

**SMALL EMPLOYER AND INDIVIDUAL HEALTH INSURANCE AVAILABILITY  
MODEL ACT**

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**Section 1. Short Title**

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

**Section 2. Purpose**

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

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

**Drafting Note:** This revised model act provides guidance to states interested in reforming their health insurance laws, particularly as they affect small employers and individuals, in order to promote the availability of health insurance coverage to those employers and individuals. In adopting this model, states should be mindful of cost implications for initial and renewal premiums on both the individual and small group markets.

### Section 3. Definitions

As used in this Act:

- A. “Actuarial certification” means a written statement signed by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer or individual carrier is in compliance with the provisions of Section 5 of this Act, based upon the person’s examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer or individual carrier in establishing premium rates for applicable health benefit plans.
- B. “Adjusted community rating” means a method used to develop a carrier’s premium which spreads financial risk in accordance with the requirements in Section 5 of this Act.
- C. “Affiliate” or “affiliated” means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
- D. “Affiliation period” means a period of time that must expire before health insurance coverage provided by a health maintenance organization becomes effective, and during which the health maintenance organization is not required to provide benefits.
- E. “Basic health benefit plan” means a lower cost health benefit plan developed pursuant to Section 15.

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

- F. “Board” means the board of directors of the program established pursuant to Section 12 of this Act.
- G. “Church plan” has the meaning given this term under Section 3(33) of the Employee Retirement Income Security Act of 1974.
- H. “Commissioner” means the insurance commissioner of this state.

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

- I. “Committee” means the health benefit plan committee created pursuant to Section 15 of this Act.
- J. “Control” shall be defined in the same manner as in [insert reference to state law corresponding to the National Association of Insurance Commissioners (NAIC) Model Insurance Holding Company System Regulatory Act].
- K. “Converted policy” means a basic or standard health benefit plan issued pursuant to Section 13 of this Act.
- L. (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 (Civilian Health and Medical Program of the Uniformed Services) (CHAMPUS). For purposes of Title 10, U.S.C. Chapter 55, “uniformed services” means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
  - (f) A medical care program of the Indian Health Service or of a tribal organization;
  - (g) A state health benefits risk pool;
  - (h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
  - (i) A public health plan, which for purposes of this act, means a plan established or maintained by a state, 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, there was a ninety (90) day period during all of which the individual was not covered under any creditable coverage.

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

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

**Drafting Note:** States without a statutory definition of dependent may wish to use the definition below. If using the suggested definition, 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 below is not intended to be limited to natural children of the enrollee.

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

**Drafting Note:** If a state is enacting both individual and small group reform, the self-employed individual should be placed in the individual market and the bracketed material below should be deleted; however, if a state is enacting small group reform only, the self-employed individual should be placed in the small group market.

- N. “Eligible employee” means an employee who works on a full-time basis with a normal work week of thirty (30) or more hours, except that at the employer’s sole discretion, the term shall also include an employee who works on a full-time basis with a normal work week of anywhere between at least seventeen and one-half (17.5) and thirty (30) hours, so long as this eligibility criterion is applied uniformly among all of the employer’s employees and without regard to health status-related factors. [The term includes a self-employed individual, a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis or who works less than seventeen and one-half (17.5) hours per week.] Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered “eligible employees” for purposes of minimum participation requirements pursuant to Section 7E(9) of this Act.

- O. “Eligible person” means a person who is a resident of this state who is not eligible to be insured under an employer-sponsored group health benefit plan.
- P. “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.
- Q. “Established geographic service area” means a geographic area, as approved by the commissioner and based on the carrier’s certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
- R. “Family composition” means:
  - (1) Enrollee;
  - (2) Enrollee, spouse and children;
  - (3) Enrollee and spouse;
  - (4) Enrollee and children; or
  - (5) Child only.

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

- S. “Federally defined eligible individual” means:
  - (1) An individual:
    - (a) For whom, as of the date on which the individual seeks coverage under this Act, the aggregate of the periods of creditable coverage, as defined in Subsection L, is eighteen (18) or more months;
    - (b) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan;
    - (c) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a state plan under Title XIX (Medicaid) of the Act or any successor program, and who does not have other health insurance coverage;
    - (d) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; and
    - (e) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, both elected and exhausted such coverage; or
  - (2) A child who is covered under any creditable coverage within [thirty (30)] days of birth, adoption, or placement for adoption, provided that the child does not experience a significant break in coverage.

**Drafting Note:** Under HIPAA, states may establish a special enrollment period longer than 30 days under Section 7E(8)(b) for a child with creditable coverage who satisfies Paragraph (2).

- T. “Genetic information” means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

**Drafting Note:** The definition of “genetic information” is derived from interim federal regulations. Prior to adopting the above definition, states should review final federal regulations to ensure that the language for the definition has not been altered.

- U. “Geographic area” is an area established by the commissioner used for adjusting the rates for a health benefit plan.
- V. “Governmental plan” has the meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.
- W. (1) “Group health plan” means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in Subsection HH, 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 Act:
  - (a) Any plan, fund or program that would not be, but for PHSA Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b), as an employee welfare benefit plan that is a group health plan;
  - (b) In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner; and
  - (c) In the case of a group health plan, the term “participant” also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual’s beneficiary who is, or may become, eligible to receive a benefit under the plan, if:
    - (i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or
    - (ii) In connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the individual is the self-employed individual.

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

- X. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Health benefit plan does include short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

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

- (2) “Health benefit plan” shall not include one or more, or any combination of, the following:
  - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
  - (b) Coverage issued as a supplement to liability insurance;

- (c) Liability insurance, including general liability insurance and automobile liability insurance;
  - (d) Workers' compensation or similar insurance;
  - (e) Automobile medical payment insurance;
  - (f) Credit-only insurance;
  - (g) Coverage for on-site medical clinics; and
  - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (3) "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.
- (4) "Health benefit plan" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
  - (b) Hospital indemnity or other fixed indemnity insurance.
- (5) "Health benefit plan" shall not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
  - (b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
  - (c) Similar supplemental coverage provided to coverage under a group health plan.

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

- (6) A carrier offering policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance shall comply with the following:
- (a) The carrier files on or before March 1 of each year a certification with the commissioner that contains the statement and information described in Subparagraph (b);

- (b) The certification required in Subparagraph (a) shall contain the following:
  - (i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance; and
  - (ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for such policies and certificates in this state and
- (c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the commissioner the information and statement required in Subparagraph (b) at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.

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

- Y. “Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

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

- Z. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.

- AA. “Health status-related factor” means any of the following factors:

- (1) Health status;
- (2) Medical condition, including both physical and mental illnesses;
- (3) Claims experience;
- (4) Receipt of health care;
- (5) Medical history;
- (6) Genetic information;
- (7) Evidence of insurability, including conditions arising out of acts of domestic violence; or
- (8) Disability.

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

- BB. “Individual carrier” means a carrier that issues or offers for issuance individual health benefit plans covering one or more residents of this state.

- CC. “Individual health benefit plan” means:

- (1) A health benefit plan other than a converted policy or a professional association plan for eligible persons and their dependents; and
- (2) A certificate issued to an eligible person that evidences coverage under a policy or contract issued to a trust or association or other similar grouping of individuals, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not being covered under the policy or contract pursuant to continuation of benefits provisions applicable under federal or state law, except that “individual health benefit plan” shall not include a certificate issued to an eligible person that evidences coverage under a professional association plan.

**Drafting Note:** In reforming the individual health insurance market, it is important that state insurance departments have jurisdiction over policies sold to individuals through trusts or associations situated outside the state. Paragraph (2) clarifies that if the certificateholder lives within the state and pays the premium for the policy, that policy is an individual health benefit plan subject to this Act, even if the policy was marketed or purchased through an out-of-state trust or association. Also, under Section 4D the commissioner has specific injunctive authority to enforce the provisions of this Act.

- DD. “Individual reinsuring carrier” means an individual carrier that is eligible to reinsure eligible persons in the reinsurance program pursuant to Section 12 of this Act.
- EE. “Individual risk-assuming carrier” means an individual carrier whose application is approved by the commissioner pursuant to Section 11 of this Act.
- FF. (1) “Late enrollee” means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days.
- (2) “Late enrollee” shall not mean an eligible employee or dependent:
- (a) Who meets each of the following:
    - (i) The individual was covered under creditable coverage at the time of the initial enrollment;
    - (ii) The individual lost coverage under creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of a spouse, divorce or legal separation; and
    - (iii) The individual requests enrollment within thirty (30) days after termination of the creditable coverage or the change in conditions that gave rise to the termination of coverage;
  - (b) If, where provided for in contract or where otherwise provided in state law, the individual enrolls during the specified bona fide open enrollment period;
  - (c) If the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;
  - (d) If a court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee’s health benefit plan and a request for enrollment is made within thirty (30) days after issuance of the court order;
  - (e) If the individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within thirty (30) days after the change in status;
  - (f) If the individual had coverage under a COBRA continuation provision and the coverage under that provision has been exhausted; or



- (g) Who meets the requirements for special enrollment pursuant to Section 7E(7) and (8) of this Act.
- GG. “Limited benefit health insurance” means that form of coverage that pays stated predetermined amounts for specific services or treatments or pays a stated predetermined amount per day or confinement for one or more named conditions, named diseases or accidental injury.
- HH. “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).
- II. “Network plan” means a health benefit plan issued by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.
- JJ. “Plan of operation” means the plan of operation of the program established pursuant to Section 12 of this Act.
- KK. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.
- LL. “Plan sponsor” has the meaning given this term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974.
- MM. (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 for small group coverage, or twelve (12) months for individual or professional association plan coverage, 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 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.
- NN. “Premium” means all moneys paid by a small employer, eligible employees or eligible persons as a condition of receiving coverage from a carrier subject to this Act, including any fees or other contributions associated with the health benefit plan.
- OO. “Producer” means [incorporate reference to definition in state’s law for licensing producers].
- Drafting Note:** States that have not adopted the NAIC Producer Licensing Model Act should substitute the term “agent” or “broker” for the term “producer” as appropriate.
- PP. “Professional association” means an association that meets all of the following criteria:
- (1) Serves a single profession which profession requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice that profession;
  - (2) Has been actively in existence for five (5) years;

- (3) Has a constitution and by-laws or other analogous governing documents thereto;
- (4) Has been formed and maintained in good faith for purposes other than obtaining insurance;
- (5) Is not owned or controlled by a carrier or affiliated with a carrier;
- (6) Does not condition membership in the association on any health status-related factor;
- (7) Has at least 1,000 members if it is a national association; 500 members if it is a state association; or 200 members if it is a local association;
- (8) All members and dependents of members are eligible for coverage without regard to any health status-related factor;
- (9) Does not make a health benefit plan offered through the association available other than in connection with a member of the association;
- (10) Is governed by a board of directors and sponsors annual meetings of its members; and
- (11) Producers only market association memberships, accept applications for membership, or sign up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the professional association.

**Drafting Note:** This definition of “professional association” is narrower than the definition of “bona fide association” contained in HIPAA because of the requirement of Paragraph (1) above that the professional association serve a single profession. Specifically, HIPAA defines “bona fide association,” with respect to health insurance coverage offered in a state, as an association, which: (1) has been actively in existence for at least 5 years; (2) has been formed and maintained in good faith for purposes other than obtaining insurance; (3) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee); (4) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member); (5) does not make health insurance offered through the association available other than in connection with a member of the association; and (6) meets such additional requirements as may be imposed under state law. Because the definition of “bona fide association” contained in HIPAA explicitly permits states to impose additional requirements, the narrower definition of “professional association” used in this model does not conflict with the federal law. As such, states can elect to adopt either definition, “professional association,” as used in this model or “bona fide association,” as used in HIPAA. States, however, should examine other provisions of this model, particularly its rating provisions, before adopting the “bona fide association” definition because HIPAA does not include any rating provisions.

QQ. “Professional association plan” means a health benefit plan offered through a professional association that covers members of a professional association and their dependents in this state regardless of the situs of delivery of the policy or contract and which meets all the following criteria:

- (1) Conforms with the provisions of Section 5 of this Act concerning rates as they apply to individual carriers and individual health benefit plans. If the health benefit plan offered by the professional association covers at least 2,000 members of the professional association, then that association’s experience pool can be the basis for setting rates. If the professional association plan covers fewer than 2,000 members of the professional association, the carrier shall community rate the experience of that professional association with the experience of other professional associations covered by the carrier;
- (2) Provides renewability of coverage for the members and dependents of members of the professional association which meets the criteria set forth in Section 6B of this Act as they apply to individual health benefit plans;
- (3) Provides availability of coverage for the members and dependents of members of the professional association in conformance with the provisions of Section 7B(1), (2) and (3) of this Act as they apply to individual health benefit plans and individual carriers, except that the professional association shall not be required to offer basic and standard health benefit plan coverage;
- (4) Is offered by a carrier that offers health benefit plan coverage to any professional association seeking health benefit plan coverage from the carrier; and

- (5) Conforms with the preexisting condition provisions of Section 7F of this Act as they apply to individual health benefit plans.
- RR. “Program” means the [State] Small Employer and Individual Reinsurance Program created by Section 12 of this Act.
- SS. “Rating period” means the calendar period for which premium rates established by a carrier subject to this Act are assumed to be in effect.
- TT. “Reinsuring carrier” means a small employer carrier participating in the reinsurance program pursuant to Section 12 of this Act.
- UU. “Restricted network provision” means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.

