

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

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Section 1. Title

This regulation shall be known and may be cited as the Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation.

Section 2. Purpose

The purpose of this regulation is to incorporate the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal regulations that prohibit carriers providing health insurance coverage under a health benefit plan in the group market from discriminating against individual participants or beneficiaries in these plans with respect to plan eligibility and in setting premium and contribution rates based on any health factor of the participants or beneficiaries.

Section 3. Definitions

As used in this regulation:

- A. “Affiliation period” means a period of time that must expire before health insurance coverage provided by a carrier becomes effective, and during which the carrier is not required to provide benefits.
- B. “Beneficiary” has the meaning stated in Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA).
- C. “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 provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. For the purposes of this regulation, carrier includes a sickness and accident insurance company, a nonprofit hospital and health service corporation, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Drafting Note: HIPAA uses the term “health insurance issuer” instead of “carrier.” The definition of “health insurance issuer” contained in HIPAA is consistent with the term “carrier,” as defined in Subsection C of this section.

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

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

- E. (1) “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:
 - (a) A group health plan;

- (b) A health benefit plan;
 - (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);
 - (e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents). For purposes of Chapter 55 of Title 10, U.S.C., “uniformed services” means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
 - (f) A medical care program of the Indian Health Service or of a tribal organization;
 - (g) A state health benefits risk pool;
 - (h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
 - (i) A public health plan, which for purposes of this regulation, means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan; or
 - (j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
- (2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

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

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

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

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

Drafting Note: If using the suggested definition above, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child above is not intended to be limited to natural children of the participant.

G. “Enrollment date” means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever is earlier.

H. (1) “Genetic information” means information about genes, gene products and inherited characteristics that may derive from the individual or a family member.

(2) “Genetic information” includes information regarding an individual’s carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

- I. (1) “Group health plan” means an employee welfare benefit plan, as defined in Section 3(1) of ERISA, to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
- (2) For purposes of this regulation:
- (a) Any plan, fund or program that would not be, but for PHSa Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b) of this paragraph, as an employee welfare benefit plan that is a group health plan;
 - (b) In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner; and
 - (c) In the case of a group health plan, the term “participant,” as defined in Subsection P, also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual’s beneficiary who is, or may become, eligible to receive a benefit under the plan, if:
 - (i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or
 - (ii) In connection with a group health plan maintained by a self-employed individual, under which, one or more employees are participants, the individual is the self-employed individual.

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

- J. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- (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.

Drafting Note: HIPAA uses the term “health insurance coverage.” “Health benefit plan,” as defined in this model regulation, is intended to be consistent with the definition of “health insurance coverage” contained in HIPAA. Paragraphs (3), (4), (5), and (6) below track the language of HIPAA that addresses “excepted benefits,” i.e., those benefits that are excepted from the requirements of HIPAA.

- (3) “Health benefit plan” shall not include one or more, or any combination of, the following:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Liability insurance, including general liability insurance and automobile liability insurance;
 - (c) Coverage issued as a supplement to 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” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (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” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under a 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 a 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; or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- K. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a medical condition, illness, injury or disease.
- L. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.
- M. (1) “Health factor” means, in relation to an individual, any of the following health status-related factors:
- (a) Health status;
 - (b) Medical condition, including both physical and mental illnesses, as defined in Subsection O;
 - (c) Claims experience;
 - (d) Receipt of health care;

- (e) Medical history;
 - (f) Genetic information;
 - (g) Evidence of insurability, including:
 - (i) Conditions arising out of acts of domestic violence; or
 - (ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or
 - (h) Disability.
- (2) For purposes of this subsection, “health factor” does not include the decision whether to elect health insurance coverage, including the time chosen to enroll, such as under special enrollment or late enrollment.

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

- N. “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).
- O. (1) “Medical condition” means any condition, whether physical or mental, including any condition resulting from illness, injury, accident, pregnancy or congenital malformation.
- (2) For purposes of Paragraph (1), genetic information is not a condition.
- P. “Participant” has the meaning stated in Section 3(7) of ERISA.
- Q. (1) “Preexisting condition” means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage.
- (2) “Preexisting condition” shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the health benefit plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.
- (3) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.
- R. “Significant break in coverage” means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.
- S. “Waiting period” means, with respect to a health benefit plan and an individual, who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to Subsection E(2), a waiting period shall not be considered a gap in coverage.

