilizing the reinsurance program would continue to be responsible for providing a full range of services to all of their small employers, regardless of whether carriers had purchased reinsurance. **1991 Proc. IB 643.**

Under the interested parties' suggestion small employers could elect, subject to the approval of the commissioner, to assume the full risk of covering high-risk individuals and small employers by not participating in the reinsurance program. Carriers electing not to participate in the program would be required to meet the same rating and underwriting rules and would be required to guarantee the issuance of coverage to all small employers. However, these carriers would not be required to pay assessments for any losses of the reinsurance program. The model draft provided for the prospective ceding of high-risk individuals and small employers to the reinsurance mechanism. Carriers would be required to retain ten percent of the risk of each case ceded, up to a \$10,000 annual per person limit. The reinsurance pool losses would be spread across small employer carriers participating in the reinsurance program. **1991 Proc. IB 643.**

While drafting revisions in 1994, some regulators expressed an interest in expanding the model to include individual policies. One opined that many non-group carriers had attempted to game the reform effort by segmenting small employers into individual policies. **1994 Proc. 3rd Quarter 685.**

The intent of the model act was to prohibit further market segmentation and to spread risk as much as possible over the small market community pool. Explicit language to that effect was added to the model as part of the 1995 amendments. **1994 Proc. 4th Quarter 827.**

During a period set aside for open comment on the working group's consideration of including nongroup coverages within the model, industry personnel commented that the group and nongroup markets should remain segregated because of the affect of "dumping" all high risk individuals on to the individual market and the potential for enormous rate hikes in so doing. Regulators commented that, if individuals were included in small groups, it was implicit that high risk individuals' costs would be borne by the individual and small group market. The question was how to broaden and still further market reform and enhance small group reform. **1994 Proc. 4th Quarter 831.**

After hearing discussions on the issue of including individuals in the model, the working group voted not to include "true individuals" in the draft, but to include self-employed individuals. The working group indicated a desire to include high-risk individuals and requested appointment of another group to study that issue. **1994 Proc. 4th Quarter 831-832.**

A drafting note was added after the purpose and intent section to emphasize the NAIC's intent to continue forward with the issue of individual market reform. Regulators discussed whether the drafting note prejudged the product of the working group, but the motioner clarified that her intent was that the working group consider amending the act, but the question was open and the working group could determine the most appropriate vehicle to achieve individual market reform. **1994 Proc. 4th Quarter 832.**

When the 1995 amendments were before the Executive Committee, several members expressed concern about the position in favor of pure community rating. Another regulator suggested deletion of a sentence at the end of the Section 2 drafting note which read: "The NAIC is committed to developing model language to assure that all persons can have guaranteed issue coverage at comparable rates for the same coverage, while ensuring that those rates are neither inadequate, excessive or unfairly discriminatory." He said the sentence was not necessary or warranted. The section and drafting note were revised in accordance with the suggestions. **1994 Proc. 4th Quarter 29-30.**

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Section 3. Definitions

B. This definition was added in 1995. At the first drafting session it was suggested that a drafting note be included for states that wanted to go even further and move to pure community rating. **1994 Proc. 2nd Quarter 673.**

C. Just before adoption of the model a definition of “affiliate” or “affiliated” was added for the purpose of applying proposed provisions on affiliated carriers and ceding arrangements in Section 4. The new term was defined in a manner consistent with the definition in the Unfair Trade Practices Act. **1992 Proc. IB 918.**

D. This definition was added while the task force addressed a charge to update the model to conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **2000 Proc. 2nd Quarter 219.**

E. When drafting amendments to the model in 1994, the proposal was made to delete any reference in the model to a basic health benefit plan, as “bare bones” plans had not proved popular. The chair pointed out that the model called for development of a basic and standard plan but did not necessarily require the basic plan to be a “bare bones” package. **1994 Proc. 3rd Quarter 654.**

G. The working group decided to amend the definition of carrier to include those entities that may be licensed outside the Insurance Department. **1994 Proc. 3rd Quarter 654.**

The last part of the second drafting note, concerning associations, was added with the amendments adopted in 1995. **1994 Proc. 4th Quarter 832.**

The definition of carrier was intended to cover entities that should be licensed but were not. **1994 Proc. 4th Quarter 832.**

The drafting note at the end of Subsection G was added while HIPAA amendments were being drafted. **2000 Proc. 2nd Quarter 220.**

H. The definition of church plan was added along with other amendments designed to address HIPAA issues. **2000 Proc. 2nd Quarter 220.**

K. The chair asked if the definition of “control” of subsidiaries was sufficiently broad to include physician/hospital organizations and newer managed care organizations being formed. The group agreed the definition was sufficiently broad to include those entities. **1994 Proc. 3rd Quarter 654.**

L. The definition of creditable coverage was added with other amendments in response to HIPAA. **2000 Proc. 2nd Quarter 220-221.**

M. Industry representatives had several concerns about the definition of dependent found in the model draft. They believed that the provision which would permit health benefit plans to expand the definition to include “other persons” would expose the program to additional risk. It was also suggested that the definition was inconsistent with current industry practice. A commissioner expressed concern that the definition might be inconsistent with definitions of the term in current state laws. The working group decided to delete the definition and substitute a reference to state law definitions; but to include the draft definition, with slight modifications, as a drafting note to assist states that have not defined the term in their statutes. **1992 Proc. IB 916.**

When drafting the 1995 amendments, the working group considered whether to include within the definition a person economically dependent on the enrollee. It was noted that many people took care of children without being legal guardians, and obtaining health insurance for the economically dependent person was sometimes impossible. The last sentence of the drafting note was added to explain that “child” means any child, not just a natural child. **1994 Proc. 4th Quarter 827.**

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Section 3 (cont.)

