MODEL REGULATION TO IMPLEMENT THE INDIVIDUAL HEALTH INSURANCE PORTABILITY MODEL ACT

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Section 1. Statement of Purpose

This regulation is intended to implement the provisions of the Individual Health Insurance Portability Model Act (the "Portability Act"). The general purposes of the Portability Act and this regulation are to provide for the availability of health insurance coverage to recently insured individuals, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates among health benefit plans; to ensure renewability of coverage; to establish limitations on eligibility requirements and the use of preexisting condition exclusions; to provide for development of "basic" and "standard" health benefit plans to be offered to all recently insured individuals; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the individual health insurance market.

The Portability Act and this regulation are intended to promote broader spreading of risk in the individual marketplace. The Portability Act and this regulation are intended to regulate all health benefit plans sold to individuals, whether sold directly or through associations or other groupings of individuals. Carriers that provide health benefit plans to individuals are intended to be subject to all of the provisions of the Portability Act and this regulation, except where otherwise specified.

Section 2. Applicability and Scope

A. (1) This regulation implements the provisions of the [insert reference to state law equivalent to the Portability Act].

(2) This regulation shall apply to a health benefit plan that:

(a) Meets one or more of the conditions set forth in [insert reference to state law equivalent to Section 4A of the Portability Act];

(b) Covers enrollees and their dependents who are residents of this state at the time of issue; and

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(c) Is in effect on or after the effective date of [insert reference to state law equivalent to the Portability Act].

Drafting Note: The Portability Act and this regulation do not apply to individuals who were residents of another state at the time their health benefit plans were issued.

B. The provisions of this regulation apply to a health benefit plan provided to individuals without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

C. A carrier that is not operating as an individual carrier in this state shall not become subject to the provisions of this regulation solely because an individual that was issued a health benefit plan in another state by that carrier moves to this state.

Drafting Note: The Portability Act excepts Medicare supplement insurance and other limited benefit policies from the definition of health benefit plan, and thus from the requirements of the Portability Act. The Portability Act did not similarly specifically except the Civilian Health and Medical Program for Uniformed Services (CHAMPUS) and CHAMPUS supplement insurance from the requirements of the Portability Act. The failure to except CHAMPUS and CHAMPUS supplement insurance from the requirements of the Portability Act was a technical drafting error. It was and is not intended that CHAMPUS and CHAMPUS supplement insurance be subject to the requirements of the Portability Act.

Section 3. Definitions

A. "Community rate for professional associations" means that, for benefit plans with similar actuarial value (as considered for a normal distribution of groups), the same rate is charged for all individuals with modifications made only for allowable rating characteristics.

B. "Converted policy" means the individual policy provided by group carriers pursuant to [insert reference to state law equivalent to the Group Health Insurance Mandatory Conversion Privilege Model Act].

C. "Geographic area" means an area used for adjusting the rates for a health benefit plan that is an allowed rating characteristic under the Portability Act. The following are the allowed geographic areas in this state: [insert allowed geographic areas].

Drafting Note: States should determine the method for setting allowed geographic areas for rating purposes within the state. States may wish to consider medical service areas, redlining issues within the state and anti-discrimination issues when prescribing allowed geographic areas.

D. "Individual basic converted policy" means the basic health benefit plan required to be issued as a converted policy by a group carrier pursuant to [insert reference to state law equivalent to Section 12 of the Portability Act].

E. "Individual standard converted policy" means the standard health benefit plan required to be issued as a converted policy by a group carrier pursuant to [insert reference to state law equivalent to Section 12 of the Portability Act].

F. "Plan actuarial value" means a value, unique to each plan, calculated using a standardized population assumption and standardized cost and utilization factors.

G. "Qualified actuary" means a member of the American Academy of Actuaries.

Drafting Note: States that recognize an individual who is not a member of the American Academy of Actuaries as a qualified actuary should be aware that such an individual is not subject to the professional guidelines or discipline of the American Academy of Actuaries.

H. "Rating factors" means the factors based on allowed rating characteristics and benefit design that are applied to the single uniform rate to determine the final rate.

I. "Relative actuarial value" means the ratio (rounded to the nearest five one-hundredths) between two plan actuarial values. The relative actuarial value for Plan A compared to Plan B shall be calculated as the ratio of Plan A's plan actuarial value to Plan B's actuarial value.

J. "Renewal" or "renews" means the occurrence of the earliest of:

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(1) The anniversary date of issue;

(2) The date on which premium rates are or by the terms of the plan can be changed; or

(3) The date on which benefits are or by the terms of the plan can be changed.

K. "Similar actuarial value" means the relative actuarial value calculated for the plans under consideration equals one.

Drafting Note: Two plans have similar actuarial value if the relative actuarial value calculated using these plans equals one.