Section 4. Applicability and Scope

This regulation shall apply to any carrier that provides coverage under a health benefit plan in the group market.

Section 5. Prohibited Discrimination in Rules for Eligibility

- A. A carrier subject to this regulation shall not establish a rule for eligibility, including continued eligibility, of an individual to enroll for benefits under the plan that discriminates based on any health factor that relates to the individual or dependent of the individual.
- B. For purposes of this section, rules of eligibility include rules relating to:
 - (1) Enrollment;
 - (2) The effective date of coverage;
 - (3) Waiting or affiliation periods;
 - (4) Late and special enrollment;
 - (5) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;
 - (6) Benefits, including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Section 7A and B of this regulation;
 - (7) Continued eligibility; and
 - (8) Terminating coverage, including disenrollment, of an individual under the plan.
- C. Nothing in this section prohibits a carrier subject to this regulation from:
 - (1) Establishing more favorable rules of eligibility for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor; or
 - (2) Subject to state law, charging a higher premium or contribution with respect to an individual with an adverse health factor if the individual would not be eligible for coverage, but for the adverse health factor.

Section 6. Prohibited Discrimination in Premium and Contribution Rates

- A.
 - (1) A carrier subject to this regulation shall not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution rate that is greater than the premium or contribution rate for a similarly situated individual enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.
 - (2) In determining an individual's premium or contribution rate, discounts, rebates, payments-in-kind and any other premium differential mechanisms shall be taken into account.
- B.
 - (1) Subject to Paragraph (2), nothing in this section restricts the aggregate amount that a carrier subject to this regulation may charge an employer for coverage under a plan.
 - (2) A carrier subject to this regulation shall not quote or charge an employer or an individual participant or beneficiary a different premium than that quoted or charged an individual in a group of similarly situated individuals based on a health factor unless permitted under Section 5C(2) of this regulation or Subsection D of this section.

- C. Notwithstanding Subsections A and B, a carrier subject to this regulation may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.
- D. Nothing in this section prohibits a carrier subject to this regulation from charging an individual a premium or contribution rate that is less than the premium or contribution rate for similarly situated individuals if the lower charge is based on an adverse health factor of the individual, such as a disability.

Section 7. Application of Section 5 to Plan Benefits; Preexisting Condition Exclusions; Similarly Situated Individuals

- A.
 - (1) Subject to Paragraph (2), Section 5 of this regulation does not require a carrier subject to this regulation to provide coverage for any particular benefit to any group of similarly situated individuals.
 - (2)
 - (a) A carrier subject to this regulation shall make the benefits provided under a plan available uniformly to all similarly situated individuals, as those groups are determined under Subsection C.
 - (b) For any restriction on a benefit or benefits provided under a plan, a carrier subject to this regulation:
 - (i) Shall apply the restriction uniformly to all similarly situated individuals; and
 - (ii) Shall not direct the restriction, as determined based on all of the relevant facts and circumstances, at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.
 - (c) A carrier subject to this regulation may impose annual, lifetime or other limits on benefits and may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the limit or cost-sharing requirement:
 - (i) Applies uniformly to all similarly situated individuals; and
 - (ii) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.
 - (d) For purposes of this paragraph, a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.
 - (3) If a carrier subject to this regulation generally provides benefits for a type of injury, the plan or carrier shall not deny an individual participant or beneficiary benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition.
 - (4) A carrier subject to this regulation with a cost-sharing mechanism, such as a deductible, copayment or coinsurance, that requires a higher payment from an individual, based on a health factor of that individual or dependent of that individual, than for a similarly situated individual under the plan, does not violate this subsection if the payment differential is based on whether the individual has complied with the requirements of a bona fide wellness program.
- B.
 - (1) Section 5 of this regulation does not prohibit a carrier subject to this regulation from imposing a preexisting condition exclusion period if the preexisting exclusion period:
 - (a) Complies with the requirements for imposing a preexisting condition exclusion period established by federal regulation;