N. The chair suggested amending the model to reduce the number of hours worked for an employee to be considered eligible from full time to 24 hours per week. Another regulator expressed the opinion that this might have an adverse impact on participation if an insurer was allowed to require 100 percent participation of people working 24 hours. He suggested that people who worked 24 hours be eligible for coverage but excluded from mandatory participation requirements. **1994 Proc. 3rd Quarter 687.**

At the group's next meeting the definition was revised further to clarify the status of persons covered under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). **1994 Proc. 3rd Quarter 654.**

One regulator suggested adding an amendment to specifically exclude seasonal employees from the definition. The working group decided on a close vote not to include specific language to address seasonal workers. **1994 Proc. 4th Quarter 833.**

The drafters discussed the 1995 amendments to this definition extensively. A long discussion was held on the number of hours to include, and whether people would game the system no matter what hour limit was set. One regulator suggested companies might legitimately want to offer coverage only to management employees, because they could not afford to pay whatever percentage of premiums was set for all of its hourly employees. One regulator asked whether the regulators were saying that, if an employer wanted the advantage of small group reform, that employer would have to offer insurance to all employees who worked a certain number of hours. An audience member said the rules must be clear because when an agent sat down with a small employer, the agent must explain the rules to the employer. He also said that, in the past, employers had changed personnel from full-time to part-time status because of the small group law. One regulator suggested separate participation requirements for full-time and part-time employees. This suggestion was adopted and the number of hours for coverage was set at 17.5 hours. **1994 Proc. 4th Quarter 827-828.**

While preparing amendments in response to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the task force decided to add a substantive provision to address HIPAA's nondiscrimination provisions. The phrase "without regard to any health status-related factor" was added. **1999 Proc. 2nd Quarter.**

Q. This definition was added as part of the amendments developed during 1994. One participant suggested inserting broader wording by adding immediately following "spouse" wherever it appeared in the model, "or additional adult." The motion failed, but the working group agreed to add a drafting note suggesting states might want to add that language. **1994 Proc. 3rd Quarter 654.**

R. A trade association recommended that this definition be deleted for two reasons. First, the term "genetic information" was not defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It was only defined in the interim rules. Second, because the term was defined only in the interim rules, it might be altered when the final rules were issued. The chair suggested the definition be retained, but that a drafting note be added to alert states that, prior to adopting this definition, a state should review the final HIPAA rules to ensure that it is adopting the correct definition. The task force agreed to that suggestion. **1999 Proc. 3rd Quarter 881.**

S. A definition of geographic area was added in 1995. It was necessitated by a change to Section 5F that gave the commissioner authority to prescribe the manner in which geographic territories were designated by small employer carriers. **1994 Proc. 3rd Quarter 654.**

T. The definition of government plan was added with other amendments in response to HIPAA. **2000 Proc. 2nd Quarter 222.**

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Section 3 (cont.)

U. When the task force began discussing issues related to implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), concern was raised that the definition of group health plans was tied to employment, and there were many health plans that were considered group health plans by the state that were not employer based. Under HIPAA, non-employer based health plans must be considered individual plans. **1998 Proc. 4th Quarter II 717.**

V. Paragraph (6) was added in December 1992 to exempt specified disease, hospital confinement indemnity and limited benefit health insurance plans from the model act as long as the insurer filed an annual certification which (1) stated that the policies and certificates were being sold as supplemental coverage and not as substitutes for comprehensive coverage, and (2) contained a brief description of the benefits provided by the policies and certificates, including their annual premiums. **1993 Proc. IB 911, 913-914.**

A number of insurers had pointed out the problems that would be faced if these policies were not excluded. The working group was concerned about the dangers of limited benefit plans being sold as substitutes for health insurance coverage to circumvent the model reforms. It was suggested that the certification process would assure that the exclusion was limited to plans sold as supplements. **1993 Proc. IB 922-923.**

As amendments to the model were being developed in 1994, the working group considered making specified disease and hospital indemnity plans guaranteed issue and subject to the act. An industry representative opined that forcing carriers into the medical expense market was something they were not equipped to deal with. Later they withdrew the decision in anticipation that it would be more fully discussed in the future. **1994 Proc. 4th Quarter 830.**

While developing amendments in 1999 in response to the Health Insurance Portability and Accountability Act (HIPAA), the task force added Paragraphs (2), (3), (4) and (5) and revised the drafting note after Paragraph (5). Staff asked whether, given the extensive “expected benefits” language added to this definition in response to HIPAA, the language in the drafting note was still appropriate. The task force decided to revise the drafting note to recommend that states examine this definition closely before adopting any additional exemptions. **1999 Proc. 3rd Quarter 881-882.**

W. The definition of health maintenance organization was adopted while amendments were being developed to address issues related to HIPAA. **2000 Proc. 2nd Quarter 223.**

X. The definition of health status-related factor was added when amendments were developed in response to HIPAA. **2000 Proc. 2nd Quarter 223-224.**

Y. In 1995 the definition of late enrollee was modified for persons who lose employer contribution and elect to choose a different health plan. **1994 Proc. 3rd Quarter 654.**

Z. When considering the 1995 amendments, a regulator noted that “limited benefit plan” was not defined anywhere in the model, and it needed to be. An appropriate definition was added. **1994 Proc. 4th Quarter 832.**

AA. Numerous new definitions were added as required by new text added in response to HIPAA. **2000 Proc. 2nd Quarter 224.**

OO. One regulator stated that the model should be amended to include a definition of a self-employed individual. She suggested the definition in use in her state, which required a tax return as proof of employment. The working group agreed to use the suggested definition. **1994 Proc. 3rd Quarter 687.**

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Section 3 (cont.)

Later a consumer representative expressed concern that the definition required taxable income, and many individuals starting a small business did not necessarily have taxable income. The working group agreed to modify the definition to reflect their intent that the self employed individual was in the business with the intent of making money (as opposed to a tax write-off). **1994 Proc. 4th Quarter 834.**

PP. The Model Health Plan for Uninsurable Individuals Act followed the HIPAA 63-day break in creditable coverage minimum standard for the purposes of determining whether an individual has had a significant break in coverage. The draft amendments to some other models provided for a 90-day break in creditable coverage. The task force members did not change this. **1999 Proc. 3rd Quarter 906.**

QQ. One regulator questioned whether the limitations should only apply to groups of 25 employees or fewer. He stated that he had seen some fairly severe underwriting for 25 to 50 employee groups, and asked if a prohibition on underwriting should be added to the model for groups of more than 25 employees. The advisory committee chair responded that he was not aware of significant problems in the more than 25 employee group market, but that the advisory committee would look at the issue if requested. **1991 Proc. IB 639.**

Under the Health Insurance Portability and Accountability Act (HIPAA), the definition of small employer was different than that in the model act. It was one regulator's opinion that the federal definition should be used throughout the model. **1999 Proc. 1st Quarter 543.**