L. "Single uniform rate" means the rate for a block of business from which the final rate for an individual will be calculated using rating factors.

M. "Standardized cost and utilization factors" means a set of common morbidity statistics used to calculate the plan actuarial value for all plans referenced in this regulation. The standardized cost and utilization factors shall remain in effect for at least one year.

N. "Standardized population assumption " means a demographic distribution using the same demographic rating characteristics which are allowed to be used by this Act and regulation. The carrier shall use the same standardized population assumption for all plan actuarial value calculations. The standardized population assumption shall remain in effect for at least one year.

Section 4. Establishment of Blocks of Business

A. A block of business is based on a classification scheme determined by the carrier based on one or more of the following factors:

(1) Distribution system;

(2) Policy form;

(3) Business directly written or acquired from another company; or

(4) Other distinguishing characteristics approved by the commissioner.

B. The basis for determining blocks of business shall not be changed unless approved by the commissioner.

C. Except for blocks of business assumed by an individual carrier pursuant to Section 5 of this regulation, an individual carrier may not create more than nine (9) blocks of business, unless the creation of additional blocks of business has been approved by the commissioner.

D. An individual carrier that establishes more than one block of business pursuant to the provisions of [insert reference to state law equivalent to Section 5 of the Portability Act] shall maintain on file for inspection by the commissioner the following information with respect to each block of business so established:

(1) A description of each criterion employed by the carrier (or any of its agents) for determining membership in the block of business;

(2) A statement describing the justification for establishing the block as a separate block of business; and

(3) A statement disclosing which, if any, health benefit plans are currently available for purchase in the block and any significant limitations related to the purchase of the plans.

E. The individual basic and standard benefit plans must be a separate block of business in order for the carrier to receive distributions for assessable losses pursuant to [insert reference to state law equivalent to Section 10 of the Portability Act].

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Drafting Note: Converted policies for carriers that do not write in the individual market are separate blocks of business and carriers may need to file the associated rate manuals.

Section 5. Transition for Assumptions of Business from Another Carrier

A. (1) An individual carrier shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering an individual in this state unless:

(a) The transaction has been approved by the commissioner of the state of domicile of the assuming carrier;

(b) The transaction has been approved by the commissioner of the state of domicile of the ceding carrier; and

(c) The transaction otherwise meets the requirements of this section.

(2) A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation or risk of one or more individual health benefit plans from or to another carrier shall make a filing for approval with the commissioner at least sixty (60) days prior to the date of the proposed assumption. The commissioner may approve the transaction if the commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Portability Act and this regulation. The commissioner shall not approve the transaction until at least thirty (30) after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems reasonable after the filing.

(3) (a) The filing required under Paragraph (2) shall:

(i) Describe the block of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded;

(ii) Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate block of business (pursuant to Subsection C) or will incorporate them into an existing block of business (pursuant to Subsection D). If the assumed health benefit plans will be incorporated into an existing block of business, the filing shall describe the block of business of the assuming carrier into which the health benefit plans will be incorporated;

(iii) Describe whether the health benefit plans being assumed are currently available for purchase by individuals;

(iv) Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed;

(v) Describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed;

(vi) Describe any other potential material effects of the assumption on the coverage provided to the individuals covered by the health benefit plans to be assumed; and

(vii) Include any other information required by the commissioner.

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(b) An individual carrier required to make a filing under Paragraph (2) shall also make an informational filing with the commissioner of each state in which there are individual health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under Paragraph (2) and shall include at least the information specified in Paragraph (3)(a) for the individual health benefit plans in that state.

(4) An individual carrier shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering an individual in this state unless it complies with the following provisions:

(a) The carrier shall provide notice to the commissioner at least sixty (60) days prior to the date of the proposed assumption. The notice shall contain the information specified in Paragraph (3) for the health benefit plans covering individuals in this state.

(b) If the assumption of a block of business would result in the assuming individual carrier being out of compliance with the limitations related to premium rates contained in Section 5A(1) of the Portability Act, the assuming carrier shall make a filing with the commissioner seeking suspension of the application of Section 5A(1) of the Portability Act.

(c) An assuming carrier seeking suspension of the application of Section 5A(1) of the Portability Act shall not complete the assumption of health benefit plans covering individuals in this state unless the commissioner grants the suspension requested pursuant to Subparagraph (b) of this paragraph.

(d) Unless a different period is approved by the commissioner, a suspension of the application of Section 5A(1) of the Portability Act shall, with respect to an assumed block of business, be for no more than fifteen (15) months and, with respect to each individual, shall last only until the anniversary date of the individual's coverage (except that the period with respect to an individual may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the block of business).