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

- VV. “Risk adjustment mechanism” means the mechanism established pursuant to Section 22 of this Act.
- WW. “Risk-assuming carrier” means a small employer carrier whose application is approved by the commissioner pursuant to Section 11 of this Act.

**Drafting Note:** Delete Subsections DD, EE, TT and WW if participation in the reinsurance program is mandatory.

- XX. “Self-employed individual” means an individual or sole proprietor who derives a substantial portion of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

**Drafting Note:** If a state is enacting both individual and small group reform, the self-employed individual should be placed in the individual market and the bracketed material below should be deleted; however, if a state is enacting small group reform only, the self-employed individual should be placed in the small group market.

- YY. “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.
- ZZ. (1) “Small employer” means any person, firm, corporation, partnership, association, political subdivision [or self-employed individual] that is actively engaged in business that on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than [insert number] eligible employees, with a normal work week of thirty (30) or more hours except as provided in Section 3N, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this Act that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. [The term small employer includes a self-employed individual.]

- (2) “Small employer” includes any person, firm, corporation, partnership, association or political subdivision that is actively engaged in business that on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed a combination of no more than [fifty (50)] eligible employees and part-time employees, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists.

**Drafting Note:** HIPAA defines “small employer” as those employers with between two (2) and fifty (50) employees with the ability of states to include groups of one. Therefore, HIPAA requires a state’s definition of “small employer” to set a maximum of at least fifty (50) employees, but a state may choose a higher maximum number of employees if it wishes its small group market to cover groups larger than fifty. Also, under HIPAA, a state may choose a threshold number of one employee if it wishes to include the self-employed in its small group market. If a state chooses not to include the self-employed in the small group market, its threshold number will be two (2) employees. States may wish to consider different threshold or maximum numbers of employees for the purposes of defining “small employer.” depending on the underwriting and marketing practices in the state and other relevant factors. In an effort to promote continuity of coverage, states should consider the adoption of more liberal standards for retaining eligibility for a small group market product, regardless of size-related eligibility standards, or extending the employer’s right to renew to the date of the plan’s second anniversary following the date on which the small employer no longer meets the size requirements of that definition.

- AAA. “Small employer carrier” means a carrier that issues or offers to issue health benefit plans covering eligible employees of one or more small employers pursuant to this Act, regardless of whether coverage is offered through an association or trust or whether the policy or contract is situated out of state.

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

- BBB. “Standard health benefit plan” means a health benefit plan developed pursuant to Section 15 of this Act.

- CCC. “Waiting period” means, with respect to a group health 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 L(2), a waiting period shall not be considered a gap in coverage.

#### **Section 4. Applicability and Scope**

- A. The provisions of this Act concerning small employer health benefit plans and the small employer carriers that offer them shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

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

- B. The provisions of this Act concerning individual health benefit plans and the individual carriers that offer them shall apply to a health benefit plan that covers eligible persons and their dependents and to a certificate issued to an eligible person that evidences coverage under a policy or contract issued to a trust or association or other similar grouping of individuals, regardless of the situs of delivery of the policy or contract, if the eligible person pays the premium and is not covered under the policy or contract pursuant to continuation of benefits provisions applicable under federal or state law and shall apply to professional association plans as specifically set forth in this Act.

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

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

- D. The commissioner shall have authority pursuant to [insert reference to state insurance code or administrative law provisions providing for injunctive enforcement relief] to prosecute violations of this Act.

## **Section 5. Restrictions Relating to Premium Rates**

- A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:
- (1) The small employer carrier and individual carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:
- (a) Geographic area;
  - (b) Family composition; and
  - (c) Age.
- (2) (a) With respect to small employer carriers, the adjustment for age in Paragraph (1)(c) above may not use age brackets smaller than five-year increments and these shall begin with age thirty (30) and end with age sixty-five (65).
- (b) With respect to individual carriers, the adjustment for age in Paragraph (1)(c) above may use one-year increment age brackets beginning at age nineteen (19).
- (3) Small employer and individual carriers may charge the lowest allowable adult rate for child only coverage.
- (4) Small employer carriers shall be permitted to develop separate rates for individuals age sixty-five (65) or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates shall be subject to the requirements of this Subsection A.

- (5) The adjustments to the rates for a health benefit plan permitted in Paragraph (1)(c) above shall not result in a rate per enrollee for the health benefit plan of more than 200 percent of the lowest rate for all adult age groups effective five (5) years after enactment of this Act. During the first two (2) years after enactment of this Act the permitted rates for any age group shall be no more than 400 percent of the lowest rate for all adult age groups and two (2) years after enactment of this Act the permitted rates for any age group shall be no more than 300 percent of the lowest rate for all adult age groups.

**Drafting Note:** The limitations on premium rate variations contained above represent one of several viable approaches that might be considered by a state and should be viewed in that way rather than as a recommended approach. The state may wish to include a provision for a recommendation to postpone the subsequent steps if a study determines the rate compression is producing unanticipated effects.

States should be mindful of the desirability of having consistent rating schemes in the small group and individual markets. Whatever the rating rules are for small employer health benefit plans in a state, they should be consistent for individual health benefit plans. However, except as provided for in Section 11E(2)(b), this model does not require front-end pooling of risks of the individual and small group markets.

- B. The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect:
  - (1) Changes to the enrollment of the small employer;
  - (2) Changes to the family composition of the employee or eligible person; or
  - (3) Changes to the health benefit plan requested by the small employer or eligible person.
- C. Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer or individual carriers pursuant to Sections 9 or 12 of this Act.
- D. Rating factors shall produce premiums for identical groups, and for identical eligible persons in the case of individual health benefit plans, that differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups or eligible persons assumed to select particular health benefit plans.
- E. For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.
- F. The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer and individual carriers are consistent with the purposes of this Act, including regulations that:
  - (1) Assure that differences in rates charged for health benefit plans by small employer and individual carriers are reasonable and reflect objective differences in plan design or coverage (not including differences due to the nature of the groups or individuals assumed to select particular health benefit plans or separate claim experience for individual health benefit plans); and
  - (2) Prescribe the manner in which geographic territories are designated by all small employer and individual carriers.

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

- G. In connection with the offering for sale of a health benefit plan to a small employer or eligible person, a small employer or individual carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

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

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

## **Section 6. Renewability of Coverage**

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

- A. For small employer health benefit plans:
- (1) A health benefit plan subject to this Act shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:
    - (a) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;
    - (b) The plan sponsor or, with respect to coverage of individual insureds under the health benefit plan, the insured or the insured's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

- (c) Noncompliance with the carrier's minimum participation requirements;
- (d) Noncompliance with the carrier's employer contribution requirements;
- (e) The small employer carrier elects to discontinue offering all of its health benefit plans delivered or issued for delivery to small employers in this state if the carrier :
  - (i) Provides advance notice of its decision under this subparagraph to the commissioner in each state in which it is licensed; and
  - (ii) Provides notice of the decision to:
    - (I) All affected small employers and enrollees and their dependents; and
    - (II) The commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provided the notice to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;
- (f) The commissioner:
  - (i) Finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations; and
  - (ii) Assists affected small employers in finding replacement coverage;
- (g) The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the small employer carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the state's small employer market if the carrier:
  - (i) Provides advance notice of its decision under this subparagraph to the commissioner in each state in which it is licensed;
  - (ii) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
    - (I) All affected small employers and enrollees and their dependents; and
    - (II) The commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;
  - (iii) Offers to each small employer issued that particular type of health benefit plan (obsolete product form) the option to purchase all other health benefit plans currently being offered by the carrier to small employers in the state; and
  - (iv) In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to Item (iii), acts uniformly without regard to the claims experience of those small employers or any health status-related factor relating to any enrollee or dependent of the enrollee or enrollees and their dependents covered or new enrollees and their dependents who may become eligible for coverage;



- (h) In the case of health benefit plans that are made available in the small employer market only through one or more professional associations, the membership of an employer in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated under this subparagraph uniformly without regard to any health status-related factor relating to any covered individual; or
- (i) In the case of health benefit plans that are made available in the small group market through a network plan, there is no longer an employee of the small employer living, working or residing within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to Section 7G(1)(b) of this Act.
- (2) (a) A small employer carrier that elects not to renew health benefit plan coverage pursuant to Paragraph (1)(b) because of the small employer's fraud or intentional misrepresentation of material fact under the terms of coverage may choose not to issue a health benefit plan to that small employer for one (1) year after the date of nonrenewal.
- (b) This paragraph shall not be construed to affect the requirements of Section 7 of this Act as to other small employer carriers to issue any health benefit plan to the small employer.
- (3) (a) A small employer carrier that elects to discontinue offering health benefit plans under Paragraph (1)(e) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.
- (b) In the case of a small employer carrier that ceases offering new coverage in this state pursuant to Paragraph (1)(e), the small employer carrier, as determined by the commissioner, may renew its existing business in the small employer market in the state or may be required to nonrenew all of its existing business in the small employer market in the state.
- (4) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in that service area.

B. For individual health benefit plans:

- (1) A health benefit plan subject to this Act shall be renewable with respect to all individuals or dependents, at the option of the enrollee, except in the following cases:

**Drafting Note:** HIPAA does not contain an exception to guaranteed renewability in the case of an enrollee's attaining eligibility for Medicare. The preamble to the interim final federal regulations for the individual insurance market states: "Becoming eligible for Medicare by reason of age or otherwise is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market, because it is not included in the statute's specifically defined list of permissible reasons for nonrenewal. If permitted by state law, however, policies that are sold to individuals before they attain Medicare eligibility may contain coordination of benefit clauses that exclude payment under the policy to the extent that Medicare pays." 62 *Fed. Reg.* at 16989 (April 8, 1997).

- (a) The individual has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;
- (b) The individual or the individual's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;
- (c) The individual carrier elects to discontinue offering all of its health benefit plans delivered or issued for delivery to individuals in this state if the carrier :
  - (i) Provides advance notice of its decision to the commissioner in each state in which it is licensed; and

- (ii) Provides notice of the decision to all affected individuals and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provided the notice to the commissioner is sent at least three (3) working days prior to the date the notice is sent to the affected individuals;
  - (d) The commissioner:
    - (i) Finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier's ability to meet its contractual obligations; and
    - (ii) Assists affected individuals in finding replacement coverage;
  - (e) The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the individual carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the state's individual insurance market if the carrier:
    - (i) Provides advance notice of its decision under this subparagraph to the commissioner in each state in which it is licensed;
    - (ii) Provides notice of the decision not to renew coverage to at least 180 days prior to the nonrenewal of any health benefit plans to:
      - (I) All affected individuals; and
      - (II) The commissioner in each state in which an affected insured individual is known to reside, provided the notice to the commissioner is sent at least three (3) working days prior to the date the notice is sent to the affected individuals;
    - (iii) Offers to each individual provided that particular type of health benefit plan (obsolete product form) the option to purchase all other health benefit plans currently being offered by the carrier to individuals in the state; and
    - (iv) In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to Item (iii), acts uniformly without regard to the claims experience of any affected individual or any health status-related factor relating to any covered individuals or beneficiaries who may become eligible for the coverage;
  - (f) In the case of health benefit plans that are made available in the individual market only through one or more professional associations, the membership of an individual in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated under this subparagraph uniformly without regard to any health status-related factor relating to any covered individual; or
  - (g) In the case of health benefit plans that are made available in the individual market through a network plan, the individual no longer resides, lives or works in the carrier's established geographic service area, provided coverage is terminated under this subparagraph without regard to any health status-related factor relating to any covered individual.
- (2) (a) An individual carrier that elects to discontinue offering health benefit plans under Paragraph (1)(c) shall be prohibited from writing new business in the individual market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in the state.

- (b) In the case of an individual carrier that ceases offering new coverage under Paragraph (1)(c), the individual carrier, as determined by the commissioner, may renew its existing business in the individual market in the state or may be required to nonrenew its business in the individual market in the state.
- (3) In the case of an individual carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in that service area.

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

**Drafting Note:** Under HIPAA, "multiple employer welfare arrangements," or MEWAs, are subject to the renewability requirements of the new Section 703 of the Employee Retirement Income Security Act of 1974 (ERISA). However, the new Section 731 of ERISA added by HIPAA specifies that this (new) part is not to be construed to affect or modify the provisions of ERISA Section 514 with respect to group health plans. It therefore appears that the states' authority over MEWAs is preserved. The interaction with state renewability requirements merits further review.

## Section 7. Availability of Coverage

**Drafting Note:** States that do not wish to take a guaranteed issue approach to individual health care reform should omit Subsection B of this section and all of Section 9, which deal solely with individual guaranteed issue and references to mechanisms for spreading individual guaranteed issue risks.

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

**Drafting Note:** The model presents two options for Paragraph (2) regarding guaranteed issue in the individual market. Option 1 is guaranteed issue 365 days per year and allows the carrier to impose a preexisting condition limitation exclusion of no more than 12 months. Option 2 is a rolling open enrollment, 30 days annually, and allows the carrier to impose a preexisting condition limitation exclusion of no more than 12 months. However, if the individual previously had creditable coverage, that individual would have 31 days from termination of the prior policy to obtain a guaranteed issue product, except that a federally defined eligible individual would have 90 days from termination of the prior policy to obtain a guaranteed issue product.

### Option 1.

- (2) Subject to Paragraph (1), an individual carrier shall issue any individual health benefit plan to any eligible person that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act, except as provided in Paragraph (3).

Option 2.

