

Draft Pending Adoption

Attachment 1

Date: 11/25/15

Market Conduct Examination Standards (D) Working Group
National Harbor, Maryland
November 21, 2015

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met in National Harbor, MD, Nov. 21, 2015. The following Working Group members participated: Bruce R. Ramage, Chair, and Martin Swanson (NE); Jim Mealer, Vice Chair (MO); Lee Backus (DC); Russ Hamblen (KY); Rick Bradley (MA); Victoria August (MD); Paul Hanson (MN); Tracy Biehn (NC); Win Pugsley (NH); Todd Oberholtzer (OH); Brian Gabbert (OK); Chris Monahan (PA); Bob Grissom (VA); Christina Rouleau (VT); Leslie Krier (WA); and Mark Hooker (WV).

1. Adopted its Oct. 29 Minutes

Ms. August made a motion, seconded by Ms. Biehn, to adopt the Working Group's Oct. 29 minutes (Attachment Six-A). The motion passed unanimously.

2. Reviewed and Discussed a Draft Outline of a Proposed New *Market Regulation Handbook* Chapter, Closing Continuum Actions, Nov. 13 Draft

Director Ramage said that, in July 2015, the Working Group began discussing a draft outline of a proposed new *Market Regulation Handbook* chapter to provide guidance to regulators regarding closing continuum actions. Mr. Mealer said that while he revised the chapter outline to incorporate comments received from Maryland, the District of Columbia and the Center for Economic Justice, some of the comments received from these individuals will be better suited to inclusion within the new chapter after drafting of the chapter content has begun.

Ms. August said the Maryland Insurance Administration has statutory guidelines for determining fines, and the draft outline should be written so that states like Maryland will have the flexibility they need to deviate from the uniform methodology provided in the proposed new chapter with regard to determining fines.

Ron Blitenthal (Old Republic National Title Insurance Company) asked how mitigating factors affect how fines are assessed to a regulated entity. Mr. Blitenthal said a state insurance department is typically given the statutory authority to fine up to a specified maximum amount, and an examiner may take mitigating factors into account when determining a fine, such as remedial measures taken by the company, past history of compliance and a history of no conscious disregard violations. Mr. Blitenthal asked that these mitigating factors be added to the draft outline. Mr. Mealer said the comments provided by Old Republic would be best incorporated into the narrative content of the new chapter.

Director Ramage said the draft outline is not an "adoptable" item, because the outline is not a document that would be incorporated into the *Market Regulation Handbook*; the outline is merely a guide for the drafting of the chapter. Director Ramage recommended that Mr. Mealer begin drafting the chapter, using the outline as a guideline, with the understanding that the outline will change. Mr. Mealer said Cliff Day (NJ) and Megan Mason (MD) volunteered to assist with drafting the content. Director Ramage said any other volunteers offering assistance in the creation of the new chapter should contact Mr. Mealer.

3. Reviewed and Discussed Draft Health Reform Market Conduct Examination Standards – Guaranteed Availability, Nov. 11 Draft for Inclusion in the *Market Regulation Handbook*

Director Ramage said that health reform-related guaranteed availability examination standards were adopted by the NAIC in 2014. On the Working Group's Oct. 29 call, during its discussion about the prohibition of preexisting condition exclusions examination standards, it was suggested that the adopted health reform-related guaranteed availability standards be re-opened and revised to include language addressing special enrollment period provisions. Timothy Stoltzfus Jost (Virginia Organizing) and Sarah Lueck (Center on Budget and Policy Priorities—CBPP) presented comments dated Nov. 16 submitted by the NAIC consumer representatives.

Mr. Jost said the 2017 benefit payment parameter proposed rules were recently posted for public comment and are, therefore, not incorporated into the Nov. 16 NAIC consumer representatives' comments. Ms. Lueck said the comments submitted by

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the NAIC consumer representatives add language regarding special enrollment period provisions in the individual and group market sections of the examination standards, and clarifying language has been provided regarding whether special enrollment period provision requirements are applicable marketwide or only within the marketplace. Ms. Lueck said that the comments submitted by the NAIC consumer representatives also add language to the examination standards to reflect that, in the small group market, there is a period from Nov. 15 to Dec. 15 where a small group employer can obtain coverage even though they do not meet the minimum participation or contribution requirements.

Ms. Lueck said that language describing annual open enrollment periods should also be incorporated within the draft. Mr. Jost said that revision can be made by reinstating the sentence that was stricken out (“A health carrier may restrict enrollment...”), in the third paragraph of the Review Procedures and Criteria section of Standard 1 and Standard 2.