B. (1) Except as provided in Paragraph (2), an individual carrier shall not cede or assume the entire insurance obligation or risk for an individual health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire block of business that includes the health benefit plan.

(2) An individual carrier may cede less than an entire block of business to an assuming carrier if:

(a) One or more individuals in the block have exercised their right under contract or state law to reject (either directly or by implication) the ceding of their health benefit plans to another carrier. In that instance, the transaction shall include each health benefit plan in the block of business except those health benefit plans for which an individual has rejected the proposed cession; or

(b) After a written request from the transferring carrier, the commissioner determines that the transfer of less than the entire block of business is in the best interests of the individuals insured in that block of business.

C. An individual carrier that assumes one or more health benefit plans from another carrier may maintain those health benefit plans as a separate block of business. However, the commissioner can order the carrier to integrate assumed blocks of business into existing blocks of business.

D. Nothing in this section or in the Portability Act is intended to:

(1) Reduce or diminish any legal or contractual obligation or requirement, including an obligation provided in [cite state statute relating to assumption reinsurance], of the ceding or assuming carrier related to the transaction;

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(2) Authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

(3) Reduce or diminish the protections related to an assumption reinsurance transaction provided in [cite state statute relating to assumption reinsurance] or otherwise provided by law.

Section 6. Restrictions Relating to Premium Rates

A. (1) An individual carrier shall develop a rate manual for each block of business. Rates charged to individuals by an individual carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection.

Drafting Note: One rate manual may be applicable to more than one block of business.

(2) (a) The specific categories of rating characteristics to which the single uniform rate applies shall be the same for all blocks of business.

(b) If a carrier does not wish to vary rates by a specific rating characteristic in a particular block, a rating factor of 1.00 may be used for that rating characteristic.

(c) There shall be only one single uniform rate per block of business.

(d) In determining a rate for an individual within a block of business, the application of rating factors based on benefit design is allowed in addition to applying rating factors based on rating characteristics.

(e) In this section, any reference to rating methodology or rating factors also applies to rate manuals in the form of rate tables.

(3) (a) An individual carrier shall not modify the rate manual rating method for a block of business unless the change has been approved as provided in this paragraph. The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially appropriate and consistent with the purposes of the Portability Act and this regulation.

(b) An individual carrier may modify the rating method for a block of business only with prior approval of the commissioner. An individual carrier requesting to change the rating method for a block of business shall make a filing with the commissioner at least thirty (30) days prior to the proposed date of the change. The filing shall contain at least the following information:

(i) The reasons the change in rating method is being requested;

(ii) A complete description of each of the proposed modifications to the rating method;

(iii) A description of how the change in rating method would affect the premium rates currently charged to individuals in the block of business, including an estimate from a qualified actuary of the number of individuals (and a description of the types of individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all individuals in a health benefit plan); and

(iv) A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for individuals that would be in violation of Section 5 of the Portability Act.

Drafting Note: The requirement for filing of a change in rating method should be consistent with existing state requirements.

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(c) For the purpose of this section a change in rating method shall mean:

(i) A change in the number of rating characteristics used by an individual carrier to determine premium rates for health benefit plans in a block of business;

(ii) A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a rating characteristic to determine premium rates for health benefit plans in a block of business; or

(iii) A change in a rating factor with respect to any rating characteristic if the change would produce a change in premium for any individual that exceeds five percent (5%). A change in a rating factor means the cumulative change with respect to the factor considered over a twelve–month period. If an individual carrier changes rating factors with respect to more than one rating characteristic in a twelve–month period, the carrier shall consider the cumulative effect of all the changes in applying the five percent (5%) test.

Drafting Note: States may wish to retain the 5% exception even if the state does require prior approval of rates.

B. An individual carrier shall test its rates for compliance with the requirements of Subsection A in accordance with the [choose one method from 1, 2 and 3 below and insert language].

[(1) *Exhaustive Method*. This method constitutes a safe harbor and requires that every possible premium rate in the rating manual for one block of business be compared to comparable rates in the other blocks of business. If two blocks of business have identical rating factor categories, an individual carrier may alternatively compare each rating factor.

(2) *Sampling Method*. The aggregate rate for a randomly selected sample of 500 individuals in one block shall be compared to comparable aggregate rates for those individuals in the other blocks. This procedure shall be repeated for each block of business.

(3) *Defined Census Method*. Aggregate rates for each block of business shall be calculated based on a defined census. A defined census is a distribution across all rating characteristics (e.g. age, family, geography or other) permitted pursuant to [insert reference to state law equivalent to Section 3AA of the Portability Act]].

C. (1) The rate manual developed pursuant to Subsection A shall specify the rating characteristics, single uniform rate and rate factors to be applied by an individual carrier in establishing premium rates for the block of business or be a series of rate tables listing all possible rates.