- (2) Subject to Paragraph (1), an individual carrier shall issue any individual health benefit plan to any eligible person that applies for the plan during the designated open enrollment period or in accordance with subparagraphs (b), (c) and (d) below and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act, except as provided in Paragraph (3).
- (a) The open enrollment period shall be based on the month of the applicant's birth so that during the month of the applicant's birth, the applicant can apply for and be issued coverage from any individual carrier issuing individual health benefit plans in this state.
  - (b) If an eligible person other than a federally defined eligible individual applying for an individual health benefit plan had creditable coverage, an individual carrier shall issue an individual health benefit plan to that eligible person if the eligible person applies for coverage within thirty-one (31) days of termination of the prior coverage.
  - (c) If a federally defined eligible individual applies for an individual health benefit plan, an individual carrier shall issue an individual health benefit plan to that federally defined eligible individual if he or she applies for coverage within ninety (90) days of termination of the prior coverage.
  - (d) Whenever the commissioner finds that an individual carrier shall cease issuing health benefit plans pursuant to Section 6A(1)(e) or B(1)(c) of this Act, which may cause eligible persons to lose coverage issued pursuant to this Subsection B, the commissioner may order an emergency open enrollment period.
- (3) An individual carrier shall not be required to issue an individual health benefit plan to an eligible person if:
- (a) The individual is covered, or is eligible for coverage, through a benefit plan that provides health care coverage which is provided by the individual's employer. A converted policy is not considered a benefit plan provided by an employer for purposes of this paragraph;
  - (b) The individual is covered, or is eligible for coverage, through a benefit plan that provides health care coverage in which the individual's spouse, parent or guardian is enrolled or eligible to be enrolled;
  - (c) The individual already has coverage under an individual health benefit plan or converted policy; except that an individual may purchase a new individual health benefit plan or converted policy and terminate coverage under the prior health benefit plan on the renewal date of the prior health benefit plan or converted policy;
  - (d) The individual is covered, or is eligible for coverage, under any other private or public health benefits arrangements, including a Medicare supplement policy or the Medicare program established under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or any other act of Congress or law of any state, except for a Medicare-eligible individual who is eligible for Medicare for reasons other than age; or
  - (e) The individual is covered, or is eligible for any continued group coverage under Section 4980B of the Internal Revenue Code of 1986, Sections 601 through 608 of the Employee Retirement Income Security Act of 1974, or pursuant to Sections 2201 through 2208 of the Public Health Service Act, as amended, or any state-required continued group coverage. For purposes of this subsection, an individual who would have been eligible for continuation coverage, but is not eligible solely because the individual or other responsible party failed to make the required coverage election during the applicable time period, shall be deemed to be eligible for group coverage until the date on which the individual's continuing group coverage would have expired had an election been made.

**Drafting Note:** States may wish to consider the implications of possible duplicate coverages of public programs, such as Medicare and Medicaid, and authorize the commissioner to promulgate regulations to preclude undesired duplication or the prospect of unintended dumping. States may also wish to add a provision allowing the commissioner to authorize exemptions from the guaranteed issue requirement for certain specific plans, such as student medical policies, in narrowly circumscribed circumstances. However, these exemptions shall not apply with respect to federally defined eligible individuals.

- C. The provisions of Subsection B shall be effective 180 days after the commissioner’s approval of the basic health benefit plan and the standard health benefit plan developed pursuant to Section 15 of this Act.
  
- D. (1) A small employer or individual carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer or individual carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.
  
- (2) The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer or individual carrier, disapprove the continued use by a small employer or individual carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this Act.
  
- E. Health benefit plans covering small employers shall comply with the following provisions:
  - (1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than six (6) months following the enrollment date of the individual’s coverage due to a preexisting condition, or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more restrictively than as defined in Section 3MM of this Act.
  
  - (2) (a) Except as provided in Paragraph (3), a small employer carrier shall reduce the period of any preexisting condition exclusion without regard to the specific benefits covered during the period of creditable coverage by the aggregate of the period of creditable coverage, provided that the last period of creditable coverage ended on a date not more than ninety (90) days prior to the enrollment date of new coverage.
  
  - (b) The aggregate period of creditable coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier, or for the normal application and enrollment process following employment or other triggering event for eligibility.
  
  - (c) A carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period that:
    - (i) Does not exceed sixty (60) days for new entrants and does not exceed ninety (90) days for late enrollees;
  
    - (ii) During which the carrier charges no premiums and the coverage issued is not effective; and
  
    - (iii) Is applied uniformly, without regard to any health status-related factor.
  
  - (d) This paragraph does not preclude application of a waiting period applicable to all new enrollees under the health benefit plan.
  
  - (3) (a) Instead of as provided in Paragraph (2)(a), a small employer carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of benefits within each of several classes or categories of benefits specified by federal regulations.
  
  - (b) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described in Subparagraph (a) shall:

- (i) Make the election on a uniform basis for all enrollees; and
  - (ii) Count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.
- (c) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described under Subparagraph (a) shall:
- (i) Prominently state that the election has been made in any disclosure statements concerning coverage under the health benefit plan to each enrollee at the time of enrollment under the plan and to each small employer at the time of the offer or sale of the coverage; and
  - (ii) Include in the disclosure statements the effect of the election.

**Drafting Note:** Federal regulations issued pursuant to PHSA Section 2701(c)(3)(B) will provide further clarification on the operation of the alternative method of crediting coverage and the method of crediting coverage for the purpose of applying any preexisting condition exclusion.

- (4) (a) A health benefit plan shall accept late enrollees, but may exclude coverage for late enrollees for preexisting conditions for a period not to exceed twelve (12) months.
  - (b) A small employer carrier shall reduce the period of any preexisting condition exclusion pursuant to Paragraph (2) or Paragraph (3).
- (5) A small employer carrier shall not impose a preexisting condition exclusion:
- (a) Relating to pregnancy as a preexisting condition; or
  - (b) With regard to a child who is covered under any creditable coverage within [thirty (30)] days of birth, adoption or placement for adoption, provided that the child does not experience a significant break in coverage, and provided that the child was adopted or placed for adoption before attaining eighteen (18) years of age.

**Drafting Note:** Under HIPAA, states may establish a special enrollment period longer than 30 days under Section 7E(8)(b) for a child with creditable coverage who satisfies the Paragraph (5)(b).

- (6) A small employer carrier shall not impose a preexisting condition exclusion in the case of 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 the medical advice, diagnosis, care or treatment was a covered benefit under the plan, provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.
- (7) (a) A small employer carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group health plan of the small employer during a special enrollment period if:
- (i) The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;
  - (ii) The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time;

- (iii) The employee's or dependent's coverage described under Item (i):
  - (I) Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or
  - (II) Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated; and
- (iv) Under terms of the group health plan, the employee requests enrollment not later than thirty (30) days after the date of exhaustion of coverage described in Item (iii)(I) or termination of coverage or employer contribution described in Item (iii)(II).
- (b) If an employee requests enrollment pursuant to Item (iv), the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

**Drafting Note:** Appendix A contains a form that may be used to comply with Paragraph (7) in regard to providing notice to employees of their special enrollment rights. The NAIC, however, does not intend that states that elect to use this form to comply with Paragraph (7) adopt it as part of this model act. Instead, states should adopt the form by regulation. In addition, because this form is derived from federal regulations, states should review the federal regulations prior to adopting the forms by regulation to determine whether any future modifications of the regulations have affected the language contained in the form.

- (8) (a) A small employer carrier that makes coverage available under a group health plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in Subparagraph (b) during which the person or, if not otherwise enrolled, the individual may be enrolled under the group health plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage if:
  - (i) The individual is a participant under the health benefit plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan, but for a failure to enroll during a previous enrollment period; and
  - (ii) A person becomes a dependent of the individual through marriage, birth or adoption or placement for adoption.
- (b) The special enrollment period for individuals that meet the provisions of Subparagraph (a) shall be a period of not less than thirty (30) days and begins on the later of:
  - (i) The date dependent coverage is made available; or
  - (ii) The date of the marriage, birth or adoption or placement for adoption described in Subparagraph (a)(ii).
- (c) If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under Subparagraph (b), the coverage of the dependent shall be effective:
  - (i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
  - (ii) In the case of a dependent's birth, as of the date of birth; and

- (iii) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
- (9)
  - (a) Except as provided in this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier.
  - (b) A small employer carrier shall not require a minimum participation level greater than:
    - (i) One hundred percent (100%) of eligible employees working for groups of three (3) or less employees; and
    - (ii) Seventy-five percent (75%) of eligible employees working for groups with more than three (3) employees.
  - (c) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met.
  - (d) A small employer carrier shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.
- (10)
  - (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.
  - (b) A small employer carrier shall not place any restriction in regard to any health status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.
  - (c) Except as permitted under Paragraphs (1) and (4) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

F. Individual health benefit plans shall comply with the following provisions:

- (1) A health carrier shall not impose on a federally defined eligible individual any exclusion because of a preexisting condition as defined in Section 3MM of this Act;
- (2) For eligible persons who are not federally defined eligible individuals, a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time, either while the eligible person held creditable coverage or during the ninety (90) days prior to the enrollment date of new coverage, shall not be a condition for which a carrier may impose a preexisting condition exclusion, provided that the treatment was a covered benefit under the creditable coverage, and provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage;



- (3) An individual health benefit plan shall not deny, exclude or limit benefits for a covered eligible person for losses incurred more than twelve (12) months following the effective date of the eligible person's coverage due to a preexisting condition. An individual health benefit plan shall not define a preexisting condition more restrictively than as defined in Section 3MM of this Act, and shall not impose on a federally defined eligible individual any exclusion because of a preexisting condition.
  - (4) (a) An individual carrier shall waive any carrier waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time an eligible person was covered by creditable coverage provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of new coverage. The period of continuous coverage shall not include any waiting period for the enrollment date of the new coverage applied by the carrier, or for the normal application and enrollment process.
  - (b) An individual carrier that does not use preexisting condition limits in any of its health benefit plans may impose or apply one or more of the following terms or conditions. However, if more than one term or condition is used, the combination of terms or conditions may not exceed the actuarial value of the twelve-month preexisting condition limit permitted by this section:
    - (i) A rating surcharge not to exceed fifty percent (50%) of the rate permitted under Section 5 for a period not to exceed twelve (12) months; or
    - (ii) An affiliation period that does not exceed ninety (90) days and during which no premiums are charged and the coverage issued is not effective and is applied uniformly without regard to any health status-related factors.
  - (c) This paragraph does not preclude application of a waiting period applicable to any new enrollee under the health benefit plan, provided that any carrier-imposed waiting period shall be no longer than ninety (90) days and shall be used in lieu of a preexisting condition exclusion.
  - (d) An affiliation period shall be waived for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of new coverage.
  - (5) Except as permitted under Paragraphs (3) and (4) of this subsection, an individual carrier shall not modify a health benefit plan with respect to an individual or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.
- G. (1) Subject to Paragraph (3), a small employer or individual carrier shall not be required to offer coverage or accept applications pursuant to Subsection A or B in the case of the following:
- (a) To a small employer or eligible person, where the small employer or eligible person is not physically located in the carrier's established geographic service area;
  - (b) To an employee of a small employer, when the employee does not live, work or reside within the carrier's established geographic service area; or
  - (c) Within an area where the small employer or individual carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups or eligible persons because of its obligations to existing group or individual policyholders and enrollees.

- (2) A small employer or individual carrier that cannot offer coverage pursuant to Paragraph (1)(c) may not offer coverage in the applicable area to new cases of employer groups with more than [insert the size of employer to correspond with the definition of small employer in Section 3], eligible employees, to any small employer groups or to eligible persons until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups or eligible persons.
  - (3) A small employer or individual carrier shall apply the provisions of this subsection uniformly to all small employers and eligible persons without regard to:
    - (a) The claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents; or
    - (b) Any health status-related factor relating to any eligible person and without regard to whether the person is a federally defined eligible individual.
- H.
- (1) A small employer or individual carrier shall not be required to provide coverage to small employers and eligible persons pursuant to Subsections A and B if:
    - (a) For any period of time the commissioner determines , the small employer or individual carrier does not have the financial reserves necessary to underwrite additional coverage; and
    - (b) The small employer or individual carrier is applying this subsection uniformly to all small employers in the small group market and all eligible persons in the individual market in this state consistent with applicable state law and without regard to:
      - (i) The claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents; or
      - (ii) Any health status-related factor relating to any eligible person and without regard to whether the person is a federally defined eligible individual.
  - (2) A small employer or individual carrier that denies coverage in accordance with Paragraph (1) may not offer coverage in the small group market or individual market for the later of:
    - (a) A period of 180 days after the date the coverage is denied; or
    - (b) Until the small employer or individual carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

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

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

- J. A small employer carrier shall not be required to provide coverage to small employers pursuant to Subsection A if the carrier makes coverage available to small employers only through one or more professional associations.
- K. This section shall not be construed to require that a health carrier offering health benefit plans only in connection with group health plans or through one or more professional associations, or both, offer health insurance coverage in the individual market.

**Section 8. Certification of Creditable Coverage**

- A. Small employer and individual carriers shall provide written certification of creditable coverage to individuals in accordance with Subsection B.
- B. The certification of creditable coverage shall be provided:
  - (1) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;
  - (2) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and
  - (3) At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Paragraph (1) or (2), whichever is later.
- C. Small employer and individual carriers may provide the certification of creditable coverage required under Subsection B(1) at a time consistent with notices required under any applicable COBRA continuation provision.
- D. The certificate of creditable coverage required to be provided pursuant to Subsection A shall contain:
  - (1) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and
  - (2) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.
- E. To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under Subsection A if the health carrier offering the coverage provides for certification in accordance with Subsection B.
- F.
  - (1) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to Section 7E(3) of this Act and the individual provides a certificate of coverage that was provided to the individual pursuant to Subsection B, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.
  - (2) The entity providing the information pursuant to Paragraph (1) may charge the requesting group health plan the reasonable cost of disclosing the information.