Later the same regulator expressed concern that the definition would be subject to manipulation. Also, if the task force deleted the former NAIC definition, it lost the ability of the employer to include part-time workers within the scope of the definition since the model provided that an eligible employee could include workers with a normal work week of 30 hours or more. The task force determined that both definitions should be retained in the model and that, if a small employer met either definitions, that employer was a small employer for purposes of the model. **1999 Proc. 2nd Quarter 559-560.**

Discussion continued on the appropriate definition of small employer. For a time the task force considered two alternative definitions: the one already existing in the small employer models and the HIPAA definition. The chair explained that the problem with the model act definition was that it excluded part-time employees. Part-time employees would be counted under the HIPAA definition. Therefore, an employer that had ten part-time employees was entitled to HIPAA's guaranteed renewability of coverage under the HIPAA definition. However, if the state law provided for counting only full-time employees, this employer would be considered to have no employees and would be denied HIPAA protections. **1999 Proc. 4th Quarter 941.**

The chair suggested that the definition be redrafted in a manner that would give the employer the best opportunity to benefit from HIPAA protections. The task force agreed with this approach. **1999 Proc. 4th Quarter 941.**

At its next meeting the group agreed to add Paragraph (2) so that an employer will be deemed to be a small employer regardless of the way the state has defined the term "eligible employer" whenever the employer has a combination of no more than 50 eligible employees and part-time employees. **2000 Proc. 1st Quarter 167-168.**

Section 4. Applicability and Scope

D. Subsection D was added as part of the 1995 amendments. This subsection stated that the Act applied to any health benefit plan when it was marketed to individual employees through an employer or at a place of business. One regulator said her state's law contained this provision and she thought it was very important. She said that if an individual was self employed—a group of one—he could go to a guaranteed issue small group reform environment when the person got sick. The chair expressed the opinion that the issue of a payroll deduction method of billing was also at issue. **1994 Proc. 4th Quarter 833.**

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Section 4 (cont.)

E. Shortly before the model was adopted, provisions were added relating to affiliate carrier and ceding arrangements. The provisions provided that affiliated carriers would be treated as one carrier for the purpose of the model, with an exception for affiliate carriers that were health maintenance organizations. The provisions also prohibited the ceding of more than 50 percent of the insurance obligations or risk for small employer health benefit plans without prior approval of the commissioner. **1992 Proc. IB 919.**

Section 5. Restrictions Related to Premium Rates

The provisions related to premium rates were first drafted for the Premium Rates And Renewability Of Coverage For Health Insurance Sold To Small Groups, which has since been deleted from the list of model laws. That discussion is recorded here.

The working group appointed to study the issue decided to focus on small group rating practices. The chair of the working group noted that very few states regulate rating practices for group insurance. One regulator commented that several states had limited or were considering limitations on tiered or durational rating. **1990 Proc. IB 504.**

Interested parties suggested rating limits in a report they prepared for the working group. **1990 Proc. IB 486-503.** These limits would require an ultimate relationship between the highest premium rate a company could offer on its entire book of business of no more than a 2.5:1 ratio compared to its lowest new business rate. Additionally there could be no more than a maximum annual premium rate increase of 35 percent plus trend (largely medical care cost inflation). **1990 Proc. IB 483.**

One regulator expressed a concern that rate change restrictions would tighten up the market too much for small employers, and noted the necessity of determining whether the private insurance system could maintain market availability with fairly tough restrictions. **1990 Proc. IB 484.**

A group of interested parties was charged with investigation of abusive rating practices, including the initial underpricing of rates. They suggested a three tier approach to restricting small group health rating practices: a) the average rate for any class (*i.e.* block of business) cannot vary by more than 20 percent from the average rate of any other class; b) the rates for groups within a class cannot be more than 30 percent above or below the average rate of the class; and c) the annual rate increase for any group within the class cannot be more than the increase in the new business rate for that class plus 15 percent. **1990 Proc. I 602-603.**

A specific exemption from the first rating restriction in the model was included for certain types of business that were not medically underwritten. This language implemented strong public policy considerations that favored the maintenance and development of this type of business for the small group market. In order to qualify for this specific exemption to the first rating restriction, the insurer could not have used health status or claims history to determine eligibility for groups or for individuals within a group. Reasonable antiselection protections were permitted, including the underwriting of late entrants and the use of minimum participation requirements. Additionally, groups and individuals could not be involuntarily moved from medically underwritten to the non-underwritten business. **1990 Proc. II 610.**

A question arose concerning the 15 percent cap on the portion of yearly rate increases that could reflect the group's claim experience or duration. One regulator asked if this could be given to all groups or become automatic. Another regulator responded that such a strategy would make the insurer non-competitive. **1991 Proc. IB 638.**

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Section 5 (cont.)

Representatives from a trade association commenting on the draft suggested the addition of a drafting note to Subsection A: this subsection exempted certain voluntary guaranteed issue insurers from rating restrictions that limited the range between the index rates in any two classes of business to 20 percent. Insurers that had a medically underwritten class of business and a currently available class of business that did not reject applicants based on claims experience or health status may be unable to stay within that range due to the higher claims costs associated with the poor risks admitted to the latter class of business. They suggested that regulators should review this subsection to ensure the exemption was broad enough to preserve current marketplace accessibility. The association felt a number of states would want to include this provision and a drafting note would emphasize the point. The working group decided the drafting note was unnecessary. **1991 Proc. IB 629, 633.**

An insurer representative asked about the trend factor permitted on closed classes of business. He expressed the position that the trend should be the change in the rate for the lowest rate rather than the trend for the most similar open class of business. He stated that fears about insurers closing classes and transferring only healthy groups out of the class were addressed by the provisions limiting transfers between classes. The working group agreed to accept this revision. **1991 Proc. IB 638.**

One regulator pointed out that the overall effect of these provisions would be higher premiums for many insured individuals. Community rating or rating bands necessarily would increase rates for some. However, groups have seen large increases or even loss of coverage resulting when group members suffered serious illness. These approaches would result in increased product availability and more stability and predictability in product pricing. **1991 Proc. IB 639.**

A report from the interested parties pointed out that many of the problems of affordability of health insurance for small employers were due to problems outside the purview of the committee. Some reasons for the high cost of small employer health care identified by the advisory committee were: limits on Medicaid eligibility that left many individuals and families with incomes below the poverty level without coverage; Medicare and Medicaid reimbursement levels that fell below the actual costs of care and result in uncompensated care; practice patterns of some providers; legislation that restricted the ability to manage care; and costs associated with excess capital expansion, medical malpractice and new technologies. The draft model did incorporate a cost-reducing concept already adopted by a number of states; that is, exemption of small employer coverage from state mandated benefit and provider laws. Such measures would allow insurers to develop lower cost benefit packages for small employers. **1991 Proc. IB 641.**