(2) An individual carrier may not use rating characteristics other than those specified in [insert reference to state law equivalent to Section 3AA of the Portability Act] without the prior approval of the commissioner. An individual carrier seeking approval shall make a filing with the commissioner for a change in rating method under Subsection A(2).

(3) An individual carrier shall use the same rating characteristics in establishing premium rates for each health benefit plan in a block of business and shall apply them in the same manner in establishing premium rates for each health benefit plan.

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(4) Differences among single uniform rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of individuals that choose or are expected to choose a particular health benefit plan. Unless the commissioner has approved health status at issue as an approved rating characteristic under [insert reference to state law equivalent to Section 3AA(4) of the Portability Act], an individual carrier shall apply rating characteristics and rate factors in a manner that assures that premium differences among health benefit plans for identical individuals vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of individuals that choose or are expected to choose a particular health benefit plan. Even if the commissioner has approved health status at issue as an approved rating characteristic under [insert reference to state law equivalent to Section 3AA(4) of the Portability Act], the rates shall comply with the overall rating restrictions under [insert reference to state law equivalent to Section 5 of the Portability Act].

Drafting Note: States may wish to consider requiring mechanisms to prevent rating spirals, such as prohibiting the closing of blocks of business and developing multiple blocks of business with essentially the same coverage.

(5) Each rate manual developed pursuant to Subsection A shall be maintained by the individual carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual.

(6) The rate manual and rating practices of an individual carrier shall comply with any guidelines issued by the commissioner.

D. The restrictions related to changes in premium rates in [insert reference to state law equivalent to Section 5 of the Portability Act] shall be applied as follows:

(1) An individual carrier shall revise its rate manual each rating period to reflect changes in single uniform rates.

(2) An individual carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in premium rates for each block of business for each rating period.

Drafting Note: Section 5 of the Portability Act limits the amount of rate variability among blocks of business written on or after the effective date of the Portability Act. After the effective date of the Portability Act, policy forms may be continued, but new issues within the existing policy form are subject to all requirements of the Portability Act and this regulation. In the event of new issues on an existing policy form, new business rates for these policy forms may need to be adjusted by more than the amount permitted by the Act (15%) in order for the carrier to comply with the requirement of the Portability Act that rates for all blocks of business written on or after the effective date of the Portability Act be within 100% of each other (see Section 5A(1) of the Portability Act).

E. The limits on rate variability in the Portability Act shall not be compared for each month's issues and renewals, but shall be interpreted over a full year of rate filings of policy forms subject to the Portability Act and this regulation.

F. (1) Carriers shall rate a professional association plan based on the plan's experience if the health benefit plan offered by the professional association covers a minimum of 2,000 members.

(2) The 2,000 member requirement is an average of the number of members covered in the health benefit plan nationwide during the preceding calendar year.

(3) If the carrier did not provide coverage for the association health benefit plan in the preceding calendar year, the member count shall be based on the average number of members that are reasonably expected to be covered in the current calendar year.

Section 7. Availability of Coverage

Individual carriers shall not require eligible family members to accept a basic or standard health benefit plan covering all family members. Those family members who qualify for an underwritten plan may be issued separate coverage from those who do not qualify for the underwritten plan but are eligible for guaranteed issue of the basic or standard plan.

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Section 8. Application to Re-enter State

A. A carrier that has been prohibited from writing coverage for individuals in this state pursuant to [insert reference to state law equivalent to Section 6B of the Portability Act] may not resume offering health benefit plans to individuals in this state until the carrier has made a petition to the commissioner to be reinstated as an individual carrier and the petition has been approved by the commissioner. In reviewing a petition, the commissioner may ask for reasonable and appropriate information and assurances.

B. In the case of an individual carrier doing business in only one established geographic service area of the state, if the individual carrier elects to nonrenew a health benefit plan under [insert reference to state law equivalent to Section 6A(4) of the Portability Act], the individual carrier shall be prohibited from offering health benefit plans to individuals in any part of the service area for a period of five (5) years. In addition, the individual carrier shall not offer health benefit plans to individuals in any other geographical area of the state without the prior approval of the commissioner. In considering whether to grant approval, the commissioner may ask for reasonable and appropriate information and assurances.

Section 9. Qualifying Previous and Qualifying Existing Coverages

A. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage for the purposes of [insert reference to state law equivalent to Section 7A of the Portability Act], an individual carrier shall interpret the Portability Act no less favorably to an insured individual than the following:

(1) A health insurance policy, certificate or other benefit arrangement shall be considered to provide benefits similar to or exceeding the benefits provided under the standard health benefit plan if the policy, certificate or other benefit arrangement provides benefits that:

(a) Have a relative actuarial value, compared to the standard health plan, that is greater than or equal to one; or

(b) Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for these services in the standard health benefit plan.