**Drafting Note:** Federal regulations to be issued pursuant to PHSA Section 2701(e) will establish rules to prevent an entity's failure to provide the information under this Section 8 with respect to previous creditable coverage of an individual from adversely affecting any subsequent coverage of the individual under another health benefit plan. In addition, federal regulations to be issued pursuant to PHSA Section 2701(c)(3)(B) will provide further clarification on the operation of the alternative method for counting creditable coverage.

**Drafting Note:** Appendix B contains certificate forms that may be used to comply with this section. Appendix C contains a form that may be used to provide the information regarding coverage under the categories of health benefits to comply with Subsection F. The NAIC does not intend that states that elect to use these forms to comply with this section adopt the forms as part of this model act. Instead, states should adopt the forms by regulation. In addition, because these forms were derived from federal regulations, states should review the federal regulations prior to adopting the forms by regulation to determine whether any future modifications of the regulations have affected the language in these forms.

## Section 9. Individual Market Risk-Spreading Mechanisms

**Drafting Note:** This model presents two options for risk-spreading across the guaranteed issue individual and small group markets. Option 1 provides for a “play or pay” approach, and assesses those carriers that do not write their proportionate share of the individual market. Option 2 provides for a reinsurance program.

### Option 1.

- A. No later than 180 days after the effective date of this Act, a carrier shall, as a condition of issuing health benefit plans in this state, offer health benefit plans in the individual market. A carrier shall be deemed to have satisfied its obligation to provide individual health benefit plans by paying an assessment pursuant to Subsection C(2) of this section.
- B. The commissioner shall have the authority to assess carriers their proportionate share of individual market losses and administrative expenses in accordance with the provisions of Subsection C of this section, and make advance interim assessments as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year.
- C. The commissioner shall by regulation establish procedures for the equitable sharing of program losses among all carriers in accordance with their total market share as follows:
  - (1) By March 1, [insert here year after first year of implementation] and following the close of the calendar year thereafter, on a date established by the commissioner:
    - (a) A carrier issuing health benefit plans in this state shall file with the commissioner its net earned premium for the preceding calendar year ending December 31; and
    - (b) A carrier issuing individual health benefit plans in this state shall file with the commissioner the net earned premium on individual health benefits plans and the claims paid and the administrative expenses attributable to those plans. If the claims paid and reasonable administrative expenses for that calendar year exceed the net earned premium and any investment income thereon, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this Act. For purposes of this subsection, “reasonable administrative expenses shall be the actual expenses or a maximum of [insert 100 minus percentage required by state law providing for minimum loss ratios for individual health insurance policies] percent, whichever is less.

**Drafting Note:** States may wish to consider broadening the definition of “net paid loss” to include some or all of the increase in individual premium rates that may result from the imposition of the guaranteed issue requirement. As currently drafted, a carrier with adequate rates will likely not experience a “net paid loss,” but it may experience a significant increase in its adjusted community rate for individuals as a result of the guaranteed issue requirement. The purpose of including some portion of this rate increase in the definition of “net paid loss” is to help spread the risk of the guaranteed issue requirement among the carriers that do not participate or “play” in the individual market.

- (2) A carrier shall be liable for an assessment to reimburse carriers issuing individual health benefit plans in this state that sustain net paid losses for the previous year, unless the carrier has received an exemption from the commissioner pursuant to Paragraph (5) of this subsection and has written a minimum number of nongroup persons as provided for in that subsection. The assessment of each carrier shall be in the proportion that the net earned premium of the carrier for the calendar year preceding the assessment bears to the net earned premium of all carriers for the calendar year preceding the assessment excluding premium for converted policies.
- (3) A carrier that is financially impaired may seek from the commissioner a deferment in whole or in part from any assessment issued by the commissioner. The commissioner may defer, in whole or in part, the assessment of the carrier if, in the opinion of the commissioner, the payment of the assessment would endanger the ability of the carrier to fulfill its contractual obligations. If an assessment against a carrier is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving the deferment shall remain liable for the amount deferred.

- (4) Payment of an assessment made under this section shall be a condition of issuing health benefits plans in this state for a carrier. Failure to pay the assessment shall be grounds for forfeiture of a carrier's authorization to issue health benefit plans of any kind in this state, as well as any other penalties permitted by law.
- (5) (a) Notwithstanding the provisions of this Act to the contrary, a carrier may apply to the commissioner, by a date established by the commissioner, for an exemption from the assessment and reimbursement for losses provided for in this section. A carrier that applies for an exemption shall agree to enroll or insure a minimum number of nongroup persons under a managed care or indemnity plan. For purposes of this subsection, nongroup persons include individually enrolled persons, conversion policies, Medicare cost and risk lives and Medicaid recipients, except that in determining whether the carrier meets the minimum number of nongroup persons required pursuant to this subsection, the number of Medicaid recipients and Medicare cost and risk lives shall not exceed fifty percent (50%) of the carrier's minimum number of nongroup persons.
- (b) Notwithstanding the provisions of Subparagraph (a) of this paragraph to the contrary, a health maintenance organization qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub. L. 93-222 (42 U.S.C. § 300e *et seq.*) and tax exempt pursuant to 26 U.S.C. § 501(c)(3), the federal Internal Revenue Code of 1986, may include up to one-third Medicaid recipients and up to one-third Medicare recipients in determining whether it meets the minimum number of nongroup persons.
- (c) The minimum number of nongroup persons, as determined by the commissioner, shall equal the total number of individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives, of all carriers in this state subject to this Act as of the end of the calendar year, multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for that calendar year, including those carriers that are exempt from the assessment.
- (d) Within 180 days after the effective date of this Act and on or before March 1 of each year thereafter, a carrier seeking an exemption pursuant to this subsection shall file with the commissioner a statement of its net earned premium for the preceding calendar year. The commissioner shall determine each carrier's minimum number of nongroup persons in accordance with this subsection.
- (e) On or before March 1 of every year, a carrier that was granted an exemption for the preceding calendar year shall file with the commissioner the number of nongroup persons, by category, enrolled or insured as of December 31 of the preceding calendar year. To the extent that the carrier has failed to enroll the minimum number of nongroup persons established by the commissioner, the carrier shall be assessed by the commissioner on a pro rata basis for any differential between the minimum number established by the commissioner and the actual number enrolled or insured by the carrier.
- (f) A carrier that applies for the exemption shall be deemed to be in compliance with the requirements of this section if:
- (i) By the end of calendar year [insert first year of operation], it has enrolled or insured at least forty percent (40%) of the minimum number of nongroup persons required;
  - (ii) By the end of calendar year [insert year after year in Item (i) above], it has enrolled or insured at least seventy-five percent (75%) of the minimum number of nongroup persons required; and
  - (iii) By the end of calendar year [insert two years after year in Item (i) above], it has enrolled or insured at least 100 percent of the minimum number of nongroup persons required.

- (g) A carrier that writes both managed care and indemnity business that is granted an exemption pursuant to this subsection may satisfy its obligation to write a minimum number of nongroup persons by writing either managed care or indemnity business, or both.
- (6) Notwithstanding the provisions of Section 7B(1) of this Act concerning the issuance of individual health benefit plans, an individual carrier may, in any calendar year, with the approval of the commissioner, suspend its duty to issue individual health benefit plans to any eligible person who applies for individual coverage if:
  - (a) The eligible person has one or more of the high risk conditions associated with high claims costs which appear on a list developed by the commissioner with input from individual carriers, providers, and other interested parties, and updated annually;
  - (b) At the time application is made by an individual carrier, the number of eligible persons with one or more high risk conditions covered by the carrier when divided by the total number of eligible persons covered by contracts, policies, and plans of the health carrier in force covering eligible persons in this state is equal to or exceeds five percent (5%) of the total number of the carrier's individuals covered by individual health benefit plans;
  - (c) The individual carrier applies to the commissioner, in a form and manner determined by the commissioner, for an immediate suspension for a specified time period of the requirement to issue an individual health benefit plan to any eligible person who applies for coverage and has one or more high risk conditions; and
  - (d) The individual carrier provides the commissioner with certified copies of the information deemed necessary by the commissioner to make a determination whether or not the health carrier has or is about to reach the five percent (5%) cap described in Subparagraph (b) above.

**Drafting Note:** If factors in a state's individual health market so warrant, a state may consider adding a provision that limits a carrier's assessment liability to a certain percentage of the aggregate net paid losses of all participating carriers, which may also include a provision for the distribution among those carriers of any unreimbursed net paid losses.

- D.
  - (1) Rates shall be formulated on contracts or policies required pursuant to subsection A of this Section so that the anticipated minimum loss ratio for a contract or policy form shall not be less than [insert percentage required by state law providing for minimum loss ratios for individual health insurance policies] of the premium. The individual carrier shall submit with its rate filing supporting data, as determined by the commissioner, and certification by a member of the American Academy of Actuaries, or other individual acceptable to the commissioner, that the carrier is in compliance with the provisions of this subsection.
  - (2) Following the close of the third full calendar year an individual carrier has issued individual health benefit plans, and each calendar year thereafter, if the commissioner determines that a carrier's loss ratio was less than [insert percentage required by state law providing for minimum loss ratios for individual health insurance policies] for that calendar year, the carrier shall be required to refund to policy or contract holders the difference between the amount of net earned premium it received that year and the amount that would have been necessary to achieve the [insert percentage required by state law providing for minimum loss ratios for individual health insurance policies] loss ratio. The loss ratio calculation made following the close of the third full calendar year a carrier has issued individual health benefit plans shall include all individual business written since [insert effective date of this Act] until the close of the third full calendar year.
  - (3) The commissioner by regulation shall prescribe the methodology to be used in determining the loss ratio.

Option 2.

**Drafting Note:** This option uses a reinsurance program as set out in Sections 10, 11 and 12.

**Section 10. Notice of Intent to Operate as Risk-Assuming Carrier or a Reinsuring Carrier**

**Drafting Note:** A state that uses Option 2 of Section 9 regarding risk-spreading mechanisms should adopt the bracketed material in this section.

- A. (1) Within thirty (30) days after the plan of operation is approved by the commissioner under Section 12 of this Act, each small employer carrier shall notify the commissioner of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 11 of this Act.
- [(2) Within thirty (30) days after the plan of operation is approved by the commissioner under Section 12 of this Act, each individual carrier shall notify the commissioner of the carrier's intent to operate as an individual risk-assuming carrier or an individual reinsuring carrier. An individual carrier seeking to operate as an individual risk-assuming carrier shall make application pursuant to Section 11 of this Act.]
- B. The decisions in Subsection A shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The commissioner may permit a carrier to modify its decision at any time for good cause shown.
- C. The commissioner shall establish an application process for small employer [or individual] carriers seeking to change their status under this subsection. In the case of a small employer [or individual] carrier that has been acquired by another such carrier, the commissioner may waive or modify the time periods established in this subsection.
- D. (1) A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any small employer health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.
- (2) An individual reinsuring carrier that applies and is approved to operate as an individual risk assuming carrier shall not be permitted to continue to reinsure any individual health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as an individual reinsuring carrier for any portion of the year that the business was reinsured.

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

**Section 11. Application to Become a Risk-Assuming Carrier**

**Drafting Note:** A state that uses Option 2 of Section 9 regarding risk-spreading mechanisms should adopt the bracketed material in this section.

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

- (4) The carrier's experience with managing the risk of small employer groups [or individuals]; and
  - (5) The carrier's business plan to comply with Sections 5 and 7 of this Act and Subsection E of this section.
- C. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier [or an individual carrier to become an individual risk assuming carrier] and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the commissioner, the carrier may request a hearing.
- D. (1) The commissioner may rescind the approval granted to a risk-assuming carrier [or individual risk assuming carrier] under this section if the commissioner finds that:
- (a) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers [or eligible persons] in compliance with Section 7 of this Act without the protection afforded by the program;
  - (b) The carrier has failed to market fairly to all small employers [or eligible persons] in the state or its established geographic service area, as applicable;
  - (c) The carrier has failed to provide coverage to eligible small employers [or eligible persons] as required in Section 7 of this Act; or
  - (d) The carrier fails to conform to the business plan submitted under Subsection B(5) above.
- (2) The commissioner may request, on an annual basis, whatever information he or she deems necessary to determine whether a finding is warranted pursuant to Paragraph (1).
- E. (1) A small employer [or individual] carrier electing to be a risk-assuming carrier [or an individual carrier electing to be an individual risk assuming carrier] shall not be subject to the provisions of Section 12 of this Act [, except that those carriers shall be subject to Section 12N of this Act.]
- (2) Risk assuming carriers and individual risk assuming carriers shall be subject to all the provisions of this Act applicable to either a small employer carrier or an individual carrier, including but not limited to:
- (a) The requirements of Section 7A and B of this Act concerning availability of coverage;
  - (b) The requirements of Section 5 of this Act concerning premium rates, except that an individual risk assuming carrier shall comply with Section 5 of this Act by establishing rates for all the small employer and individual health benefit plans it issues that are uniform, subject only to the consistent application of factors for varying rates permitted under Section 5 of this Act.]

**Drafting Note:** States should consider establishing special rules for carriers whose charter and bylaws place limits on the types or kinds of individuals that can be insured by the carrier. Such carriers should be permitted to operate as risk-assuming carriers [or individual risk assuming carriers], provided that they accept all eligible small employers [or eligible persons], regardless of any health status-related factor, that would be eligible for coverage pursuant to the charter and bylaws of the carrier.