Director Rame said the deadline for comments on the draft is Dec. 11. The NAIC consumer representatives’ comments and the reinstatement of the sentence in the third paragraph of the Review Procedures and Criteria section of Standard 1 and Standard 2 will be incorporated into the draft and it will be distributed for review, discussion and possible consideration of adoption on the next Working Group conference call, which is scheduled to occur in December.

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

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Guaranteed Availability of Coverage 12-29-15

PROVISION TITLE: Consumer Rep 11-16-15 Comments Guaranteed Availability of Coverage (Individual and ~~Small~~ Group Market Health Insurance)

CITATION: PHSA §2702

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

PROVISION: Consumer Rep 11-16-15 Comments The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual ~~and small or~~ group markets in a state must offer to any individual or employer in the applicable state all products approved for sale in the applicable market, and must accept any eligible individual or ~~small group~~ employer applying for any of those products.

BACKGROUND: Consumer Rep 11-16-15 Comments Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth the requirement that a health carrier offering health insurance coverage in the individual and ~~small~~ group market in a state must accept for coverage, in the applicable state, every ~~eligible~~ individual and ~~small~~ employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions ~~agrees to satisfy the other reasonable provisions of the health benefit plan that are not in~~ consistent with ~~final regulations~~ federal and state law.

Consumer Rep 11-16-15 Comments Health carriers are permitted to limit enrollment to designated annual open and ~~designated~~ special enrollment periods.

Consumer Rep 11-16-15 Comments This provision applies to all health carriers in the individual market and to ~~small~~ group ~~employer~~ plans. This provision applies to non-grandfathered group health plans. This provision also applies to grandfathered small group health plans, which were already required to comply with guaranteed availability of coverage requirements under HIPAA.

FAQs: See the HHS website for guidance.

NOTES:

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE

Consumer Rep 11-16-15 Comments (INDIVIDUAL MARKET)

Standard 1

Consumer Rep 11-16-15 Comments A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any **eligible** individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) **meets other reasonable conditions consistent with federal and state law.** ~~agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).~~

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

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

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

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

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

_____ Complaint register/logs/files

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

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

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

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificate holders and beneficiaries, **Consumer Rep 11-16-15 Comments** including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

NAIC References

Individual Market Health Insurance Coverage Model Regulation (#26)

Individual Market Health Insurance Coverage Model Act (#36)

Other References

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

Review Procedures and Criteria

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

Consumer Rep 11-16-15 Comments Review health carrier underwriting policies and procedures related to guaranteed availability to verify adequate and appropriate policies and procedures are in place to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to eligible plan applicants in compliance with final regulations established by HHS, the DOL and the Treasury and does not place unallowable conditions on such availability.

Consumer Rep 11-16-15 Comments ~~A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods, and coverage issued during an open or special enrollment period must become effective consistent with the dates set forth in federal regulations. However,~~ **Consumer Rep 11-21-15 Comments** ~~A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods, and coverage issued during an open or special enrollment period must become effective consistent with the dates set forth in federal regulations.~~ **Consumer Rep 11-16-15 Comments** Verify that a health carrier ~~may be subject to~~ has complied with any requirements that would allow for continuous open enrollment based upon certain circumstances of failing to file rates and forms and have them approved prior to open enrollment period.

Consumer Rep 11-16-15 comments ~~Review health carrier underwriting files to verify that the health carrier establishes special enrollment periods for qualifying events as specified in final regulations established by HHS, the DOL and the Treasury.~~

Consumer Rep 12-08-15 Comments Individual Health Insurance Coverage – Open Enrollment Period
A health insurance issuer in the individual market must allow an individual to purchase health insurance coverage during the annual open enrollment period described in 45 CFR 155.410(e).

Consumer Rep 11-16-15 Comments Individual Health Insurance Coverage – Special Enrollment Periods

Verify that a health carrier that restricts enrollment to defined enrollment periods, including open enrollment periods, limited open enrollment periods, and special enrollment periods, and provides those periods pursuant to 45 CFR 147.104 and 155.420 as well as in accordance with state-specific requirements.

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

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

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

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

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

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

selected after the date of coverage loss, then coverage is effective the first day of the month following plan selection.

Note: In some circumstances, federal rules permit states or the marketplace in a state to implement alternative coverage effective dates. Examiners should verify that issuers are complying with any state-specific requirements that may apply.

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

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

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

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

Network Plans

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

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

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

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

Note: Examiners need to be aware that:

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

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

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

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

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

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

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

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

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

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

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

Consumer Rep 11-16-15 comments Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds.