(2) In making a determination under Paragraph (1), an individual carrier shall evaluate the previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its decision solely on the fact that one portion of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the standard health benefit plan.

Drafting Note: For states using the Portability Model as an acceptable alternative mechanism under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), a person who had 18 months qualifying previous coverage (creditable coverage in HIPAA) with no break in coverage greater than 63 days (or a "HIPAA eligible individual") must have an unconditional choice of two policy forms for the purposes of guaranteed issue in the federal law. Thus, the qualification contained in Section 7A of the Portability Act that a carrier need only guarantee issue the individual basic health benefit plan to a recently insured individual whose qualifying previous coverage had benefits that were not comparable to or did not exceed the individual standard health benefit plan cannot be applied to a HIPAA eligible individual.

B. For the purposes of [insert reference to state law equivalent to Section 7G(1) of the Portability Act], an individual will be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement covering the individual met the definition of qualifying previous coverage contained in [insert reference to state law equivalent to Section 3Z of the Portability Act] and provided any benefit with respect to the service.

C. An individual carrier shall ascertain the source of previous or existing coverage of each individual and each dependent of an individual at the time the individual or dependent initially enrolls into the health benefit plan provided by the individual carrier. The individual carrier shall have the responsibility to contact the source of the previous or existing coverage to resolve any questions about the benefits or limitations related to the previous or existing coverage.

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Section 10. Restrictive Riders

A restrictive rider, endorsement or other provision that would violate the provisions of [insert reference to state law equivalent to Section 7I of the Portability Act] and that was in force on the effective date of this regulation in an individual basic or standard health benefit plan may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this regulation. An individual carrier shall provide written notice to those individuals whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan.

Section 11. Disclosure of Information

Information required to be disclosed pursuant to of [insert reference to state law equivalent to Section 5I of the Portability Act] shall be provided in a manner that is understandable by the average individual and shall be accurate and sufficiently comprehensive to reasonably inform individuals of their rights and obligations under the plan.

Section 12. Rules Related to Fair Marketing

A. (1) An individual carrier shall actively market each of its health benefit plans to individuals in this state. An individual carrier may not suspend the marketing or issuance of the basic and standard health benefit plans unless the individual carrier has good cause and has received the prior approval of the commissioner.

(2) In marketing the basic and standard health benefit plans to individuals, an individual carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to individuals. A producer authorized by an individual carrier to market health benefit plans to individuals in the state shall also be authorized to market the basic and standard health benefit plans.

Drafting Note: The regulation requires the active marketing of all individual health benefit plans offered by a carrier, even though the basic and standard health benefit plans are the only products required to be guarantee issued to recently insured individuals. This requirement is present to prevent targeted marketing by a carrier or producer. Marketing materials should make clear, however, that not all persons are eligible for all individual health benefit plans issued by the carrier. Those materials should also make clear that some individual health benefit plans may only be available in certain geographic areas.

B. (1) An individual carrier shall offer at least the basic and standard health benefit plans to any recently insured individual that applies for or makes an inquiry regarding health insurance coverage from the individual carrier. The offer may be provided directly to the individual or delivered through a producer. The offer shall be in writing and shall include at least the following information:

(a) A general description of the benefits contained in the basic and standard health benefit plans and any other health benefit plan being offered to the individual; and

(b) Information describing how the individual may enroll in the plans.

Drafting Note: HIPAA requires that HIPAA eligible individuals must have an unconditional choice of two policy forms for the purposes of guaranteed issue in the federal law. The carrier may elect the two most popular policy forms, or two policy forms with representative coverage as defined in HIPAA. Depending on the actuarial value of the basic and standard health benefit plans under state law, they may or may not meet the requirements of representative coverage under HIPAA. States may wish to ensure that the basic and standard health benefit plans meet the requirements of representative coverage under HIPAA.

(2) (a) An individual carrier shall provide a price quote to an individual (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and information necessary to provide the quote. An individual carrier shall notify an individual (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the individual carrier to provide the quote.

(b) An individual carrier may not apply more stringent or detailed requirements related to the application process for the basic and standard health benefit plans than are applied for other health benefit plans offered by the individual carrier.

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(3) (a) If an individual carrier denies coverage under a health benefit plan to a recently insured individual, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to confidentiality of medical information). The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the individual carrier. The explanation shall include at least the following:

(i) A general description of the benefits contained in each plan;

(ii) A price quote for each plan; and

(iii) Information describing how the individual may enroll in the plans.

(b) The written information described in this paragraph may be provided within the time periods provided in Paragraph (2) directly to the individual or delivered through an authorized producer.