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

## **Section 12. Small Employer [and Individual] Carrier Reinsurance Program**

**Drafting Note:** A state that uses Option 2 of Section 9 regarding risk-spreading mechanisms should adopt the bracketed material in this section.

- A. (1) Reinsuring carriers [and individual reinsuring carriers] shall be subject to all provisions of this section.



- [ (2) All individual carriers, small employer carriers, group carriers issuing health benefit plans, and carriers renewing health benefit plans pursuant to Section 7I of this Act, and carriers writing stop loss policies for employer-sponsored or Taft-Hartley health coverage plans shall be subject to the assessment in Subsection N and as specified in that subsection.]

**Drafting Note:** Delete Subsection A(1) if participation in the reinsurance program is mandatory.

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

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

- (b) In the event that the program becomes eligible for additional financing pursuant to Subsection P(3) [or N(1)], the board shall be expanded to include two (2) additional members who shall be appointed by the commissioner. In selecting the additional members of the board, the commissioner shall choose individuals who represent [include reference to representatives of sources for additional financing identified in Subsection P(3)(b)]. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing under Subsection P(3) [or N(1)].
- (3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.
- (4) A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.
- D. Within sixty (60) days of the effective date of this Act, each small employer [and individual] carrier shall make a filing with the commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers [or eligible persons] in this state in the previous calendar year.
- E. Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the commissioner.
- F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

- G. The plan of operation shall:
- (1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;
  - (2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;
  - (3) Establish procedures for reinsuring risks in accordance with the provisions of this section;
  - (4) Establish procedures for collecting assessments to fund claims and administrative expenses incurred or estimated to be incurred by the program;
  - (5) Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers through capitation or salary; and
  - (6) Provide for any additional matters necessary for the implementation and administration of the program.
- H.
- (1) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals.
  - (2) In addition to Paragraph (1), the program shall have the specific authority to:
    - (a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;
    - (b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;
    - (c) Take any legal action necessary to avoid the payment of improper claims against the program;
    - (d) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act;
    - (e) Establish rules, conditions and procedures for reinsuring risks under the program;
    - (f) Establish actuarial functions as appropriate for the operation of the program;
    - (g) Make assessments in accordance with the provisions of Subsection[s] P [and N], and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;
    - (h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and
    - (i) Borrow money to affect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

- I. A reinsuring carrier [or individual reinsuring carrier] may reinsure with the program as provided for in this subsection:
- (1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.
  - (2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.
  - (3)
    - (a) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.
    - (b) An individual reinsuring carrier may reinsure an eligible person within sixty (60) days following the effective date of coverage.
  - (4)
    - (a) The program shall not reimburse a reinsuring carrier [or an individual reinsuring carrier] with respect to the claims of a reinsured employee or dependent [or eligible person] until the carrier has incurred an initial level of claims for such employee or dependent [or eligible person] of \$5,000 in a calendar year for benefits covered by the program. In addition, the carrier shall be responsible for ten percent (10%) of the next \$50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A carrier's liability under this subparagraph shall not exceed a maximum limit of \$10,000 in any one calendar year with respect to any reinsured individual.
    - (b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the commissioner approves a lower adjustment factor.
  - (5) A small employer [or individual] carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer, or [an eligible person,] on an anniversary of the health benefit plan.
  - (6) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in Paragraph (4), shall be reduced to reflect that portion of the risk above the amount set forth in Paragraph (4) that may not be ceded to the program, if any.
- Drafting Note:** Federal law prohibits federally-qualified health maintenance organizations from reinsuring the first \$5,000 of covered benefits. States that adopt an initial retention level of less than \$5,000 under Paragraph (4) should include the above language.
- (7) A reinsuring carrier [or individual reinsuring carrier] shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.
- J. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers [and eligible persons] pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in Paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the

approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers [or eligible persons] by small employer carriers [and individual carriers] for health benefit plans with benefits similar to the standard health benefit plan (adjusted to reflect retention levels required under this Act).

- (2) Premiums for the program shall be as follows:
    - (a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this paragraph.
    - (b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph.
    - (c) An eligible person covered by an individual health benefit plan may be reinsured for a rate that is 1.5 times the base reinsurance premium rate for the individual established pursuant to this paragraph.
  - (3) The board periodically shall review the methodology established under Paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.
  - (4) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.
- K. If a health benefit plan for a small employer [or eligible person] is entirely or partially reinsured with the program, the premium charged to the small employer [or eligible person] for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 5 of this Act.
- L. Prior to March 1 of each year, the board shall determine [, separately account for,] and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses [for:
- (1) Reinsured small employer groups, eligible employees and their dependents, and
  - (2) Reinsured eligible persons].
- M. (1) Any net loss [from reinsuring small employer groups, eligible employees or their dependents] for the year shall be recouped by assessments of reinsuring carriers.
- (2) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers.
  - (3) The assessment formula shall be based on:
    - (a) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and
    - (b) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

- (4) The formula established pursuant to Paragraph (3)(a) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150 percent of an amount which is based on the proportion of (i) the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (ii) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.
- (5) The board may, with approval of the commissioner, change the assessment formula established pursuant to Paragraph (3)(a) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.
- (6) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300, *et seq.*, to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

#### Option 1.

**Drafting Note:** This option for Subsection N uses broad-based carrier assessments as a funding source for program net losses from reinsuring eligible persons.

- N.
- (1) Any net loss from reinsuring eligible persons for the year shall be recouped by assessments on all carriers offering a health benefit plan or providing stop loss coverage for an employer-sponsored or Taft-Hartley health plan, except that individual risk assuming carriers shall be exempt from the assessment.
  - (2) The board shall establish as part of the plan of operation a formula by which to make assessments against the carriers described in Paragraph (1). The assessment formula shall be based on each carrier's share of the total premiums earned in the preceding calendar year in this state from health benefit plans and stop loss policies described in Paragraph (1) excluding premium for converted policies.
  - (3) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. 300, *et seq.*, to the extent, if any, that restrictions are placed on them that are not imposed on other carriers.

#### Option 2.

**Drafting Note:** This option for Subsection N uses health care system-based assessments as a broad-based funding source for program net losses from reinsuring eligible persons.

- N.
- (1) Any net loss from reinsuring eligible persons for the year shall be recouped by health care system assessments on [see drafting note below].

**Drafting Note:** The United States Supreme Court, in the *New York State Conference of Blue Cross & Blue Shield Plans et al. v. Travelers Insurance Co. et al.* decision, specifically approved an assessment relating to hospital services. States may wish to consider a broader category as an assessment base. For example, assessments could be charged to patients on a per visit or per stay basis or to providers based on collections. However, case law has made it clear that states may not assess self-funded health plans or third party administrators based on claim volume.

- (2) The following recipients of health care services are exempt from the assessment set forth in Paragraph (1):
  - (a) Medicare beneficiaries;
  - (b) Medicaid beneficiaries; and
  - (c) The uninsured.

- O. Prior to March 1 of each year, the board shall determine[, separately account for] and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year[, for;
- (1) Reinsured small employer groups, eligible employees and their dependents, and
  - (2) Reinsured eligible persons].
- P. (1) If the board determines that the assessments of reinsuring carriers needed to fund the losses from reinsuring small employer groups incurred by the program in the previous calendar year will exceed the amount specified in Paragraph (2) the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety (90) days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.
- (2) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers [or individuals] in this state by reinsuring carriers.
  - (3)
    - (a) If assessments in each of two (2) consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Subparagraph (b).
    - (b) The additional funding provided for in Subparagraph (a) shall be obtained from [the state should specify one or more sources of additional revenue to fund the program. States may wish to consider the alternative revenue sources provided in the NAIC Model Health Plan for Uninsurable Individuals Model Act]. The amount of additional financing to be provided to the program shall be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five percent (5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two (2) previous calendar years pursuant to this subparagraph, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose of the calculation in the previous sentence.
    - (c) Additional financing received by the program pursuant to this subparagraph shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two (2) calendar years.

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

- Q. (1) If assessments exceed net losses [from reinsuring small employers] of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce small employer carrier premiums. As used in this paragraph, “future losses” includes reserves for incurred but not reported claims.
- (2) If assessments exceed net losses from reinsuring eligible persons of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce individual carrier premiums. As used in this paragraph, “future losses” includes reserves for incurred but not reported claims.]

- R. Each carrier's proportion of an assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.
- S. The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.
- T. A carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a carrier if the commissioner determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.
- U. Neither the participation in the program as reinsuring carriers [or individual reinsuring carriers], the establishment of rates, forms or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.
- V. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer [or individuals,] the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.
- W. The program shall be exempt from any and all taxes.

**Section 13. Special Rules Relating to Converted Policies**

**Drafting Note:** If a state elects not to adopt Option 1 or Option 2 in Section 7 regarding guaranteed issue in the individual market, it should not adopt this section.

- A. Effective 180 days after approval of the basic and standard health plans pursuant to Section 15 of this Act, all carriers required to offer to an individual a converted policy pursuant to [insert appropriate reference to the Group Health Insurance Mandatory Conversion Privilege Model Act] shall offer as a converted policy a choice of the basic and standard health benefit plans only.
- B. Persons with a converted policy issued prior to the effective date of the requirement contained in Subsection A above shall have the right at each annual renewal of the converted policy to elect a basic or a standard health benefit plan as a substitute converted policy except that at the carrier's option if the person has not made an election within three (3) years after the effective date of this Act, the carrier may require the person to make an election. Once a person has elected either the basic or the standard health benefit plan as a substitute converted policy, that person may not elect another converted policy.
- C. For rating purposes only, basic and standard health benefit converted policies shall be rated pursuant to Section 5 of this Act as if they were small employer policies. Carriers that do not write in the small employer market shall set the premiums for their basic and standard health benefit plan converted policies at the average rates charged by the five largest small employer carriers (as measured by their premium volume) for their basic and standard health benefit plans. These averages shall be calculated each year by the commissioner.
- D. New and renewal rates for persons with the same converted policies who have the same case characteristics shall be the same.
- E. Carrier losses on their basic and standard health benefit plan converted policies shall be spread across the carrier's entire book of small employer and large group health benefit plan business in the state.

- F. The commissioner shall develop regulations for the implementation of this section.

**Drafting Note:** States may need to include conforming amendments to their existing conversion coverage statutes and regulations, especially with respect to the types of converted policies a carrier may offer and the rating of such policies.

**Section 14. Prohibited Activities**

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

**Section 15. Health Benefit Plan Committee**

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

**Section 16. Periodic Market Evaluation**

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



## **Section 17. Waiver of Certain State Laws**

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

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

## **Section 18. Administrative Procedures**

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

## **Section 19. Standards to Assure Fair Marketing**

- A. Subject to Section 7A(1) and 7B(1) of this Act, each small employer and individual carrier shall actively market all health benefit plans sold by the carrier to eligible small employers and individuals in the state.
- B. (1) Except as provided in Paragraph (2), no small employer or individual carrier or producer shall, directly or indirectly, engage in the following activities:
  - (a) Encouraging or directing small employers or individuals to refrain from filing an application for coverage with the small employer or individual carrier because of any health status-related factor, industry, occupation or geographic location of the small employer or individual;
  - (b) Encouraging or directing small employers or individuals to seek coverage from another carrier because of any health status-related factor, industry, occupation or geographic location of the small employer or individual.
- (2) The provisions of Paragraph (1) shall not apply with respect to information provided by a small employer or individual carrier or producer to a small employer or individual regarding the established geographic service area or a restricted network provision of a small employer or individual carrier.
- C. (1) Except as provided in Paragraph (2), no small employer or individual carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of any initial or renewal health status-related factor, industry, occupation or geographic location of the small employer or individual.
- (2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of any health status-related factor, industry, occupation or geographic area of the small employer or individual.
- D. No small employer or individual carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the initial or renewal health status-related factor, occupation or geographic location of the small employers or individuals placed by the producer with the small employer or individual carrier.
- E. A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee or dependent from health coverage or benefits provided in connection with the employee's employment.

- F. Denial by a small employer or individual carrier of an application for coverage from a small employer or individual shall be in writing and shall state the reason or reasons for the denial.
- G. The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers and individuals in this state.
- H.
  - (1) A violation of this section by a small employer or individual carrier or a producer shall be an unfair trade practice under [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].
  - (2) If a small employer or individual carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers or individuals in this state, the third-party administrator shall be subject to this section as if it were a small employer or individual carrier.

**Section 20. Separability**

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

**Section 21. Restoration of Terminated Coverage**

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

**Section 22. Risk Adjustment Mechanism**

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

**Drafting Note:** Upon satisfactory development of a risk adjustment mechanism, states should consider phasing out the use of the reinsurance pool established in Section 14 of this Act.

**Section 23. Effective Date**

The Act shall be effective on [insert date].

**APPENDIX A**

**MODEL DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS**

If you are declining enrollment for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

**APPENDIX B**

**CERTIFICATE OF  
GROUP HEALTH PLAN COVERAGE**

**\*IMPORTANT** -- This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: \_\_\_\_\_
  2. Name of group health plan: \_\_\_\_\_
  3. Name of participant: \_\_\_\_\_
  4. Identification number of participant: \_\_\_\_\_
  5. Name of any dependents to which this certificate applies: \_\_\_\_\_
- \_\_\_\_\_
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. For further information, call: \_\_\_\_\_
  8. If the individuals identified in line 3 and line 5 have at least 18 months of creditable coverage (disregarding periods of coverage before a 90-day break), check here \_\_\_\_\_ and skip lines 9 and 10.
  9. Date waiting period or affiliation period (if any) began: \_\_\_\_\_
  10. Date coverage began: \_\_\_\_\_
  11. Date coverage ended: \_\_\_\_\_ (or check here if coverage is continuing as of the date of this certificate: \_\_\_\_\_).