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

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

STANDARDS
GUARANTEED AVAILABILITY OF COVERAGE
Consumer Rep 11-16-15 Comments (GROUP MARKET)

Standard 2

Consumer Rep 11-16-15 comments A health carrier offering ~~small~~-group market health insurance coverage shall issue any applicable health benefit plan to any ~~eligible small group~~-employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) meets other reasonable conditions consistent with state and federal law. ~~agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).~~

Apply to: **Consumer Rep 11-16-15 comments** All ~~small~~-group health products (non-grandfathered products) for policy years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140. **Consumer Rep 11-16-15 comments** However, grandfathered small group health plans were already required to comply with guaranteed availability of coverage requirements under HIPAA

This standard does not apply to transitional plans

Priority: Essential

Documents to be Reviewed

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

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

_____ Complaint register/logs/files

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

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

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

_____ Health carrier communication and educational materials related to guaranteed availability of coverage provided to applicants, enrollees, policyholders, certificateholders and beneficiaries. **Consumer Rep 11-16-15 comments** including communications with producers

_____ Training materials

_____ Producer records

_____ Applicable state statutes, rules and regulations

Others Reviewed

NAIC References

Small Group Market Health Insurance Model Act (#106)

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

Other References

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

Review Procedures and Criteria

Consumer Rep 11-16-15 comments Verify that the health carrier has established and implemented policies and procedures regarding guaranteed availability of ~~small~~-group market health insurance coverage in accordance with final regulations provided by HHS, the DOL and the Treasury.

Consumer Rep 11-16-15 comments Review health carrier underwriting policies and procedures related to guaranteed availability to verify that adequate and appropriate policies and procedures are in place to ensure the health carrier makes ~~small~~-group market health insurance coverage available on a guaranteed availability basis to eligible ~~small~~-employers in compliance with final regulations provided by HHS, the DOL and the Treasury and that the carrier does not place unallowable conditions on such availability.

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

- **Consumer Rep 11-16-15 comments** Offers coverage to all eligible employees of the eligible ~~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; and
- **Consumer Rep 11-16-15 comments** Does not limit the offer of coverage to only certain individuals or dependents in the ~~small~~-group or to only part of the ~~small~~-group.

~~Consumer Rep 11-16-15 comments A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods.~~ **Consumer Rep 11-21-15 comments A health carrier may restrict enrollment in coverage as described above to open or special enrollment periods.** **Consumer Rep 11-16-15 comments** Review health carrier underwriting files to verify that the health carrier establishes special enrollment periods for qualifying events as specified in final regulations established by HHS, the DOL and the Treasury.

Consumer Rep 11-16-15 comments Group Plans – Special Enrollment Periods

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

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

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

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

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

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

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

- The death of the covered employee;

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

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

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

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

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

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

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

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

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

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

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

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

Consumer Rep 11-16-15 comments Review the health carrier’s underwriting files to verify the requirements used by a health carrier in determining whether to provide coverage to an ~~an~~ **small**-employer are applied uniformly among all **small**-employers applying for coverage or receiving coverage from the health carrier.

Consumer Rep 11-16-15 comments Review health carrier underwriting files to verify that if the health carrier ~~requires does not, with regard to~~ small employers applying for coverage outside of the November 15 to December 15 small group open enrollment period to meet, ~~require~~ a minimum participation level greater than:

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

Consumer Rep 12-08-15 comments – remove the above paragraph and replace it with: Review health carrier underwriting files to verify that any minimum participation level that a health carrier establishes for small employers applying for coverage outside of the Nov. 15 to Dec. 15 small group open enrollment period is not greater than:

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

Consumer Rep 11-16-15 comments Review health carrier underwriting files to verify the health carrier, in applying minimum participation requirements with respect to a small employer, that applies for coverage outside of the November 15 to December 15 time period, does not consider employees or dependents of employees who have creditable coverage in determining whether the applicable percentage of participation is met.

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

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

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

- For any period of time the health carrier demonstrates, and the commissioner determines, the health carrier does not have the financial reserves necessary to underwrite additional coverage; and
- **Consumer Rep 11-16-15 comments** The health carrier cannot offer coverage for reason of lack of financial reserves and is applying that reason uniformly to all ~~small~~-employers in the ~~small~~-group market in the applicable state consistent with applicable state statutes, rules and regulations and without regard to the claims experience of an ~~small~~-employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

Consumer Rep 11-16-15 comments With regard to a health carrier that denies coverage for reason of lack of financial reserves, review the health carrier underwriting files to verify the health carrier does not offer coverage in the ~~small~~-group market in the applicable state until the later of:

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

Consumer Rep 11-16-15 comments Network Plans

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

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

Consumer Rep 11-16-15 comments Review health carrier underwriting files to verify that a health carrier that cannot offer coverage for reason of lack of network capacity does not offer coverage in the ~~small~~-group market in the applicable geographic service area to new cases of ~~small~~-employer groups 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.