(c) The price quote required under Subparagraph (a)(ii) shall be for the lowest-priced basic and standard health benefit plan for which the individual is eligible.

C. An individual carrier shall maintain a toll-free telephone service that answers its telephone calls in a timely manner to provide information to individuals regarding the availability of individual health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the individual carrier. The information may include the names and telephone numbers of producers located geographically proximate to the caller or other information reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

Drafting Note: Some states with smaller populations may determine that this provision is not necessary to assure fair marketing of individual health benefit plans in their state. For those states that determine this provision is necessary, it is imperative that the toll-free number be accessible. With the prevalence of managed care and preauthorization requirements, it is of paramount importance to the enrollee that the telephone be answered in a timely fashion.

D. The individual carrier shall not require an individual to join or contribute to an association or group as a condition of being accepted for coverage by the individual carrier, except that if membership in an association or other group is a requirement for accepting an individual into a particular health benefit plan, an individual carrier may apply that requirement, subject to the requirements of [insert reference to state law equivalent to Section 8A(2)(b) of the Portability Act].

E. An individual carrier may not require, as a condition to the offer or sale of a health benefit plan to an individual that the individual purchase or qualify for any other insurance product or service.

F. (1) An individual carrier shall file annually the following information with the commissioner related to health benefit plans issued by the individual carrier to individuals in this state:

(a) The number of individuals that were issued health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

(b) The number of individuals that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year (separated as to newly issued plans and renewals and as to block of business);

(c) The number of individual health benefit plans in force in each county (or by zip code) of the state as of December 31 of the previous calendar year;

(d) The number of individual health benefit plans that were voluntarily not renewed by individuals in the previous calendar year;

(e) The number of individual health benefit plans that were terminated or nonrenewed (for reasons other than nonpayment of premium) by the individual carrier in the previous calendar year; and

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(f) The number of individual health benefit plans that were issued to individuals that were uninsured for at least the three (3) months prior to issue.

(2) The information described in Paragraph (1) shall be filed no later than March 15 of each year.

G. An individual carrier may not create financial incentives or disincentives for producers to sell or to not sell any of its individual health benefit plans, including the individual basic and standard health benefit plans. The commissioner shall have authority to review an individual carrier's commission structure to ensure no financial incentives or disincentives to sell or to not sell any of its individual health benefit plans are created by the structure.

Drafting Note: This subsection does not require that individual health benefit plans be sold only through producers. This subsection also does not require that commissions for the sale of open enrollment health benefit plans be comparable to commissions for the sale of non-open enrollment health benefit plans if the individual carrier can demonstrate a more efficient distribution system for open enrollment health benefit plans. States should be wary, however, of unfairly low commissions for the sale of the basic and standard individual health benefit plans which may have an adverse effect on a producer's desire to sell those plans. States may wish to consider setting minimum commissions for the sale of basic and standard individual health benefit plans to prevent a financial disincentive for their sale.

Section 13. Status of Carriers as Individual Carriers

A. Within thirty (30) days after the effective date of the Portability Act, each carrier providing individual health benefit plans in this state shall make a filing with the commissioner indicating whether the carrier intends to operate as an individual carrier in this state under the terms of this regulation.

B. Subject to Subsection C, an individual carrier shall not offer health benefit plans to individuals, or continue to provide coverage under health benefit plans previously issued to individuals in this state, unless the filing provided pursuant to Subsection A indicates that the carrier intends to operate as an individual carrier in this state.

C. (1) If the filing made pursuant to Subsection A indicates that a carrier providing individual health benefit plans in this state does not intend to operate as an individual carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to individuals in this state only if the carrier complies with the requirements of the Portability Act with respect to each of the health benefit plans previously issued to individuals by the carrier; and

(2) An individual carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the Individual Health Benefit Plan Association established under [insert reference to state law equivalent to Section 10 of the Portability Act].

D. If the filing made pursuant to Subsection A indicates that a carrier does not intend to operate as an individual carrier in this state, the carrier shall be precluded from operating as an individual carrier in this state (except as provided for in Subsection C) for a period of five (5) years from the date of the filing. Upon a written request from an individual carrier, the commissioner may reduce the period provided for in the previous sentence if the commissioner finds that permitting the carrier to operate as an individual carrier would be in the best interests of the individuals in the state.

Section 14. Allowable Conversion Coverage Offerings

A. Carriers that are required to offer a converted policy pursuant to [insert reference to state law equivalent to the Group Health Insurance Mandatory Conversion Privilege Model Act] shall meet this requirement either by offering a converted policy that meets the requirements of [cite state's minimum coverage requirements for a conversion policy contained in state law equivalent to the Group Health Insurance Mandatory Conversion Privilege Model Act] or by offering a choice of the individual basic or standard health benefit plans only pursuant to this regulation.

