

**MODEL LANGUAGE FOR PROHIBITION ON
PREEXISTING CONDITION EXCLUSIONS FOR INDIVIDUALS UNDER THE AGE OF 19**

Table of Contents

Section 1.	Definitions
Section 2.	Applicability and Scope
Section 3.	Prohibition on Preexisting Condition Exclusions for Individuals Under the Age of 19—Individual Health Insurance Coverage; Open Enrollment Period
Section 4.	Prohibition on Preexisting Condition Exclusions for Individuals Under the Age of 19—Group Health Insurance Coverage

Section 1. Definitions.

- A. “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.
- B. “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 G, 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.
- C. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Patient Protection and Affordable Care Act (Affordable Care Act) uses the term “health insurance coverage.” The definition of “health benefit plan” 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 the Affordable Care Act.

- (2) “Health benefit plan” includes 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.
- (3) “Health benefit plan” does not include:
- (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.
- (4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;

- (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
 - (5) “Health benefit plan” does 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.
 - (6) “Health benefit plan” shall not include the following if offered as a separate policy, certificate or contract of insurance:
 - (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
 - D. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
- Drafting Note:** The Affordable Care Act uses the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” is consistent with the term “health insurance issuer.”
- E. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for the covered person’s responsibility for copayments, coinsurance or deductibles.
 - F.
 - (1) “Individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.
 - (2) For purposes of this subsection, a health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.
 - G. “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).

- H. “Open enrollment” means, with respect to individual health insurance coverage, the period of time during which any individual has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and shall be accepted for coverage under the plan without regard to a preexisting condition.
- I.
 - (1) “Preexisting condition exclusion” means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage.
 - (2) “Preexisting condition exclusion” includes any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage, or if the coverage is denied, the date of denial, under the health benefit plan, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Drafting Note: The definition of “preexisting condition exclusion” was derived from the interim final regulations published in the *Federal Register* June 28, 2010.

Section 2. Applicability and Scope.

- A. Except as provided in subsection B, these sections apply to any health carrier providing coverage under an individual or group health benefit plan.
- B.
 - (1) These sections apply to grandfathered plan coverage for group health insurance coverage.
 - (2) These sections do not apply to grandfathered plan coverage for individual health insurance coverage.
 - (3) For purposes of this subsection, “grandfathered plan coverage” means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with federal regulations.

Section 3. Prohibition on Preexisting Condition Exclusions for Individuals Under the Age of 19—Individual Health Insurance Coverage; Open Enrollment Period.

- A. A health carrier shall not limit or exclude coverage under an individual health insurance health benefit plan for an individual under the age of nineteen (19) by imposing a preexisting condition exclusion on that individual.
- B.
 - (1) Where a health carrier offers individual health insurance coverage that only covers individuals under age nineteen (19), such health carrier shall offer such coverage continuously throughout the year, or during one or more open enrollment periods of [insert the number of days and date(s) open enrollment is to begin and each year thereafter for your State].

Drafting Note: States may take different approaches to reduce the potential for adverse selection related to the enrollment of children under the age of 19 with preexisting conditions. As provided above, states may require health carriers to hold one or more open enrollment periods during which children may be enrolled on a guaranteed issue basis. State may also permit health carriers, at the option of the health carrier, to provide such open enrollment periods. Some states may want to have year-round guaranteed issue. States may want to also consider establishing qualifying events similar to those in the group market, such as employer termination of a contribution for dependent coverage, that permit children to enroll in child-only policies as special enrollees. Another option that states may want to consider is to require health carriers in the individual market to accept applications from children under the age of 19 as a condition of participation in the individual market in the State.

- (2) During an open enrollment period, a health carrier shall not deny or unreasonably delay the issuance of a policy, refuse to issue a policy or issue a policy with any preexisting condition exclusion rider or endorsement to an applicant or insured who is under the age of nineteen (19) on the basis of a preexisting condition.
- (3) Coverage shall be effective for those applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

- (4) Each health carrier shall provide ~~prior~~ prominent public notice on its Internet website and ~~prior~~-written notice to each of its policyholders ~~annually~~at least ninety (90) days before any open enrollment period of the open enrollment rights for individuals under the age of nineteen (19) and provide information as to how an individual eligible for this open enrollment right may apply for coverage with the carrier during an open enrollment period.

Drafting Note: States may want to consider adding language with respect to open enrollment that prohibits health carriers from directly or indirectly discouraging applicants from exercising their open enrollment rights, as provided in subsection B above. In addition, states may want to prohibit health carriers from penalizing insurance producers for submitting applications for those that qualify for open enrollment under subsection B above. States may also want to consider adding language to clarify that nothing in this section would prohibit health carriers from establishing eligibility criteria for child-only health insurance where an individual is enrolled in or eligible for other sources of creditable coverage, provided that such criteria apply without regard to preexisting conditions. ~~States may wish to limit the types of creditable coverage that a health carrier is allowed to decline coverage to only those applicants with such coverage such as high risk pools and mini-medical plans.~~ States may wish to limit the types of such creditable coverage to exclude high risk pools and mini-medical plans. States electing to address anti-dumping may also wish to limit the declinations to only those applicants that have such creditable coverage rather than to those that are simply eligible for creditable coverage.

Section 4. Prohibition on Preexisting Condition Exclusions for Individuals Under the Age of 19—Group Health Insurance Coverage.

A health carrier shall not limit or exclude coverage under a group health insurance health benefit plan for an individual under the age of nineteen (19) by imposing a preexisting condition exclusion on that individual.

W:\Health Care Reform\Patient Protections Templates\PreEx Under Age 19 Template4.doc