- (b) Is applied uniformly to all similarly situated individuals, as those groups are determined under Subsection C; and
 - (c) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.
- (2) For purposes of this subsection, a plan amendment relating to a preexisting condition exclusion that is applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.
- C. (1) This subsection applies only within a group of individuals who are treated as similarly situated individuals.
- (2) (a) Subject to Paragraph (4) of this subsection, Section 5 of this regulation does not prohibit a carrier subject to this regulation from treating participants as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among groups of participants is based on a bona fide employment-based classification that is consistent with the employer's usual business practice.
- (b) (i) Whether an employment-based classification is bona fide shall be determined based on all of the relevant facts and circumstances.
 - (ii) For purposes of Item (i), relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage, such classifications may include:
 - (I) Full-time versus part-time status;
 - (II) Geographic location;
 - (III) Membership in a collective bargaining unit;
 - (IV) Date of hire;
 - (V) Length of service;
 - (VI) Current employee versus former employee status; and
 - (VII) Occupation.
 - (iii) A classification based on a health factor shall not be determined to be a bona fide employment-based classification for purposes of this subsection unless the requirements of Section 5C and Section 6D of this regulation are satisfied.
- (3) (a) Subject to Paragraph (4), Section 5 of this regulation does not prohibit a carrier subject to this regulation from treating beneficiaries as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among the groups of beneficiaries is based on any of the following factors:
- (i) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;
 - (ii) Relationship to the participant (e.g., as a spouse or as a dependent child);
 - (iii) Marital status;
 - (iv) With respect to a child of the participant, age or student status; or

- (v) Any other factor, if the factor is not a health factor.
- (b) Subparagraph (a) of this paragraph shall not be construed to prevent a carrier subject to this regulation from providing more favorable treatment of individuals under the plan with adverse health factors in accordance with Section 5C and Section 6D of this regulation.
- (4) Notwithstanding Paragraphs (2) and (3), unless permitted under Section 5C or Section 6D of this regulation, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on a health factor of the participants or beneficiaries, the classification is not permitted under this subsection.

Section 8. Application of Sections 5 and 6 to Nonconfinement and Actively-at-Work Provisions

- A. Except to the extent permitted under Subsection B(2) or Subsection C, in accordance with Sections 5 and 6 of this regulation, a carrier subject to this regulation shall not establish a rule of eligibility or set an individual's premium or contribution rate based on:
 - (1) Whether the individual is confined in a hospital or other health care institution; or
 - (2) The individual's ability to engage in normal life activities.
- B. (1) In accordance with Sections 5 and 6 of this regulation, a carrier subject to this regulation shall not establish a rule for eligibility or set an individual's premium or contribution rate based on whether the individual is actively-at-work, including whether an individual is continuously employed, unless absence from work due to any health factor is treated, for purposes of the plan, as being actively-at-work.
 - (2) Notwithstanding Paragraph (1), a carrier subject to this regulation may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before coverage under the plan becomes effective if the rule for eligibility applies regardless of the reasons for the absence.
- C. Notwithstanding Subsections A and B, a carrier subject to this regulation may establish a rule of eligibility or set an individual's premium or contribution rate with respect to similarly situated individuals, as those groups are determined under Section 7C of this regulation.

Section 9. Enforcement

- A. The commissioner shall conduct a reasonable investigation based on a complaint [add any means by which the commissioner receives complaints] received by the commissioner and issue a prompt determination as to whether a violation of this regulation may have occurred.
- B. If the commissioner finds from the investigation that a violation of this regulation may have occurred, the commissioner shall promptly begin an adjudicatory proceeding.
- C. The commissioner may address a violation of this regulation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these.
- D. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

Drafting Note: States may wish to delete this section if the substance of it already exists in state law.

Section 10. Effective Date

This regulation shall be effective on [insert date].