**NOTE:** Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

**CERTIFICATE OF  
INDIVIDUAL HEALTH INSURANCE COVERAGE**

**\*IMPORTANT** -- This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll, if medical advice, diagnosis, care, or treatment was recommended or received for the condition during the 6 months before your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to establish your right to buy coverage for yourself or your family, with no exclusion for previous medical conditions, if you are not covered under a group health plan.

1. Date of this certificate: \_\_\_\_\_
2. Name of policyholder: \_\_\_\_\_
3. Identification number of policyholder: \_\_\_\_\_
4. Name of any dependents to which this certificate applies: \_\_\_\_\_

---

5. Name, address, and telephone number of issuer responsible for providing this certificate:  
\_\_\_\_\_  
\_\_\_\_\_

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6. For further information, call: \_\_\_\_\_
7. If all individuals identified in lines 2 and 4 have at least 18 months of creditable coverage (disregarding periods of coverage before a 90-day break), check here \_\_\_\_\_ and skip lines 8 and 9.
8. Date coverage began: \_\_\_\_\_
9. Date that a substantially completed application was received from this policyholder: \_\_\_\_\_
10. Date coverage ended: \_\_\_\_\_ (or check here if coverage is continuing as of the date of this certificate: \_\_\_\_\_).

**NOTE:** Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

**APPENDIX C**

**Model for Categories of Benefits (Alternative Method)**

**INFORMATION ON CATEGORIES OF BENEFITS**

1. Date of original certificate:
2. Name of group health plan providing the coverage:
3. Name of participant:
4. Identification number of participant:
5. Name of individuals to whom this information applies:
6. The following information applies to the coverage in the certificate that was provided to the individuals identified above:
  - a. MENTAL HEALTH:
  - b. SUBSTANCE ABUSE TREATMENT:
  - c. PRESCRIPTION DRUGS:
  - d. DENTAL CARE:
  - e. VISION CARE:

For each category above, enter “N/A” if the individual had no coverage within the category or either (i) enter both the date that the individual’s coverage within the category began and the date that the individual’s coverage within the category ended (or indicate if continuing), or (ii) enter “same” on the line if the beginning and ending dates for coverage within the category are the same as the beginning and ending dates for the coverage in the certificate.

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

*1995 Proc 4<sup>th</sup> Quarter 792, 821, 824-848 (adopted through Accident & Health Insurance (B) Committee; held there for further action).*

*1996 Proc. 1<sup>st</sup> Quarter 29-32, 32-56, 125, 625 (adopted by Plenary).*

*2000 Proc. 3<sup>rd</sup> Quarter 13, 14, 163, 200, 276-310 (amended and reprinted).*

## **SMALL EMPLOYER AND INDIVIDUAL HEALTH INSURANCE AVAILABILITY MODEL ACT**

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

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

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**KEY:**

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

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

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

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. ADMIN. CODE r. 482-1-116 (1997/2001) (portions of previous version of model); ALA. CODE §§ 27-52-1 to 27-52-30 (1997/2014).
Alaska		ALASKA STAT. §§ 21.54.110 to 21.54.130 (1997/2009); § 21.54.500 (1997/2019) (definitions); §§ 21.56.110 to 21.56.250 (1993/2016).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-2301 to 20-2341 (1993/2000).
Arkansas		ARK. CODE ANN. §§ 23-86-201 to 23-86-209 (1991/1997); §§ 23-86-301 to 23-86-314 (1997/2003).
California		CAL. INS. CODE § 10112.300 (2014); §§ 10700 to 10752.8 (1992/1999); § 10113.95 (2006/2013); CAL. HEALTH & SAFETY CODE § 1367.012 (2014); §§ 1357 to 1357.19 (1992/2013).
Colorado		COLO. REV. STAT. §§ 10-16-101 to 10-16-113 (1992/2013); § 10-16-118 (1994/2013); 3 COLO. CODE REGS. § 702-4:4-6-8 (1995/2016); BULLETIN B-4.50 (#2 & #3) (2015/2016); BULLETIN B-4.65 (2013).
Connecticut		CONN. GEN. STAT. §§ 38a-564 to 38a-574 (1990/2014).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Delaware		DEL. CODE ANN. tit. 18, §§ 7201 to 7217 (1991/2013) (portions of previous version of model).
District of Columbia		D.C. CODE §§ 31-3301.1 to 31-3303.14 (1998).
Florida		FLA. STAT. § 627.6699 (1992/2016) (previous version of model); FLA. STAT. § 627.6425 (1996/2016); § 627.6475 (1997/2015).
Georgia		GA. CODE ANN. §§ 33-29A-1 to 33-29A-35 (1997/2013); § 33-30-12 (1990/1997); GA. COMP. R. & REGS. 120-2-10-.12 (1990/2009); 120-2-67-.03 to 120-2-67-.04 (1996/1998).
Guam	NO CURRENT ACTIVITY	
Hawaii		HAW. REV. STAT. § 431:2-201.5 (1997/2013).
Idaho		IDAHO CODE ANN. §§ 41-4701 to 41-4716 (1993/2013) (previous version of model); §§ 41-5201 to 41-5213 (1994/2004).
Illinois		215 ILL. COMP. STAT. ANN. 93/1 to 93/99 (1999); 97/1 to 97/99 (1997/2005); BULLETIN 2013-20 (2013).
Indiana		IND. CODE §§ 27-8-15-1 to 27-8-15.5-34.1 (1992/1998).
Iowa		IOWA CODE §§ 513B.1 to 513B.18 (1991/2017) (previous version of model).
Kansas		KAN. STAT. ANN. §§ 40-2209b to 40-2209p (1992/2019).
Kentucky		KY. REV. STAT. ANN. § 304.17A-005 (1998/2019); § 304.17A-0952 (1998/2010); § 304.17A-150 (1994/2012); § 304.17A-200 (1998/2010); § 304.17A-220 (1998/2010); §§ 304.17A-240 to 304.17A-250 (1998/2013).
Louisiana		LA. REV. STAT. ANN. §§ 22:1091 to 22:1099 (1991/2016); §§ 22:1061 to 22:1076 (1997/2019).
Maine		ME. REV. STAT. ANN. tit. 24-A, § 2808-B (1991/2019); § 2849-B (1989/2019).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Maryland		MD. CODE ANN., INS. §§ 15-1201 to 15-1225 (1997/20149; BULLETIN 17-2006).
Massachusetts		MASS. COMP. LAWS §§ 176J:1 to 176J:16 (1991/2016); §§ 176M:1 to 176M:7 (1996/1999); §§ 176N:1 to 176N:4 (1996/2013).
Michigan		MICH. COMP. LAWS §§ 500.3701 to 500.3723 (2003/2016).
Minnesota		MINN. STAT. §§ 62L.01 to 62L.22 (1992/2017) (previous version of model); MINN. STAT. § 62A.65 (1992/2013).
Mississippi		MISS. CODE ANN. §§ 83-63-1 to 83-63-11 (1994/1997).
Missouri		MO. REV. STAT. §§ 379.930 to 379.952 (1992/2016) (portions of previous version of model).
Montana		MONT. CODE ANN. §§ 33-22-1801 to 33-22-1828 (1993/2013) (previous version of model).
Nebraska		NEB. REV. STAT. §§ 44-5223 to 44-5267 (1994/2003) (portions of previous version of model).
Nevada		NEV. REV. STAT. §§ 689C.015 to 689C.355 (1997/2013); §§ 689C.610 to 689C.940 (1995/2013).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-G:1 to 420-G:16 (1997/2013).
New Jersey		N.J. STAT. ANN. §§ 17B:27A-1 to 17B:27A-53 (1992/2002).
New Mexico		N.M. STAT. ANN. §§ 59A-23C-1 to 59A-23C-10 (1991/1998); §§ 59A-23E-1 to 59A-23E-20 (1997/2000).
New York		N.Y. INS. LAW § 3221; §§ 3231 to 3233; §§ 4317 to 4318; § 4326 (1992/2015).
North Carolina		N.C. GEN. STAT. §§ 58-50-100 to 58-50-150 (1991/2013); §§ 58-68-25 to 58-68-75 (1997/2019).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
North Dakota		N.D. CENT. CODE §§ 26.1-36.3-01 to 26.1-36.3-12 (1993/2013); N.D. CENT. CODE §§ 26.1-36.4-01 to 26.1-36.4-09 (1995/1999).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 3924.01 to 3924.14 (1992/2015); § 3923.57 (1992/2014).
Oklahoma		OKLA. STAT. tit. 36, §§ 6511 to 6530 (1992/2013) (portions of previous version of model).
Oregon		OR. REV. STAT. §§ 743B.010 to 743.020 (1991/2019).
Pennsylvania		40 PA. CONS. STAT. § 764j (2010).
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		R.I. GEN. LAWS §§ 27-50-1 to 27-50-16 (2000) (previous version of model); §§ 27-18.5-1 to 27-18.5-10 (2000/2007).
South Carolina		S.C. CODE ANN. §§ 38-71-910 to 38-71-990 (1991/1997) (portions of previous version of model); §§ 38-71-1310 to 38-71-1450 (1994/2013) (previous version of model); §§ 38-71-840 to 38-71-880 (1997/2009); §§ 38-71-670 to 38-71-680 (1997).
South Dakota		S.D. CODIFIED LAWS §§ 58-18B-1 to 58-18B-60 (1991/2013) (previous version of model).
Tennessee		TENN. CODE ANN. §§ 56-7-2201 to 56-7-2211 (1992/2008); §§ 56-7-2801 to 56-7-2814 (1997/2008).
Texas		28 TEX. ADMIN. CODE §§ 26.3 to 26.30 (1993/2017); TEX. INS. CODE ANN. §§ 1501.001 to 1501.358 (2003).
Utah		UTAH CODE ANN. §§ 31A-30-101 to 31A-30-115 (1994/2014); UTAH ADMIN. CODE R590-269-1 to R590-269-6 (2013).
Vermont		VT. STAT. ANN. tit. 8, § 4080g (1991/1997); INS ORDER 3-13-2013 (2013).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		VA. CODE ANN. §§ 38.2-3430.1 to 38.2-3437 (1992/2019).
Washington		WASH. REV. CODE ANN. § 48.20.028 (1995/2006); §§ 48.21.045 to 48.21.120 (1990/2010); §§ 48.43.001 to 48.43.035 (1995/2009); §§ 48.44.022 to 48.44.024 (1990/2010); §§ 48.46.064 to 48.46.068 (1990/2010).
West Virginia		W. VA. CODE §§ 33-15-2a to 33-15-2g (1997); §§ 33-16D-1 to 33-16D-15 (1991/1997).
Wisconsin		WIS. STAT. §§ 635.01 to 635.19 (1991/2013); WIS. ADMIN. CODE INS. §§ 8.40 to 8.69 (1992/1994).
Wyoming		WYO. STAT. ANN. §§ 26-19-301 to 26-19-310 (1992/1997).

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Development of this model began with an assessment of the problems related to individual health reform. The task force identified a number of topics that needed to be addressed, including prevention of risk segmentation between the individual and small group markets (and the concurrent problem of cherry-picking healthy individuals in the individual market and dumping unhealthy individuals as one-life groups into the small group market); small group reform which as co-requisite requires reform of the individual market; spreading health insurance risk more broadly, i.e., across as much of the individual, small and large group markets as possible; insufficiency of high-risk pool guarantee issue programs to assure reasonable individual access to health insurance coverage; portability of coverage for individuals, including not being locked into a particular carrier once health problems arise; better rate protection for individuals (e.g. problems with tier rating); ability of individuals to make meaningful comparisons among policies; variance of rates among people in similar circumstances with similar coverage; and excessive expense associated with obtaining conversion coverage. **1995 Proc. 1<sup>st</sup> Quarter 572.**

In a letter from the chair of the task force, the charges were reiterated: develop model provisions for individual market reforms, including but not limited to such issues as rating, portability, guaranteed issue/renewability, and conversion; and consider whether such reforms should be included or merged into the Small Employer Health Insurance Availability Model Act. **1995 Proc. 4<sup>th</sup> Quarter 823.**

The letter explained that at the very outset of the process of developing an individual health reform model, the task force sat down with both regulator actuaries and members of the American Academy of Actuaries to seek their counsel on how to write a viable individual reform model that minimized or eliminated possible undesirable effects. The task force relied heavily on the suggestions contained in the American Academy of Actuaries' 35-page report. In nearly every instance, the task force adopted the NAIC actuarial working group and American Academy of Actuaries recommendations of ways to dampen unwanted market effects. **1995 Proc. 4<sup>th</sup> Quarter 823.**

The letter quoted a draft monograph distributed by the American Academy of Actuaries, in which the authors wrote:

A new system [which provides for guaranteed issue in a voluntary private health insurance market] characterized by compromise can be designed within the framework of a voluntary system... The clear benefit of such a compromise would be greater numbers of people with access to the private insurance market. The compromise might involve, say, a pre-existing condition exclusion limitation as a deterrent for adverse selection, a reinsurance pool (or other risk adjustment allocation method) to transfer any unintended cost shifts between markets, combined with premiums that are only slightly higher than today.