A. Industry representatives strongly opposed a revision to the draft that would permit the commissioner to establish regulations related to case characteristics. The purpose of the provision was to assist in assuring that carriers were in compliance with the rating bands established by the models. Members of the industry suggested that the language could be used as a “back door” to community rating. A regulator responded that the industry was assuming that a commissioner would act unreasonably, and that the working group had relied on commissioner discretion in several places in the draft model to provide additional flexibility desired by the industry. An alternative might be to list the case characteristics that were commonly accepted as reasonable and to require prior approval if an insurer chose to use additional characteristics. **1992 Proc. IB 916.**

The draft adopted contained a provision to permit the commissioner to establish by regulation the form and manner in which case characteristics were used, including establishing uniform characteristics for the marketplace. The suggested language provided that a small employer carrier could not use case characteristics other than age, gender, industry, geographic area, family composition and group size without prior approval of the commissioner. One regulator suggested that “lifestyle” factors be included to recognize health promotion. The suggested wording was “destructive voluntary behaviors” which would include choosing to smoke or not wear a seat belt, or not taking all possible remedial actions to control weight, blood pressure or cholesterol level. While others agreed with the concept, they were unable to agree upon appropriate wording, so the suggestion was not included in the model. **1992 Proc. IB 917, 919.**

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Section 5A (cont.)

When revisions were being considered for the model, the subject of healthy lifestyle factors came up again. One regulator opined that adjusting for lifestyle factors was a proxy for experience rating. **1994 Proc. 2nd Quarter 683.**

When amending the model to prepare for federal health care reform efforts in 1994, one of the early suggestions was to include some form of adjusted community rating. The drafters considered what type of adjustments should be made and what type of phase-in period would be necessary. After some discussion, the working group agreed to adjust for geographic location and age, but not for gender. The chair observed that premiums would also reflect differences in family composition, but that was more of a contract issue than a rating adjustment mechanism. **1994 Proc. 2nd Quarter 683.**

The chair asked how to specifically adjust for geography. Another regulator suggested a state could adjust by county or for population areas of greater than 250,000 persons. One in attendance asked if the geographic adjustment factor would be implemented by the insurer or the state. The regulators agreed that it should not be left to the insurer because all should play by the same rules, and agreed to a flexible approach by proposing that geographic location could be defined by ZIP codes with the first three digits, but recognized additional factors might be used. **1994 Proc. 2nd Quarter 683.**

The working group discussed how adjustments to the community rate should be made based on age. The chair suggested the same rating methodology should be used inside and outside of an alliance. The working group agreed to divide rating cells based on 30 years and under, with five-year increments between 30 and 65, and age 65 and older. **1994 Proc. 2nd Quarter 683.**

At one point the working group considered a recommendation from the actuarial task force to include gender as a rating factor and to place no limitations with regard to age in community rating. The working group decided not to follow the recommendation. **1994 Proc. 4th Quarter 833.**

Another issue discussed when drafting revisions in 1994 was creation of rate bands to compress the differences in premium prices charged for the highest and lowest cost plans sold in the small group marketplace. The working group tentatively agreed to use a 4:1 ratio. **1994 Proc. 2nd Quarter 683.**

A report prepared by the chair suggested a 3:1 limit for age. In other words, the price difference of the highest benefit package offered to an eligible small employee could not be more than three times the cost of the lowest priced policy with the same benefits based upon age as an adjustment factor. **1994 Proc. 2nd Quarter 676.**

An actuarial subgroup reported that currently the claims costs for age 63 were about eight or nine times higher than for age 23 in the individual market and about six times higher for small groups. The working group decided to set the ratio at 4:1 during the first two years of implementation, for the next three years the ratio be set at 3:1, and that beyond the fifth year of implementation the ratio be set at 2:1. The working group later changed to a 6:1 ratio grading down to a 4:1 ratio, but changed back before the model was adopted. **1994 Proc. 4th Quarter 829.**

One participant suggested that the model should be amended to require disclosure of the medical cost portion of the adjusted community rate and the administrative expense portion of the community rate, thereby enabling consumers to judge the relative value of purchasing through the various distribution methods. **1994 Proc. 3rd Quarter 686.**

One regulator suggested redesigning Section 5A with three alternatives: (1) the modified community rating already agreed upon; (2) pure community rating; and (3) no rating restrictions based on community rating. The working group agreed that these were concepts that needed further discussion and that future efforts in individual market reform would provide the vehicle for more study. **1994 Proc. 4th Quarter 835.**

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Section 5A (cont.)

After the working group had completed its task, the actuarial group expressed concern about the inclusion of groups of one. The concern was that, without individual rate resolution, there was a danger of dumping poorer risks into the one-life group category. Younger, healthier males will go to the current individual forms while the unhealthy become a single group. This is caused by the modified community rating. **1995 Proc. 1st Quarter 818.**

When the revised draft was being considered by the Executive Committee in March of 1995, a number of commissioners expressed concern about the rating section. One said the adjustment of rating for age was excessively restrictive, and suggested the drafters reevaluate the adjustment of rating for age provisions in Section 5. **1994 Proc. 4th Quarter 27.**

Another regulator expressed concern about the community rating provisions. The chair of the health insurance committee responded that the drafting note to Section 5A expressed the concerns of the drafters of the proposed model in that it suggested states monitor the effect on the market of the community rating provisions. She noted that the drafting note provided significant flexibility for states to enact provisions to meet their individual needs. **1994 Proc. 4th Quarter 27.**

Another regulator pointed out the experience in his state. The legislature had recently adopted modified community rating and the compression of rates based on gender. This had caused some insurers to attempt to avoid the effects of the law by going through associations or through ERISA. However, he said, individuals were included in his state's small employer health insurance availability law to prevent insurers from attempting to avoid the effects of the law. He predicted the provisions of Section 5 would cause significant problems in the markets of each state. **1994 Proc. 4th Quarter 27.**

Another commissioner said her state had an 80% deviation in rates and that the problems anticipated by insurers had not materialized. Another commissioner echoed similar experience in her state. **1994 Proc. 4th Quarter 28.**