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

2002 Proc. 1st Quarter 13, 14, 177, 184, 211-218 (adopted).

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

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

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**NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN
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KEY:

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

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

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

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO CURRENT ACTIVITY	
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas	NO CURRENT ACTIVITY	
California	NO CURRENT ACTIVITY	
Colorado	NO CURRENT ACTIVITY	
Connecticut	NO CURRENT ACTIVITY	
Delaware		DEL. CODE ANN. tit. 18, § 3574 (2001/2013) (rate discrimination).
District of Columbia	NO CURRENT ACTIVITY	
Florida	NO CURRENT ACTIVITY	
Georgia	NO CURRENT ACTIVITY	
Guam	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Hawaii	NO CURRENT ACTIVITY	
Idaho	NO CURRENT ACTIVITY	
Illinois		215 ILL. COMP. STAT. § 97/25 (1997) (eligibility discrimination).
Indiana	NO CURRENT ACTIVITY	
Iowa		IOWA ADMIN. CODE r. 191-15.11 (1963/2009).
Kansas	NO CURRENT ACTIVITY	
Kentucky		KY. REV. STAT. ANN. § 304.17A-200 (1998) (eligibility and rate discrimination).
Louisiana	NO CURRENT ACTIVITY	
Maine	NO CURRENT ACTIVITY	
Maryland		MD. CODE ANN., INS. § 15-1407 (1997) (rate discrimination).
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota	NO CURRENT ACTIVITY	
Mississippi		19 Code Miss. R. Pt. 1, R. 26.01 to 26.09 (2012).
Missouri	NO CURRENT ACTIVITY	
Montana	NO CURRENT ACTIVITY	
Nebraska	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Nevada		NEV. REV. STAT. § 689B.550 (1997) (eligibility discrimination); NEV. ADMIN. CODE § 689B.305 (2002) (rate discrimination).
New Hampshire	N.H. CODE ADMIN. R. ANN. 1907.03 to 1907.07 (2006).	
New Jersey		N.J. STAT. ANN. § 17B:27-64 (1997) (eligibility discrimination); § 17B:27-65 (1997) (rate discrimination).
New Mexico		N.M STAT. ANN. §§ 59a-23e-11 to 59a-23e-12 (1997/1998).
New York	NO CURRENT ACTIVITY	
North Carolina	NO CURRENT ACTIVITY	
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. § 3923.571 (1999) (rate discrimination).
Oklahoma	NO CURRENT ACTIVITY	
Oregon		OR. REV. STAT. § 743B.104 (1999/2015) (eligibility discrimination).
Pennsylvania	NO CURRENT ACTIVITY	
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		R.I. GEN. LAWS § 27-18.6-4 (2000) (eligibility discrimination).
South Carolina	NO CURRENT ACTIVITY	
South Dakota		S.D. ADMIN. R. §§ 20:06:46:01 to 20:06:46:15 (2002).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Tennessee		TENN. CODE ANN. §§ 56-7-2801 to 56-7-2814 (1997).
Texas	NO CURRENT ACTIVITY	
Utah	NO CURRENT ACTIVITY	
Vermont	NO CURRENT ACTIVITY	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	NO CURRENT ACTIVITY	
Washington	NO CURRENT ACTIVITY	
West Virginia		W. VA. CODE § 33-16-3n (1997) (eligibility discrimination).
Wisconsin	NO CURRENT ACTIVITY	
Wyoming	NO CURRENT ACTIVITY	

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Proceedings Citations

Cited to the Proceedings of the NAIC

This model began its development when NAIC staff reported that the three federal agencies charged with drafting regulations to implement the Health Insurance Portability and Accountability Act of 1996 (HIPAA) had published an interim final rule implementing the nondiscrimination provisions of HIPAA. The chair recommended to the task force that it request NAIC staff to review NAIC model acts and regulations to determine whether the provisions of this interim rule could be incorporated in an existing NAIC model act or regulation or whether a new NAIC model regulation would have to be developed. **2001 Proc. 1st Quarter, 108.**

When the model was considered for adoption by the entire NAIC membership, the chair of the committee responsible for health issues said that the model regulation incorporates group nondiscrimination requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and was not controversial. **2002 Proc. 1st Quarter 13.**

Section 1. Title

Section 2. Purpose

The model regulation was drafted for compliance with an interim final rule issued by the three federal agencies charged with administering the provisions of HIPAA). The interim final rule prohibited group health carriers from discriminating against individuals and their dependents in enrollment requirements and in setting premium rates based on a health status-related factor. **2001 Proc. 2nd Quarter 117.**