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B. Carriers that elect to meet the requirement to offer a converted policy by offering a choice of the individual basic and standard health benefit plans only shall notify the commissioner and the Individual Health Benefit Plan Association established in [insert reference to state law equivalent to Section 10 of the Portability Act], in writing, of this election. Once a carrier has made this election, it cannot be revoked. Notification to the Individual Health Benefit Plan Association of a carrier's election shall automatically make that carrier eligible for distributions according to the terms of the Individual Health Benefit Plan Association's plan of operation.

Section 15. Choice of Basic or Standard Health Benefit Plans

A. A carrier that elects to offer as a converted policy a choice of the individual basic or standard health benefit plans only:

(1) Shall, at a minimum, offer to an applicant qualified for a converted policy at least one individual basic converted policy and at least one individual standard converted policy of the same type (i.e., traditional indemnity, preferred provider, or health maintenance organization (HMO)) as the coverage from which the applicant is converting. At its discretion, the carrier may additionally offer other types of individual basic or standard health benefit plans as converted policies; and

(2) Shall not offer other converted policies either in addition to or in lieu of the individual basic and standard converted policies.

Drafting Note: For example, with regard to Paragraph (1), a person converting from an HMO group plan shall be offered a choice of an individual HMO basic or standard converted policy and may additionally be offered, at the carrier's discretion, a choice of an individual indemnity or individual preferred provider organization (PPO) basic or standard converted policy.

B. An individual basic and standard converted policy shall not be modified in any way, except that carriers may offer optional riders to the individual basic or standard converted policy that would add additional coverage, only if the riders are offered to all applicants for a converted policy and are guarantee issued to any person requesting the additional coverage.

Section 16. Converted Policies Issued Prior to a Carrier's Election to Offer Individual Basic and Standard Converted Policies Only

A. A carrier that elects to offer only individual basic and standard health benefit plans as converted policies shall notify all persons covered under a converted policy issued before the date of the carrier's election, in writing, each time their policy renews, of their right to change from their existing converted policy to an individual basic or standard converted policy. The notification shall:

(1) At the first renewal after the carrier's election, include the premium amounts the person would have to pay for the existing converted policy, and the premium amounts the person would have to pay an individual basic or standard converted policy;

(2) At the first renewal after the carrier's election, include a comparison of benefits under the person's existing converted policy and the individual basic or standard converted policy; and

(3) At each renewal, allow a person with a converted policy issued prior to the carrier's election, thirty (30) days from the date the notice is issued, to substitute for the existing converted policy an individual basic or standard converted policy.

B. The decision to substitute an individual basic or standard converted policy shall be solely at the discretion of the policyholder, except that, at the carrier's option, if the policyholder has not made an election within three (3) years after the date of the carrier's election, the carrier may require the policyholder to make the election.

C. Once a person has elected either the individual basic or standard converted policy as a substitute converted policy, that person may not elect another converted policy.

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D. A person electing to substitute for an existing converted policy, originally issued prior to a carrier's decision to offer only individual basic and standard converted policies, an individual basic or standard converted policy, shall not be subject to any new preexisting condition exclusion period when he or she substitutes plans.

E. Once a person has elected to substitute for the existing converted policy an individual basic or standard converted policy, a carrier shall not allow that person to change the converted policy again.

(1) A carrier shall not allow a person electing to substitute for the existing converted policy an individual basic converted policy to subsequently change coverage to either an individual standard converted policy or to their prior converted policy, once they have been enrolled under the individual basic converted policy.

(2) A carrier shall not allow persons electing to substitute for their existing converted policy an individual standard converted policy to subsequently change their coverage to either an individual basic converted policy or to the prior converted policy, once the person has been enrolled under the individual standard converted policy.

F. Carriers shall require all persons who elect to substitute for their existing converted policies pursuant to Subsection A of this section to sign a statement certifying that:

(1) The person understands that the decision to substitute for the existing converted policy the individual basic or standard converted policy is solely the person's to make;

(2) The person has not been encouraged or induced by the carrier, a broker, a producer or their representatives to substitute the individual basic or standard converted policies; and

(3) The person understands that once made, the decision to substitute an individual basic or standard converted policy for the existing converted policy is irrevocable.

Section 17. Setting Rates for Individual Basic and Standard Converted Policies

A. Carriers that issue coverage in both the group and individual markets and that offer individual basic and standard converted policies shall set premiums for the individual basic and standard converted policies as if they were individual basic or standard health benefit plans, pursuant to [insert reference to state law equivalent to Section 5 of the Portability Act].