Another commissioner pointed to the drafting note and its flexibility and said the equivocation reflected in these drafting notes indicated that the work was not complete and needed additional review. Another state regulator opined that NAIC model laws were frequently cited as authoritative sources on the subject matter and he thought the proposed amendments were overreaching. **1994 Proc. 4th Quarter 28.**

The commissioner of another state said he would have preferred a pure community rating law with a shorter phase-in period, but urged adoption of the draft. Another regulator pointed out that many of these same concerns had been raised by the drafters. He thought the NAIC should carefully study the effects of the model law through experience. **1994 Proc. 4th Quarter 28.**

The health insurance committee chair reiterated that the members that had participated in the development of the proposed amendments had carefully considered the issues being raised and had not ignored them or failed to afford due process to those persons and organization raising issues. The proposed amendments represented a compromise among diverse opinions that had been deliberated openly and thoroughly over a year and a half period. **1994 Proc. 4th Quarter 29.**

In adopting model laws, the NAIC essentially set a national standard, opined another commissioner, and said she was not prepared to support this rating standard. Another commissioner did not agree with the request to review and study the draft more before adoption. She suggested the model as a standard provided commissioners with guidelines to review as reforms were proposed. She saw the model as a valuable resource for the state even if some concerns remained. **1994 Proc. 4th Quarter 29.**

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Section 5A (cont.)

Before final adoption of the model by the Plenary, a revised drafting note for Section 5A was crafted. The substitute note clarified that the NAIC was not advocating that the provisions of this model were the only approach to be taken to health care reform. The note also suggested a trigger mechanism for a method for the process to be altered if there were unanticipated effects and recognized that there might be problems with respect to implementation of the limitations in the model act before including individual insurance. **1994 Proc. 4th Quarter 16.**

B. Subsection B was new language adopted in 1995. **1994 Proc. 4th Quarter 842-843.**

D. A change in Subsection D (which had been Paragraph (8)(a)) added language to clarify that rating factors for determining premiums should not be based on assumed differences in selection between health benefit plans. **1992 Proc. IB 919.**

E. Subsection E was revised in December 1992 (while it was designated Subsection A(9)) to correct a drafting error. The term “restricted provider network” was deleted and “restricted network provision,” which was a defined term, was substituted. **1993 Proc. IB 911, 913.**

At one point when drafting the 1995 amendments, this subsection was stricken. The working group decided to reinsert the provision so the good experience of a network could result in lower premiums based on proven efficiencies of that network, but not based on the type of risk attracted to the plan. **1994 Proc. 4th Quarter 830.**

When the model was changed in 1995 to allow the commissioner the authority to prescribe the method in which geographic territories were designated, a drafting note was added to give guidance to states indicating that they should use a geographic region no less than a county or a three digit ZIP code. One consumer representative brought information that indicated that the use of the three digit ZIP code might result in discrimination among minorities and low-income individuals. An association representative said he was concerned with the use of metropolitan statistical service areas because in some locations this encompassed significantly different regions the often results in different claims costs. **1994 Proc. 3rd Quarter 654.**

G. When the 1995 amendments were under development, Paragraph (4) was added to require that all products for which a small employer was eligible must be actively marketed. A representative from an insurance trade association indicated his concern that it would be a problem to be required to do premium projections for all plans. **1994 Proc. 4th Quarter 835.**

I. The language of this subsection and the drafting note following were adopted in 1995. **1994 Proc. 4th Quarter 16.**

Section 6. Renewability of Coverage

Much of this section was discussed as part of the earlier drafting of the Premium Rates And Renewability Of Coverage For Health Insurance Sold To Small Groups which was deleted from the official list of NAIC models. The discussion is included here for reference.

The model law proscribed terminating individuals and small businesses due to poor claims experience. It also imposes certain conditions upon the termination of a block of business. The conditions are designed to make termination of a block difficult and prevent “gaming” the restrictions by terminating blocks. However, if the restrictions on termination were too severe, they significantly increased insurers’ underwriting risks and raised significant solvency issues, particularly for smaller insurers. Interested parties suggested that any further restrictions that limited insurers’ rights to address widespread underwriting problems by terminating business require something like a reinsurance pool. **1990 Proc. II 610.**

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Section 6 (cont.)

The model draft authorized a small employer carrier to cease to renew all plans under a class of business, subject to the limitations on conditions set forth in Subsection B. One commentator on the draft suggested that in the case of an HMO doing business in the small employer market, the limitation should only apply to the service area and not state-wide. The working group decided not to accept the suggestion. Insurers also vary business practices by geographic area, and it would be inequitable to permit HMOs to drop coverage in selected areas. **1991 Proc. IB 629, 632.**

A. The model originally adopted contained a provision allowing nonrenewal in the case of repeated misuse of a provider network provision. One regulator suggested that this could be used as leverage by a carrier against an unwanted enrollee. Another regulator agreed this was a vague provision and the group drafting the amendments adopted in 1995 agreed to delete the provision. **1994 Proc. 4th Quarter 830.**

While drafting amendments in response to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the chair noted that HIPAA grounds for nonrenewal were different from those in the NAIC model in that fraud by an individual enrollee was not grounds for nonrenewal. **1999 Proc. 2nd Quarter 560.**

The task force held extensive discussion about the exceptions to the guaranteed renewability requirements under HIPAA. Numerous changes were made to Subsection A. **1999 Proc. 2nd Quarter 560.**

B. Subsection B was added as part of the HIPAA amendments. **2000 Proc. 2nd Quarter 229.**

C. The advisory committee suggested an approach to the working group where a carrier could only cancel a group by canceling all its small group business. A carrier that did so would be prohibited from reentering the market for five years. **1991 Proc. IB 639.**

While drafting HIPAA amendments, the task force changed Subsection C from “nonrenew” to “discontinue offering” since that was the language HIPAA used. Staff explained that HIPAA was unclear regarding, when a carrier elected to abandon the market entirely, whether a state could require that the carrier service existing contracts or conversely, whether the state could prohibit the carrier from servicing existing contracts and force the carrier to nonrenew those contracts. It was suggested that the NAIC should take the position in its model that the states have the same flexibility in the group and individual markets. **1999 Proc. 2nd Quarter 560.**

D. When considering the 1995 amendments, the working group decided to include a drafting note suggesting that any state that had not enacted the NAIC models on group coordination of benefits and on discontinuance and replacement do so. **1994 Proc. 4th Quarter 834.**

Section 7. Availability of Coverage

Interested parties committ favored a model with requirements that carriers cover the whole group, guarantee renewability unless the carrier is exiting the market, provide portability for groups and individuals switching carriers, limit preexisting condition limitations to 12 months, apply participation requirements uniformly, and restrict rates within reasonable bands. **1991 Proc. IIB 742.**

A. When considering testimony at a working group meeting, the drafters heard several comments in favor of guaranteed issue where reinsurance was available. One association’s position was that guaranteed issue should only be required of the ten largest carriers, which should be given preferential access to the reinsurance pool. Others expressed a preference for requiring all carriers to guarantee access. **1991 Proc. IIB 745-746.**

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Section 7 (cont.)