Health carriers must begin compliance with the interim final rule as of July 1, 2001. **2001 Proc. 2nd Quarter 126.**

Section 3. Definitions

When the draft was revised, references to the term “group health plan” were deleted This maintained consistency with other NAIC model acts, which used the term “health carrier.” **2001 Proc. 4th Quarter 221.**

E. NAIC staff explained that revisions made in the third draft included deleting references to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in Subsections E(1)(e) and J(6)(b) because the name of that program changed to “TRICARE.” TRICARE was not specifically referenced because its name could change again in the future. **2002 Proc. 1st Quarter 184.**

J. NAIC staff explained that the definitions were taken from other NAIC models. NAIC staff noted that the definition of “group market” in Subsection J was new and that the definition of “health factor” in Subsection N was derived from the interim final rule. **2001 Proc. 2nd Quarter 126.**

R. NAIC staff asked the task force for its position with respect to the proposed 90-day window within which insureds could obtain health insurance coverage before incurring a significant break in coverage under HIPAA. HIPAA provided for a 63-day window. NAIC staff noted that the 90-day window proposed in the draft would be consistent with action taken by the task force in other NAIC models that were revised to conform to HIPAA. **2001 Proc. 2nd Quarter 126.**

Section 4. Applicability and Scope

Section 5. Prohibited Discrimination in Rules for Eligibility

NAIC staff explained that Section 5 prohibited health carriers from establishing a rule for eligibility, including continued eligibility, of an individual to enroll in the carrier’s health benefit plan based on any health factor of the individual or dependent of the individual. The language in this section was designed to mirror the interim rule’s provisions. **2001 Proc. 2nd Quarter 126.**

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Section 6. Prohibited Discrimination in Premium and Contribution Rates

This section set out the requirements that health carriers must follow when setting premium and contribution rates. It prohibited health carriers from charging an individual insured a higher premium or contribution rate than other similarly situated individuals based on a health factor of the individual insured or a dependent of the individual insured. NAIC staff noted that the language in this section mirrored the interim rule's provisions. **2001 Proc. 2nd Quarter 126.**

Section 7. Application of Section 5 to Plan Benefits; Preexisting Condition Exclusions; Similarly Situated Individuals

A. Subsection A described the requirements that health carriers must follow with respect to providing plan benefits. This subsection was not intended to require health carriers to provide coverage for a particular benefit, but for any benefit provided under a plan, the benefit must be made available uniformly to all similarly situated individuals in the plan. **2001 Proc. 2nd Quarter 126.**

B. Subsection B outlined requirements with respect to preexisting condition exclusions. This subsection was not intended to prohibit a health carrier from imposing a preexisting condition exclusion period. If the health carrier chose to do so, however, the exclusion period must apply uniformly to all similarly situated individuals in the plan. **2001 Proc. 2nd Quarter 126.**

C. NAIC staff said the most important provision in Section 7 was Subsection C, which set out the requirements that health carriers must follow when establishing categories to be used to determine a group of individuals who were to be treated as similarly situated individuals. The categories must be based on a bona fide employment-based classification consistent with the employer's usual business practice. Paragraph (2) set out the classifications that may be used for plan participants. Classifications that could be used for plan beneficiaries were set out in Paragraph (3). **2001 Proc. 2nd Quarter 126.**

Section 8. Application of Sections 5 and 6 to Nonconfinement and Actively-at-Work Provisions

A. Subsection A established requirements that health carriers were required to follow with respect to the use of nonconfinement clauses, as those clauses affected an individual's plan eligibility or premium or contribution rate. **2001 Proc. 2nd Quarter 126.**

B. Subsection B provides similar provisions with respect to actively-at-work clauses. **2001 Proc. 2nd Quarter 126.**

Section 9. Enforcement

This section established provisions that insurance commissioners could use to enforce provisions of the model regulation. NAIC staff explained that the language for this section was derived from another NAIC model act that also involved nondiscrimination issues. **2001 Proc. 2nd Quarter 126.**

Section 10. Effective Date

Chronological Summary of Action

June 2002 Adopted model.