B. Pursuant to [insert reference to state law equivalent to Section 5D of the Portability Act], the rates for individual basic and standard coverages shall not exceed 150 percent of the lowest rate available for issuance after adjustment for benefit design and allowed rating characteristics.

C. Carriers that issue coverage in the group market but not in the individual market and that offer individual basic and standard converted policies shall set premiums for individual basic and standard converted policies at not more than the average premium charged by the five (5) largest individual carriers (as measured by their premium volume) for, respectively, their individual basic and standard health benefit plans for each (e.g., indemnity, PPO, or HMO) of the basic or standard health benefit plans. These averages shall be calculated each year by the commissioner and published no later than December 1. Those carriers subject to the maximum average premium rates referenced above may revise premiums for all in-force and newly issued converted policies on any single day between January 1 and February 1 of the following year regardless of how long those policies have been in force. If rates are changed during this period, rates may not be changed on the policy anniversary date.

Drafting Note: The average premium should be a weighted average with premium volume as the weights (but no one carrier to exceed 50%). The average should be based on premium filings, where applicable, that will be in effect in January of the following year. Different carriers may have different rate variations (e.g., age, geography, or family composition), different rating methodology (e.g. attained age or issue age rating) and these rate variations should be taken into consideration when calculating the average premium.

D. A carrier that does not elect to offer only the basic and standard converted policies shall set rates for converted policies as follows:

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(1) For plans having a relative actuarial value, compared to the standard health plan, that is greater than or equal to one, as the average premium charged by the five (5) largest individual carriers (as measured by their premium volume) for their individual standard health benefit plans; and

(2) For all other plans, as the average premium charged by the five (5) largest individual carriers (as measured by their premium volume) for their individual basic health benefit plans.

E. New business and renewal rates for persons with the same converted policies who have the same rating characteristics shall be the same.

Section 18. Health Benefit Plan Committee

A. The commissioner shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, eligible persons, 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 individual carriers pursuant to [insert reference to state law equivalent to Section 8 of the Portability Act].

C. The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan that 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.

(1) 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.

(2) The committee shall submit the health benefit plans described in Paragraph (1) to the commissioner for approval within 180 days after the appointment of the committee.

Section 19. Determination of Significantly Disproportionate Share

The board of directors of the Individual Health Benefit Plan Association shall determine, pursuant to Section 10M of the Portability Act, whether a carrier may seek remedy from writing a significantly disproportionate share of individual basic or standard policies in relation to total premiums written in this state for health benefit plans. The board's determination shall be subject to review by the commissioner.

Drafting Note: What constitutes a "significantly disproportionate share" will vary from state to state. In a smaller market, a 10% differential may be a relatively few number of people and may be insignificant, while in a larger market such a differential may be significant.

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Section 20. Assessments and Distributions

A. Following the close of each calendar year, assessments and distributions for carriers issuing individual basic and standard health benefit plans shall be determined as follows:

(1) The board of directors of the Individual Health Benefit Plan Association shall calculate the aggregate ratio of paid claims to earned premiums for all carriers in the state issuing individual basic and standard health benefit plans.

(2) A carrier having a ratio of paid claims to earned premiums for individual basic and standard health benefit plans in excess of the aggregate ratio shall receive a distribution equal to the individual basic and standard health benefit plans earned premium times the difference between the carrier's ratio and the aggregate ratio.

(3) A carrier having a ratio of paid claims to earned premiums for its individual basic and standard health benefit plans below the aggregate ratio shall pay an assessment equal to the individual basic and standard health benefit plans earned premium times the difference between the carrier's ratio and the aggregate ratio.

B. When the aggregate ratio of paid claims to earned premiums for individual basic and standard health benefit plans exceeds ninety percent (90%):

(1) Assessments on all members of the Individual Health Benefit Plan Association are required.

(a) The amount of the total assessment is the sum of the following:

(i) The dollar difference between ninety percent (90%) of earned premiums and the paid claims;

(ii) The necessary operating expenses for the Individual Health Benefit Plan Association; and

(iii) Any other additional expenses as provided by law.

(b) Each member of the Individual Health Benefit Plan Association shall be assessed a proportional share of the total assessment.

(2) Disbursements shall be made to carriers issuing individual basic and standard health benefit plans. The amount of the disbursement to a carrier shall equal the carrier's earned premium for individual basic and standard health benefit plans times the difference between the aggregate ratio determined according to Section [insert reference to state law equivalent to Section 10I of the Portability Act] and ninety percent (90%).

C. The Individual Health Benefit Plan Association may also provide for initial or interim assessments to meet operating expenses of the association.

Section 21. Severability

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

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Section 22. Effective Date

The regulation shall be effective on [insert date].

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

1998 Proc. 2nd Quarter 11, 13, 752, 828, 855-868 (adopted).

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