By providing for so-called “bare-bones” (basic) health coverage to be offered under guaranteed issue, some relief could be provided to small employers struggling with the cost of health care coverage. The avoidance of mandates might produce a one-time cost reduction from three percent to 20 percent, depending on the number of mandated coverages in the state. It was hoped these basic care plans would enable motivated small employers, heretofore unable to afford standard coverage, to provide their employees coverage. It was recognized that these basic products did nothing for health care cost containment, but rather put more of the cost burden on the individual. If the opponents of these “no frills” plans were right, the current problems of the uninsured might be replaced by a growing problem of *under-insured*. **1992 Proc. IB 953.**

When considering amendments to the model in response to federal health care reform proposals, one of the first suggestions was a change from guaranteed issue of only a basic and standard health plan to guaranteed issue by carriers of all products sold to small employers. **1994 Proc. 2nd Quarter 682.**

After the draft was changed, a representative of a managed care association expressed concern about the impact on federally qualified HMOs that were prohibited from having a preexisting exclusionary period. **1994 Proc. 3rd Quarter 654.**

C. The American Medical Association sent comments on the draft of the original small group rating model (Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups) and suggested it failed to address preexisting conditions, which was a central concern for the small group market, and the issue of whether a particular individual within a group may be excluded. The chair of the small group rate review working group replied that this information would be provided to the working group considering health care access issues. **1991 Proc. IB 630-631.**

There was consensus of the working group that each small employer carrier must meet the guarantee issue requirements without regard to the presence or activities of affiliated carriers. The working group had been asked if the guarantee issue provisions could be met by one carrier for an entire group of affiliated carriers. **1993 Proc. IB 922.**

Interested parties expressed concern with respect to the provision in the draft model that required waiver of preexisting condition limitations for previously insured individuals. **1992 Proc. IB 916.**

Section 7C(2) was amended in December 1992 to increase the portability period (the period for which new preexisting condition limitations were waived) between the previous coverage and the effective date of new coverage from 30 days to 90 days. The amendment also added a sentence to clarify that waiting periods prior to the effective date of the new coverage would not be counted in calculating the portability period. **1993 Proc. IB 911-912.**

The original model provision allowed a 12-month preexisting condition limitation. When considering amendments in 1994, the drafters considered whether a six-month waiting period would be more appropriate. Discussion also took place regarding the six-month “look back” period. The decision during the June 1994 discussion was to retain the 12-month preexisting condition limitation for groups with one or two lives and reduce the time frame to six months for groups of three lives and above. The working group also agreed to remove a provision that applied the “prudent person” concept to the preexisting condition limitation. **1994 Proc. 2nd Quarter 683.**

Subsection C(2) was modified in 1995 to add most of the language in the last half of the paragraph. There was a discussion by the drafters regarding carrier-imposed affiliation periods for carriers that did not use preexisting conditions. It was generally agreed that any waiting period should not be longer than 60 days for new entrants, and must be in lieu of a preexisting condition exclusion. **1994 Proc. 4th Quarter 832.**

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Section 7C (cont.)

From its initial adoption, the model allowed the small employer carrier to vary application of minimum requirements for participation by the size of the small employer group. That was changed in 1995 to allow a 100 percent requirement for groups of three or less, but to allow no greater than a 75 percent participation of eligible employees for groups of more than three employees. A small employer could satisfy this requirement so long as the appropriate percentage threshold was reached in the aggregate. **1994 Proc. 2nd Quarter 677.**

During discussion NAIC staff raised an issue concerning whether the Health Insurance Portability and Accountability Act of 1996 (HIPAA) would permit a carrier to impose a waiting period. The chair said he did not believe HIPAA would permit a carrier-imposed waiting period. A representative from the federal Health Care Financing Administration (HCFA) stated that this issue would be addressed in the final HIPAA regulations. The task force agreed to delete reference to a carrier-imposed waiting period. **2000 Proc. 2nd Quarter 173.**

During the development of amendments in response to HIPAA, the task force considered the requirement that health benefit plans accept late enrollees. The modifications to Subsection C(4) were added to clarify that late enrollees were entitled to the same reduction in any period of a preexisting condition exclusion for any periods of credible coverage as those individuals who had enrolled in the health benefit plan in a timely manner. An interested party commented that requiring health benefit plans to accept late enrollees was not in compliance with HIPAA. A regulator disagreed; the provisions of HIPAA are ambiguous. He also noted that when the model act was adopted the intent was that late enrollees should be accepted. Therefore, by stating clearly that late enrollees must be accepted, this requirement was consistent with the model act's original intent. **1999 Proc. 4th Quarter 941-942.**

Paragraph (5)(b) originally prohibited carriers from using restrictive riders or endorsements only for standard and basic health benefit plans. The modifiers were removed so that the section prohibited carriers from using restrictive riders or endorsements for all health benefit plans sold to small employers. **1993 Proc. IB 911, 914.**

When discussing amendments in response to HIPAA, NAIC staff noted that HIPAA referred to special enrollment periods. She suggested that it might be desirable to add the special enrollment category to the model act to avoid confusion between HIPAA and the model act. **1999 Proc. 1st Quarter 543.**

Extensive change to Subsection C resulted from the redraft of the model to conform to the requirements of HIPAA. **2000 Proc. 2nd Quarter 230-233.**

E. Most of Subsection E was added with the HIPAA amendments adopted in 2000. **2000 Proc. 2nd Quarter 233.**

F. This subsection was added in 2000, along with other changes made during the amendments designed to conform to HIPAA. **2000 Proc. 2nd Quarter 233-234.**

Section 8. Certification of Creditable Coverage

In 1999 the NAIC assigned a task force to make amendments to a number of model acts to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The discussion focused on the Small Employer and Individual Health Insurance Availability Model Act with the understanding that the proposals would also be incorporated into the Small Employer Health Insurance Availability Model Act. **2000 Proc. 1st Quarter 168.**