The chair noted that in developing the model, the task force adopted this compromise approach. **1995 Proc. 4<sup>th</sup> Quarter 823.**

A regulator explained that the task force had committed to work on an alternative model, the Individual Health Insurance Portability Model Act. Another regulator suggested holding the model until the arrival of the portability model, so that both models could be moved to Executive and Plenary together. **1995 Proc. 4<sup>th</sup> Quarter 792.**

A regulator stated that as the model was developed, a number of concessions were made to address the concerns of all parties. She stated that moving forward with the portability model would provide even more options for the states so that states could choose which option would better suit their marketplaces. **1995 Proc. 4<sup>th</sup> Quarter 792.**

At the plenary session, a commissioner stated that some associations claimed that they would be hurt by the Small Employer and Individual Health Insurance Availability and Individual Health Insurance Portability Model Acts. A commissioner stated that some associations met with NAIC members about their concerns and that this meeting seemed to have allayed the fears of these associations. **1996 Proc. 1<sup>st</sup> Quarter 29.**

A commissioner stated the NAIC should avoid adopting controversial models. Another commissioner noted that states were already adopting provisions similar to those contained in these models, further noting that these models contain a range of choices that provide flexibility to the states. **1996 Proc. 1<sup>st</sup> Quarter 29.**

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**Section 1. Short Title**

**Section 2. Purpose**

A commissioner stated that insurance regulators needed a framework to approach the problems of affordability and availability of individual health insurance. She urged the adoption of both models, noting that the Small Employer and Individual Health Insurance Availability Model Act had been worked on for a long time. Insurance regulators realize that the two models might not be appropriate for all states and that the members were open to changes and alternatives such as those set forth in the Individual Health Insurance Portability Model Act. She stated that because of the range of options and the flexibility provided in these models, they should be adopted. **1996 Proc. 1<sup>st</sup> Quarter 31.**

**Section 3. Definitions**

A regulator indicated that the experience in his state had been that it is hard to keep the individual and small group markets separate. He believed that if reform includes both the individual market and guaranteed issue; the self-employed person should be in the individual market. He believed the task force could take the language from the definition of self-employed and place it in a definition of individual. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

B. The chair addressed Subsection B on adjusted community rating wherein a trade association requested amendments to specifically allow separate claims experience for individuals and groups. Task force members noted that this was a loaded issue and also touched on the issue of allowing separate pools inside and outside of alliances. The association noted that it had also requested this change to go in Section 5, where it might belong better than in the definitions, but wanted a clear statement that with regard to the process of rating, the markets may stay separate. The association also commented that drafting notes fall out of adopted legislation. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

D. In Subsection D regarding the basic health benefit plan, a regulator questioned whether the group wanted to continue requiring a basic plan considering its unpopularity. There was some discussion of option for a standardized benefits package with low, medium and high co-payment and deductibles. However, task force members were leery because amendments to the small group model were also being suggested. Also, many states had adopted the basic and standard plans framework in their small group laws. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

F. A regulator suggested the use of the word “provides” in Subsection F with regard to the definition of “carrier” was too narrow. A regulator suggested “issues” or “offers” for issuance should be used to be broad enough to cover all delivery vehicles to the marketplace and also suggested including any other entity providing a health benefit plan to an eligible person or employer. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

P. With regard to the definition of health benefit plan, the regulator stated that he believed stop loss insurance needed to be regulated on the individual side as well. He also would limit hospital confinement and indemnity and include those limits in the definitions section. Further, he believed that in the definition of eligible person, associations and trusts that insure college students are covered by the definition. He noted that the task force might want to exempt accident and limited insurance because the task force did not want to force comprehensive insurance policies on those individuals. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

The regulator commenting on Subsection P pointed out that as presently defined, family composition would preclude the use of gender as a rating factor. If the task force decided to use gender as a rating factor, that definition would need to be amended. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

An interested party stated that he would like to have the task force exempt short-term products from the requirements of the model. A regulator stated that in his state they had gone back and exempted student medical plans from the applicability provisions of the act. A regulator stated that as a compromise in his own state, they had agreed to insert a clause that companies with products that are short term or for some explicit purpose can go to the commissioner for an exemption. An interested party indicated that he believed a few states had gone back to give such special consideration as well. The task force reached a consensus that a drafting note could indicate that the commissioner could be given the authority to exempt



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**Section 3 (cont.)**

certain specific plans from the guaranteed issue requirement such as a student medical policy in narrowly circumscribed circumstances. A regulator indicated he would assist staff with language in this regard. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

With regard to the definition of health benefit plan, an industry representative requested that short-term insurance be exempted from the definition. No motion was made in response to the request. **1995 Proc. 4<sup>th</sup> Quarter 819.**

Q. NAIC staff was instructed to make the definition consistent because it stated that a carrier “markets and sells,” whereas an earlier definition referred to “issues or offers.” **1995 Proc. 3<sup>rd</sup> Quarter 794.**

R. With regard to the definition of individual health benefits plan, a regulator indicated that as drafted, if any portion of the premium was paid for by an employer, even a nickel, it was small group coverage. He recommended a bright line test that would clearly differentiate one circumstance from another. For example, if at least 10% of the premium was paid by the employer, the product was in the group market, whereas if the individual paid at least 90% of the premium, the product was in the individual market. He indicated such a bright line test was necessary, especially where dealing with associations and trusts. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

An audience member emphasized the necessity of insurance to be affordable and stated that cost was a critical piece of the puzzle. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

An industry representative indicated that in his reading of the definition of eligible employee and health benefit plans, conversion plans were included and he believed there should be an exception for conversion policies in the model. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

The necessity of defining small employer health benefit plans, using parallel language from individual health benefit plans, and to reach trusts and associations was discussed. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

The task force discussed individual market reform. Based on the discussions of the prior few meetings, the chair flagged certain topics where she believed the task force had reached consensus and wanted the permission of the task force to go ahead with actual drafting on those points. The task force decided to construct a drafting note with regard to a sole proprietor being in the individual or small group market so that if the state was doing both individual and small group pursuing small group reform, the sole proprietor should remain in the small group market. Also, the language in Section 3 was expanded because “provides” was too narrow. **1995 Proc. 2<sup>nd</sup> Quarter 588.**

It was pointed out that the definition of individual health benefits plan did not exclude conversion plans. The task force may be inadvertently dragging group carriers into the definition of individual carriers, thereby placing them in the individual market. The task force members were sympathetic to the issue, and a regulator indicated he would propose an amendment. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

T. An interested party recommended that the definition of “genetic information” be deleted for two reasons. First, the term “genetic information” was not defined in the Health Insurance Portability and Availability Act (HIPAA). It was only defined in the interim rules. Second, because the term was defined only in the interim rules, it might be altered when the final rules were issued. Therefore, it would be premature to adopt the definition. The chair suggested that the definition be retained, but that a drafting note be added to alert states that prior to adopting this definition states should review the final HIPAA rules to ensure that it was adopting the correct language for the definition. Without objection, the task force adopted the chair’s suggestion that the definition be retained and that a drafting note be added. **1999 Proc. 3<sup>rd</sup> Quarter 881.**

U. The task force discussed the comments by a regulator suggesting that the geographic area be defined so as to insure consistency among carriers. Regulators indicated they believed that ability existed in the model in the definitions section for the commissioner to establish geographic areas for the state. **1995 Proc. 3<sup>rd</sup> Quarter 733.**

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**Section 3 (cont.)**

X. With respect to the drafting note for the definition of “health benefit plan” in Section 3X, the task force discussed whether, given the extensive “excepted benefits” language added to this definition for the purpose of complying with HIPAA, the language in the drafting note was still appropriate. The chair suggested that the drafting note be revised to recommend that states examine this definition closely before adopting any additional exemptions. **1999 Proc. 3<sup>rd</sup> Quarter 881.**

Y. With regard to the definition of qualifying previous coverage and qualifying existing coverage, the task force members discussed carving out non-complying self-funded ERISA plans. They believed that while the presence of that carve out in the definitions was addressing an anti-dumping concern, it created problems of non-coverage for certain individuals.

There was further discussion regarding adding an exception to the carve out for individuals who have exhausted their Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

An industry representative stated that he believed the old language on qualifying previous coverage was better and that the task force should write new language on anti-dumping. It was also mentioned that while federal law prohibited insurance companies from considering Medicaid eligibility when issuing insurance, state law could prohibit state Medicaid programs from dumping their high-risk individuals into the individual insurance market. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

BB. A commissioner raised the issue as to whether insurance producers would be able to market memberships in professional associations, noting the restrictions in the Small Employer and Individual Health Insurance Availability Model Act and the Individual Health Insurance Portability Model Act. The commissioner moved that the existing language in these provisions be replaced with the following language:

Producers may only market association memberships, accept applications for membership, or sign up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the professional association. **1996 Proc. 1<sup>st</sup> Quarter 31.**

KK. A regulator stated that he would like to see the drafting note at the end of Section 1 expanded to say that states should be mindful when adopting the draft model of cost implications on both the individual and small group markets. Another regulator stated that, when the drafting note discusses cost, the task force should not be too narrow in its description, as the drafting note should address both initial premiums and renewal premiums. **1995 Proc. 2<sup>nd</sup> Quarter 584.**

II. A definition of “network plan” was added in Section 3II because of other changes made in Sections 7 and 6 of the model, which concern the availability and renewability of coverage, respectively. **1999 Proc. 3<sup>rd</sup> Quarter 882.**

Another regulator indicated he was concerned with regard to associations because most individual insurance in his state is purchased through such plans. **1995 Proc. 2<sup>nd</sup> Quarter 585.**

PP. Several technical discussions were held concerning what constitutes a “professional association” under these models. One way to resolve the matter would be to delete the reference to professional associations in these models. Another approach emphasizes that the definition of “professional association” recognizes that a “professional” can be someone with lots of education, training or experience. A commissioner reminded the group that the purpose of the definition of “professional association” was to defeat associations that appear to be a sham, not to impose undue restrictions on legitimate associations and suggested that, under the definition, each state had sufficient flexibility in determining who is a professional. **1996 Proc. 1<sup>st</sup> Quarter 29.**

Another commissioner agreed that the definition of “professional association” was not born of an elitist attitude, but stated she could not be in favor of these models if farmers were excluded from those who could form a “professional association.” Her interpretation is that farmers are included among those who may form a “professional association.” **1996 Proc. 1<sup>st</sup> Quarter 29.**

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**Section 3PP (cont.)**

A commissioner stated that deleting the provisions relating to professional associations would mean that all association groups would be subject to these models if adopted in a state. Another commissioner confirmed, adding that the previously suggested compromise of permitting the marketing of association memberships may be the best approach. One commissioner opposed earlier versions of the model due to concerns about the economic impact of these models as discussed. The commissioner stated that he opposed a version of the Small Employer and Individual Health Insurance Availability Model Act that was introduced in his state in 1995, and that legislation was not adopted. **1996 Proc. 1<sup>st</sup> Quarter 31.**

A commissioner received a letter expressing the concerns of associations. Another commissioner addressed two association concerns. First, insurance producers should be able to market association memberships and second, the definition of “professional association” is vague. The amendment previously proposed deals with the issue of insurance producers marketing association memberships and as to the supposed vagueness of the definition of “professional association,” the definition provides flexibility to state insurance regulators. **1996 Proc. 1<sup>st</sup> Quarter 32.**

Numerous comments were received on this definition from various interest groups. The comments recommended that this definition be stricken and that HIPAA’s definition of “bona fide association” be used in its place. NAIC staff noted that no significant changes had been made to this definition since the prior draft, and as reflected in the language of the drafting note for the definition, the definition of “professional association” differed from HIPAA’s definition of “bona fide association” only in one way substantively. The definition of “professional association” requires that an association wishing to meet the definition of “professional association” serve a single profession. **1999 Proc. 3<sup>rd</sup> Quarter 882.**

The chair stated that he was aware of the comments and wanted to provide some background on this issue. The issue of professional associations and what requirements were needed to be considered a professional association was discussed extensively when the model was initially adopted. In addition, the chair stated that the charge of the task force was to revise NAIC models and regulations to comply with HIPAA requirements. If changes were made to the definition of “professional association,” as recommended by some interested parties, the changes would go beyond the task force’s charge. The chair also noted that HIPAA’s definition of “bona fide association” explicitly permits a state to impose additional requirements. As such, the narrower definition of “professional association,” as reflected in this model, does not conflict with HIPAA and does not require a revision to comply with HIPAA requirements. **1999 Proc. 3<sup>rd</sup> Quarter 882.**

An industry representative commented that the requirements of this definition would eliminate the right of some associations to sell because they cannot meet the requirements. He believed that the definition of “professional association” goes beyond the requirements of HIPAA and, as such, should be revised to mirror HIPAA’s “bona fide association” definition. The industry representative also noted that the language for this definition was adopted pre-HIPAA. When this model was initially adopted, bona fide associations were not contemplated. Another industry representative echoed these comments, pointing out that another provision in the definition, which limits the size of an association, is restrictive to small associations. **1999 Proc. 3<sup>rd</sup> Quarter 882.**

A regulator asked about the practical applications of this definition. It was explained that, due to HIPAA’s guaranteed availability requirements for the small group market, one consequence of not satisfying the definition of “professional association” could be that the association would become a small group carrier and be required to offer all of its plans to groups that are not members of the association. Another regulator stated that this definition could affect some associations in his state that are operating as bona fide associations. The definition could prevent them from operating. **1999 Proc. 3<sup>rd</sup> Quarter 882.**