Consumer Rep 11-16-15 comments Review health carrier underwriting files to verify the health carrier is applying its noncompliance with guaranteed availability requirements for reason of lack of network capacity, on a uniform basis, to all ~~small~~-employers without regard to the claims experience of the ~~small~~ employer and its employees and their dependents or any health status-related factor relating to such

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employees and their dependents and their dependents or any health status-related factor relating to such individuals and their dependents.

Note: Examiners need to be aware that:

- **Consumer Rep 11-16-15 comments** A health carrier subject to the guaranteed availability provisions of the final regulations established by HHS, the DOL and the Treasury is not required **by such regulations** to provide small group market health insurance coverage if the health carrier elects not to offer new coverage to small employers in the applicable state;
- A health carrier that elects not to offer new coverage may be allowed, as determined by the commissioner, to maintain its existing policies in the applicable state; and
- **Consumer Rep 11-16-15 comments** ~~Review health carrier underwriting files to verify that a~~ health carrier that elects not to offer new coverage to small employers in the applicable state has provided notice of its election to the commissioner and does not write new business in the small group market in the applicable state for a period of 5 years beginning on the date the carrier ceased offering new coverage in the applicable state.

General Review Procedures and Criteria

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

Consumer Rep 11-16-15 comments Review complaint records to verify that if the health carrier has not offered health insurance coverage on a guaranteed availability basis to an eligible ~~small~~ employer, the above reasons for noncompliance notwithstanding, the health carrier has taken appropriate corrective action/adjustments regarding making an offer of coverage in a timely and accurate manner.

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

Consumer Rep 11-16-15 comments Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible ~~small~~ employer that was not offered health insurance coverage on a guaranteed availability basis.

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

Consumer Rep 11-16-15 comments Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of ~~small~~ group market health insurance coverage.

Consumer Rep 11-16-15 comments Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about guaranteed availability of ~~small~~ group market health insurance coverage.

Consumer Rep 11-16-15 comments Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to guaranteed availability of ~~small~~ group market health insurance coverage.

Consumer Rep 11-16-15 comments Review health carrier training materials to verify that information provided therein is complete and accurate with regard to guaranteed availability of ~~small~~ group market health insurance coverage.

Consumer Rep 11-16-15 comments Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to guaranteed availability and does not discourage the enrollment of applicants/proposed insureds.

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

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

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From: Sarah Lueck [mailto:lueck@cbpp.org]
Sent: Tuesday, December 08, 2015 9:11 AM
To: Wallace, Petra
Cc: jostt@wlu.edu
Subject: guaranteed availability -- response to your questions and one addition

Hi Petra – I put my responses and edits in red below. Please call or email if you have any additional questions. Thanks!

1. As discussed at the last national meeting, we need to add a mention of the non-group open enrollment period. So, on page 4, prior to the paragraph with the heading “Individual Health Insurance Coverage – Special Enrollment Periods,” we suggest adding the following:

Individual Health Insurance Coverage – Open Enrollment Period

A health insurance issuer in the individual market must allow an individual to purchase health insurance coverage during the annual open enrollment period described in 45 CFR 155.410(e)

And now for your questions:

Page 5 Does “or” occur before

“Permanent move that results in access to new individual market plans (including release from incarceration.”

“Person demonstrates to the exchange in the state, in accordance with federal guidelines, that the individual meets other exceptional circumstances as the exchange may provide”

“For loss of minimum essential coverage, the first day of the month following the loss of previous coverage if the qualified health plan is selected before or on the day of the loss. If the plan is selected after the date of coverage loss, then coverage is effective the first day of the month following plan selection.”

Yes, “or” should be added.

Page 11 Does “or” occur before

“Under the terms of the health benefit plan, the employee requests enrollment not later than thirty days after the triggering event.”

“A proceeding in a case under Title 11, commencing on or after July 1, 1986 with respect to the employer from whose employment the covered employee retired at any time.”

Yes and yes. You are correct.

On Page 13 of the document, here is clearer language for the paragraph you noted was garbled:

Review health carrier underwriting files to verify that any minimum participation level that a health carrier establishes for small employers applying for coverage outside of the Nov. 15 to Dec. 15 small group open enrollment period is not greater than:

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

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