The entire section was new material added when the model was revised to comply with HIPAA. **2000 Proc. 2nd Quarter 234.**

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Section 9. Notice of Intent to Operate as a Risk-Assuming Carrier for a Reinsurance Carrier

Some issues the working group had to consider were whether carriers who accept all applicants would actually insure the referred risks or merely act as servicing carriers, how to assure a fair distribution of substandard risks across the marketplace, and whether some method of assuring rate equivalency across carriers would be needed. **1991 Proc. IB 645.**

In identifying key design issues for the model, the drafters considered whether some carriers should be allowed to opt out of reinsurance. Some carriers were willing to guarantee the issue of coverage without access to reinsurance. They considered whether this decision ought to be a one-time permanent option. The advisory committee recommended that carriers be able to switch two years after their initial election and every five years thereafter. **1991 Proc. II 743.**

A. An amendment to the model, adopted in December 1992, changed the time period for carriers applying to become risk-assuming carriers. The amendment added a phrase at the beginning of Subsection A to require carriers to apply within 30 days of the approval of the plan of operation by the commissioner. The model had originally provided for application within 30 days of the effective date of the Act. The change permits carriers to review the plan of operation of the reinsurance program prior to determining whether to opt-out and become a risk-assuming carrier. **1993 Proc. IB 911-912.**

A sentence was added in December 1992 to permit the commissioner to waive or modify the time period for applying to change a carrier's status under Section 10 of the model in the case of an acquisition of a carrier by another carrier. **1993 Proc. IB 911, 913.**

Section 10. Application to Become a Risk-Assuming Carrier

One regulator stated that he expected some large carriers would choose to be risk-assuming carriers and asked how that would affect the overall marketplace. An industry spokesman responded that the key problem was assuring that carriers who opted out took their fair share of poorer risks. One person expressed concern that a small employer assigned to such a carrier might get much higher rates. The chair noted that some method of assuring rate equivalency across carriers could be needed. **1991 Proc. IB 645.**

B. The issue was raised whether carriers with large market share but thin capitalization should be able to opt out. Standards would be needed to determine whether a carrier should be able to opt out. **1991 Proc. IIB 743.**

Section 11. Prohibited Activities

This section was added in 1995. As first drafted, it prohibited insurers from serving as third-party administrators for small employer groups that, if they purchased insurance, would be subject to the Act. Later the drafters agreed to amend the provision to prohibit claims agents and carriers from acting both as small group carriers and stop loss carriers. **1994 Proc. 4th Quarter 834, 848.**

When the Executive Committee considered adoption of the revised model in March of 1995, one commissioner said the proposed amendments did not adequately reflect the intent of the members of the Accident and Health Insurance (B) Committee because Section 11 as drafted would prohibit small employer insurers, subsidiaries of insurers, or controlled individuals of holding companies from serving as claims administrators or claims payment agents on behalf of small employer groups that were subject to the model act. She suggested a new Section 11, which was adopted. **1994 Proc. 4th Quarter 26-27.**

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Section 12. Small Employer Carrier Reinsurance Program

When the NAIC was drafting the original small group rating model bill (Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups) interested parties suggested that some of the solutions to problems identified required structural reforms, such as a reinsurance pool. **1990 Proc. II 610.**

When the Health Care Access Working Group was constituted, it discussed the issues with interested parties. From the viewpoint of the industry, the real issue in development of a health insurance access model was how the industry would share the net costs of including the now rejected risks in the private insurance system. Interested parties described two alternatives. The first approach was “Guaranteed Issue With the Carriers’ Right to Reinsure.” The second approach was “Carrier Option to Guarantee Issue or Refer to Issuing Carriers.” In this option, carriers would have the option to choose to take all applicants or to continue traditional underwriting practices and refer unacceptable risks to other carriers who would take all applicants. Exclusionary carriers would be required to share in the losses (through reinsurance) of the carriers who agree to accept all applicants, an option could be included to permit some carriers to guarantee issue and accept all of the risk without reinsurance. **1991 Proc. IB 645.**

One regulator asked why a carrier would choose not to accept all applicants but agree to reinsure others. He was told that smaller carriers may not want to handle larger claim volume or modify systems. The principle advantage of this approach was that it preserved the right to aggressively underwrite. A regulator stated that he saw legitimate business reasons why a carrier might not want to accept all applicants, but that the goal of the working group had been to reduce fragmentation caused by such underwriting practices. He stated that he did not want to unnecessarily complicate the model act merely to respond to carrier administrative concerns. **1991 Proc. IB 645.**

A third option described by the interested parties was “Guaranteed Issue With Reinsurance After a Stop Loss Limit.” Under this option, individuals with certain types of conditions that made them uninsurable would be reinsured after their claims passed a designated yearly threshold (*e.g.*, \$10,000). This approach would keep the size of the reinsurance pool small. It would also reduce or eliminate the need for initial medical underwriting, thereby reducing administrative costs. It would provide incentives for carriers to manage claims by requiring them to keep a larger portion of the risk and permitting them to reinsure only 90 percent of the amount over the threshold. One regulator stated his support for this approach; it was his experience that larger pools led to rates being set politically. **1991 Proc. IB 645.**

An insurance company representative said his company was also interested in keeping the pool small, but that increasing the risk retained by primary carriers would enhance the incentives for them to look for ways around the guaranteed issue requirement. **1991 Proc. IB 645.**

One regulator asked whether this approach would be actually insuring an individual or a disorder. It would seem that for some insured individuals, some claims would be handled by the carriers and some would be reinsured by the pool. Another regulator stated that this approach would be far more intrusive into the carrier’s business practices by requiring the carrier to take and retain certain risks they would otherwise reject. In the reinsurance approach, the carrier could cede risks that it did not want to insure; in this approach, it would be required to take the risk up to the threshold level. Another regulator stated that the goal of the NAIC small group reforms was to encourage premium stability, but that retrospective reinsurance would build renewal underwriting back into the system. **1991 Proc. IB 645-646.**

Other issues identified by the working group for consideration were whether the reinsurance would be retrospective, prospective or both; how to distinguish reinsurable risks from other large risks; where to set the stop loss threshold to produce both an acceptable amount of risk for small carriers while limiting the overall size of the pool; and whether the stop loss reinsurance threshold should vary by carrier or by size of group. **1991 Proc. IB 645.**

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Section 12 (cont.)

An insurance company representative stated that a stop loss reinsurance approach would make sense only if assessments to fund a reinsurance pool would be too high. Another responded that keeping the pool size small was fundamental. Smaller companies did not want to, or could not keep, all of the risk up to the stop loss amount. Insurers were in the business of underwriting and the approaches being considered took that tool away. **1991 Proc. IB 646.**

The working group chair asked how the administrative costs of operating a reinsurance pool would affect premiums. An interested party responded that administrative costs were one of the key factors for choosing among the options considered. The costs of underwriting and choosing when to reinsure were actually more significant than the costs of administering the pool. **1991 Proc. IB 639.**

C. The insurance industry believed the board should be selected by the industry and approved by the commissioner. If the proposed language calling for the commissioner to appoint the board was retained, the industry felt that the majority of the board should be composed of reinsuring carriers. **1992 Proc. IB 916-917.**

In December of 1992 an amendment to Paragraph (2)(a) changed to composition of the board of reinsurance program, to remove a requirement that at least five members of the board be representatives of reinsuring carriers. The drafting note that follows was added at the same time. **1993 Proc. IB 912-913.**

The amendment was needed because, at the time the board was appointed, the commissioner would not know whether the carriers appointed would eventually apply to become risk-assuming carriers. **1993 Proc. IB 920.**

G. A new Paragraph (5) was added in 1992 to require the plan of operation of the reinsurance program to contain a method of estimating the retention (and other specific dollar limits) for HMOs and other capitated arrangements. **1993 Proc. IB 920.**

I. The issue of insurer retention under the reinsurance program was raised as the drafters were considering comments on the revised draft. One association of insurers expressed a belief that the retention level should be a legislative decision. Several members of the industry stated that the trend factor used to increase the retention level should be tied to general health care costs and utilization and not to cost increases under the program. The working group agreed with this observation. **1992 Proc. IB 917.**

Just before adoption of the model, the working group voted to bracket Paragraph (6) and added a drafting note to indicate the provision was only needed in cases where a state chose an initial retention level lower than the \$5,000 level established in the model. The subsection was needed to address the legal restraints facing federally qualified health maintenance organizations. **1992 Proc. IB 921.**

L. In terms of financing the reinsurance pool, one association spokesman said his members believed the first tier of financing (up to four percent) should be borne by the small group market and that broad-based funding should be available if larger losses occurred. **1991 Proc. IIB 745.**

N. Just before adoption the working group added this subsection which provided for the board to establish standards for reasonable compensation to be paid to producers for the sale of the basic and standard health benefit plans. **1992 Proc. IB 920.**

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Section 13. Health Benefit Plan Committee

As the working group began gathering information to draft the models, one individual was asked to explain the basic and standard benefit plans that would be developed. He responded that the plans would be developed in the private sector and approved by the commissioner. **1991 Proc. IB 638.**

Section 14. Periodic Market Evaluation

Section 15. Waiver of Certain State Laws

The draft incorporated a cost-reducing concept already adopted by a number of states; that is, exemption of small employer coverage from state mandated benefit and provider laws. **1991 Proc. IB 641.**

When drafting model amendments in 1994, the drafters considered deletion of this whole section. One regulator said she did not believe that the basic plan should be divorced from mandated benefits. There was some discussion among regulators about the difference in mandated benefits from state to state. The drafters voted to retain the section because, in states that had heavily mandated benefits, it would be too burdensome on the basic package to require it to include the mandated benefits. **1994 Proc. 4th Quarter 832.**

Section 16. Administrative Procedures

Section 17. Standards to Assure Fair Marketing

A. The original provisions adopted contained a sentence explaining what to do if coverage was denied to a small employer on the basis of health status or claims experience of the small employer or its employees. When the provisions of Section 7A were changed, this part of Section 17 was deleted. **1994 Proc. 4th Quarter 848.**

C. This provision prohibited a small employer carrier from having a commission structure that would pay 60 percent the first year, but if a group turned out to be an unhealthy risk, would not pay anything. The goal was equal compensation, not to discriminate against the higher risk. **1992 Proc. IB 920.**

Shortly before adoption several new provisions relating to market conduct were added. Interested parties agreed with their intent but would have liked more time to consider the ramifications of the actual provisions. The working group chair asked if they were comfortable with the elimination of a provision basing agent compensation on loss ratios in this market. Several industry members said they were. **1992 Proc. IB 917.**

D. Concern was raised about the requirement in the proposed model that would require insurers to pay a reasonable commission for business placed through the program. One industry representative suggested a finder's fee would be more appropriate and would reduce administrative costs. A regulator responded that a finder's fee may not be sufficient to compensate as agent for placing and servicing the business. **1992 Proc. IB 916.**

Just before adoption of the model this subsection was revised. A requirement to pay the same commission for the basic and standard plan as the carrier pays for its most popular plan was deleted. **1992 Proc. IB 920.**

Section 18. Separability

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Section 19. Restoration of Terminated Coverage

This section was added in December 1992. It was seen as a partial answer to the problem of carriers dumping some of their small employer business just prior to the effective date of the model act in their state for the purpose of positioning themselves competitively. The new section authorized the commissioner to promulgate regulations to require carriers, as a condition of continuing to transact small group business in the state, to reissue any benefit plan to a small employer that had been terminated or not renewed after a date that was six months prior to the date of enactment of the model. The working group considered the constitutionality and potential impact of the proposal before adopting it. **1993 Proc. IB 911, 914.**

Section 20. Risk Adjustment Mechanism

When the working group considered community rating, some discussion took place on the need for risk adjustment between health plans. A suggestion was made that the reinsurance program might not be needed if universal coverage was attained. **1994 Proc. 2nd Quarter 677.**

The first draft included a wait of three years before implementation of the risk adjustment mechanism. The chair suggested this would allow the impact of movement toward community rating to be fully realized prior to developing a risk adjustment mechanism. **1994 Proc. 3rd Quarter 686.**

Section 21. Effective Date

Chronological Summary of Action

December 1991: Model adopted.

December 1992: Several amendments, most of a technical nature, were made.

March 1995: Revised model to provide for small groups of one. Provided for adjusted community rating, and revised model extensively.

December 2000: Model revised throughout and Section 8 added to address issues raised by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the federal regulations promulgated pursuant to HIPAA.

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