The chair again stressed that this definition was in place prior to HIPAA and has been adopted as part of the model. The charge of the task force was to revise NAIC models and regulations for HIPAA compliance. The task force does not have the authority to alter previous policy decisions. The chair repeated that this definition was not preempted by HIPAA because HIPAA explicitly allowed states to impose additional requirements. The chair suggested that the definition’s drafting note be changed to include HIPAA’s “bona fide association” definition and that language be added to the drafting note explaining that states can decide which definition to use, the “bona fide association” definition or the “professional association” definition. However, states should look at other provisions in the model before adopting the “bona fide association”

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definition, particularly the rating provisions, because HIPAA did not include any rating provisions. The task force voted to adopt the chair's recommendation. **1999 Proc. 3rd Quarter 881-882.**

QQ. The next item for discussion was professional association plan language. A regulator proposed language that did not create a separate definition for "professional association carrier," but did not force the carriers that offered such plans to become individual carriers. However, the carriers were to be subject to the requirements of the individual market without becoming individual carriers. The regulator accepted a friendly amendment from the chair that agents could not enroll members into the association. The regulator clarified that her motion was not to force the carriers to be individual carriers and included authority to staff to make sure the language was narrowly crafted. After further discussion, the association language proposed by the regulator and as amended by the chair was adopted. **1995 Proc. 4<sup>th</sup> Quarter 820-821.**

ZZ. There were two alternatives for the definition of "small employer." The definition entitled "Alternative 1" is was the existing model act definition of small employer. This definition uses used the defined term "eligible employee" as a basis for counting the number of employees for the purpose of determining whether an employer is a small or large employer. The "Alternative 2" definition of small employer is was the Health Insurance Portability and Accountability Act (HIPAA) definition. This definition uses used the Employee Retirement Income Security Act of 1974 (ERISA) definition of "employee" as a basis for counting the number of employees for the purpose of determining whether an employer is a small or large employer. These draft amendments to the definition were made before a bulletin addressing HIPAA group size issues was issued by the Health Care Financing Administration (HCFA) in September. Given the position of HCFA, as conveyed in the bulletin regarding the types of employees that must be counted to determine whether an employer is a small or large employer, the proposed amendments to the definition of small employer most likely would have to be revised. **1999 Proc. 4<sup>th</sup> Quarter 940.**

The chair explained the problem with the model act definition of small employer and counting of employees for the purpose of determining whether the employer is a small or large employer. He stated the problem arises whenever a state has defined the term "eligible employee" in a manner that excludes the counting of part-time employees. Using the ERISA definition of "employee" provided under Section 3(6), HIPAA defined employee as "any individual employed by an employer." As such, part-time employees would be counted under the HIPAA definition. Therefore, an employer that has 10 part-time employees was entitled to HIPAA's guaranteed availability of coverage under the HIPAA definition of employee because the employer has two or more employees. However, if state law provided for counting only "full-time" employees, this employer would be considered to have no employees, and therefore, having less than two employees, the employer would be denied HIPAA protections. **1999 Proc. 4<sup>th</sup> Quarter 941.**

The chair suggested to the task force that the definition of small employer be redrafted in a manner that would give the employer the best opportunity to benefit from HIPAA protections, particularly those employers with lower numbers of employees. An interested party suggested that the definition of small employer be revised to use the HIPAA definition of employee for counting the number of employees for the purpose of determining whether an employer is a small or large employer. The chair stated that revising the definition in such a manner would be beyond the scope of the task force's charge to conform the model to HIPAA provisions. **1999 Proc. 4<sup>th</sup> Quarter 941.**

The addition of Paragraph (2) was intended to resolve the problem with regard to the availability model's definition of "small employer" and its use of the defined term "eligible employee" as a basis for counting the number of employees for the purpose of determining whether an employer is a small or large employer. The problem arises with the use of this defined term whenever a state has defined "eligible employee" in a manner that excludes the counting of part-time employees. Using the definition of "employee" provided under section 3(6) of ERISA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines "employee" as "any individual employed by an employer." As such, part-time employees would be counted under the HIPAA definition. Consequently, using the HIPAA definition of "employee," an employer with 15 part-time employees would be considered a small employer and entitled to HIPAA's guaranteed availability of coverage to small employers because the employer has two or more employees. However, if state law defines "eligible employee" to mean only full-time employees, then, by definition, this employer would have no employees. As such, the employer would not be considered a small employer and would be denied HIPAA's guaranteed availability protections. By adding Paragraph (2) to

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the definition of “small employer,” an employer will be deemed to be a small employer regardless of the way a state has defined the term “eligible employee” whenever the employer has a combination of no more than 50 eligible employees and part-time employees. **2000 Proc. 1<sup>st</sup> Quarter 167-168.**

**Section 4. Applicability and Scope**

It was the consensus of the group that the fundamental framework of the model was set, i.e., two options for guaranteed issue, guaranteed renewability, two options for risk-spreading mechanisms in the individual market, portability, rating restrictions. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

There was then some discussion with regard to how to treat pre-reform business. In one state, plans issued prior to the effective of the act are subject to the Act for assessment purposes but not for standardized products requirements. There was some discussion about the difference in the market and the states, however, and that some transition period may be necessary. The issues are rating reforms for pre-reform business; the assessment base; and what can be charged as a loss. A regulator indicated that this issue would be flagged and members of the industry were invited to suggest language to address the issue. It was noted that it could be dealt with in a drafting note indicating the need to look at the transition based on the prior market if a state adopted the New Jersey approach. **1995 Proc. 3<sup>rd</sup> Quarter 794.**

**Section 5. Restrictions Relating to Premium Rates**

The task force discussed whether the gender issue was significantly more compelling in the individual market versus in the group market. The necessity for flexibility throughout the model to account for the experiences of the states was noted. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

The chair addressed Section 3B on adjusted community rating wherein an interested party requested amendments to specifically allow separate claims experience for individuals and groups. Task force members noted that this also touched on the issue of allowing separate pools inside and outside of alliances. The interested party noted that it had also requested this change to go in Section 5, where it might belong better than in the definitions, but they wanted a clear statement that with regard to the process of rating, the markets may stay separate. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

An interested party stated that the task force might want to consider combining and pooling small group and individual rates, or consider tying the individual to the small group rates. As presently structured, there is separate rate setting in both markets and he suggested the task force consider combining or pooling both. **1995 Proc. 3<sup>rd</sup> Quarter 792.**

The chair indicated that an interested party had raised the issue of rate setting in the two markets. A regulator stated that different companies are in each market and that insurers argued that small employers were unfairly burdened when combined with the individual market. He suggested a drafting note be added that a state might want to consider it. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

A regulator stated the assumption that the individual market burdens the small group market. In one state, there was evidence that the small group products are under-priced and in fact the individual market has been picking up the slack. Another regulator suggested allowing companies to write in both markets but everyone participates in the assessment mechanism, which was thereby reflected in the rates spread across the individual and small group markets. It was agreed that the issue could be revisited as part of a discussion on spreading assessment costs. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

A regulator addressed the task force regarding an editorial about the “safety net” issue that had been enacted in his state at the time of market reforms. He cautioned that his state’s experience was a lesson in how not to proceed with market reforms. He believed that it was a problem with a transitional program and not a failure of the market reforms. A consumer in the safety net program addressed how his premiums had increased since the enactment of market reform. **1995 Proc. 3<sup>rd</sup> Quarter 728.**

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An interested party indicated opposition to an all markets approach and stated that her company had no experience in retail markets. She supported different options including the high-risk pool, which might be the only political option in some states. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

A regulator urged the task force not to forget the outcry against abusive rating practices, and the unavailability of insurance, stating that he believed the task force should look at broad-based subsidies that might ameliorate some of the task force concerns. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

There was some discussion regarding the issue of the effective dates relating to Section 5. In the present draft, the rating restrictions will apply to all new business, but are phased in over three years for old business. No motion was made to amend this section of the draft. **1995 Proc. 3<sup>rd</sup> Quarter 733.**

A regulator stated that as long as there was a voluntary marketplace, the reforms enacted in the model would be disruptive but mentioned he did not wish to return to square one. He acknowledged that the model could be utilized by states but preferred the draft be kept within the task force until the Iowa piece was finished and they would be moved up together. **1995 Proc. 4<sup>th</sup> Quarter 821.**

Another regulator echoed support for the regulator's position. He stated there are some problems in the individual marketplace, yet was not sure this model was the answer to those problems. He was, however, gratified that the task force would be looking at another alternative. **1995 Proc. 4<sup>th</sup> Quarter 821.**

The chair noted the full grandfathering of existing individual business, that is, existing individual business does not need to comply with the act. **1995 Proc. 4<sup>th</sup> Quarter 819.**

A. With regard to adjustments to modified community rating for age, a regulator indicated that he believed the issue of integral age in the individual market was important so as to avoid individuals receiving a dramatic jump in price when the age bracket changed every five years. Staff was instructed to so amend the draft. **1995 Proc. 3<sup>rd</sup> Quarter 794.**

H. The certification issue was raised by an interested party. After discussion, the regulators indicated that they want the certification process to remain for the individual rates as well as for group rates. **1995 Proc. 4<sup>th</sup> Quarter 819.**

**Section 6. Renewability of Coverage**

Task force members discussed the American Academy of Actuaries' question as to whether guaranteed renewability is necessary in a guaranteed issue environment. Task force members also discussed the issue of closed blocks of business with regard to obsolete insurance products, reiterating that the commitment was if persons entered the system and were willing to pay the premium, the model would ensure continuity of coverage. With regard to the obsolete products, the task force members indicated the task force could adopt the Academy's recommendation and place a provision in the model that would allow the commissioner of insurance to give permission to an insurance company to replace an obsolete product with comparable coverage. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

Insurance industry representatives pointed out that what is guaranteed issue is relevant to the issue of what is guaranteed renewable. Industry representatives also noted that with regard to this draft model, the task force needed to review existing models to determine what needed to be repealed. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

The chair had flagged certain topics on which the task force had reached consensus: guaranteed renewability, specifically obsolete products that the insurance commissioner could give permission to an insurance company to replace an obsolete product with comparable coverage; a second option with regard to guaranteed issue to reflect a rolling open enrollment, 30 days annually, with a 12/12 period existing condition limitation exclusion, but for a person who had qualifying previous coverage, that person would have 30 days from termination of the prior policy to obtain a guaranteed issued product; adding a definition of preexisting conditions that would clarify that once in the system, the person is covered for a condition that was

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not preexisting prior to coverage, but occurred early in coverage; and with regard to risk-spreading. **1995 Proc. 2<sup>nd</sup> Quarter 588.**

An interested party indicated concern with stacking of coverages and preventing individuals from carrying multiple coverages. If an individual already had a health benefit plan, that individual should not be eligible for a guaranteed issue product. He noted that coordination of benefits provisions did not apply to the individual market in many states. He indicated he would provide language to the task force as a proposed amendment. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

With regard to guaranteed renewability, an interested party indicated the same dumping issues were present as with availability, and that he would provide the task force with recommended language. **1995 Proc. 3<sup>rd</sup> Quarter 792.**

A. Subsection A(1)(b) was revised to reinsert language initially stricken that provided for an exception to guaranteed renewability with respect to an individual insured if the insured or the insured's representative performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of coverage. NAIC Staff noted that similar language was added in Subsection B(1)(b) as an exception to guaranteed renewability for individual health benefit plans whenever the insured or the insured's representative committed fraud or made an intentional misrepresentation of a material fact under the terms of coverage. NAIC Staff next explained a new provision added at the request of the task force, Subsection A(2), that would allow a small employer carrier to choose not to issue a health benefit plan to a small employer whenever that small employer carrier had elected not to renew the health benefit plan with that small employer due the small employer's fraud or intentional misrepresentation of a material fact under the terms of coverage. NAIC Staff noted, however, that this new exception to guaranteed availability of coverage only applied to that small employer carrier. All other small employer carriers still would be required to issue coverage to that small employer under HIPAA's guaranteed availability of coverage requirements. **1999 Proc. 4<sup>th</sup> Quarter 941.**

B. Regulators agreed to change "misrepresentation" to "material misrepresentation." **1995 Proc. 4<sup>th</sup> Quarter 819.**

**Section 7. Availability of Coverage**

Task force members noted that the section dealing with the availability of coverage was an appropriate place in the model to lay out alternative approaches. The model reflected a 365 days/year guaranteed issue approach. Alternative two was a 30-day rolling open enrollment period with a 12/12 preexisting condition limitation exclusion. Alternative two also would include language that a person who had qualifying previous coverage would have the ability to enroll in a guaranteed issue product within 30 days of termination of the prior coverage. Some task force members envisioned their states maintaining the high-risk pool and believed that the high-risk pool has had the effect of stabilizing the market by pulling out the extremely high cost individuals. Task force members noted that the model needed to address dumping problems. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

An interested party stated that his company could accept the theory of guaranteed issue in the individual market if all carriers in the small group market were mandated to participate in the individual market. The company would prefer a rolling open enrollment, perhaps based on month of birth, for administration purposes. Another interested party also expressed some concern that a two

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month affiliation period was not the equivalent of a 12/12 preexisting condition limitation exclusion and put forth the notion that a surcharge as an alternative method of equalizing the risk might be appropriate. He stated another option was an enrollment cap. The company would prefer that only the basic and standard health plans be guaranteed issue instead of all policies. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

An industry representative indicated that there were some studies indicating individual premiums would need to increase 10% to cover the portability liability if all COBRA-eligible persons are allowed to guarantee issue into the individual market. The chair requested that HIAA share whatever data it could on the subject. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

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The task force agreed that a second option would be written into the draft to reflect a rolling open enrollment, 30 days annually, with a 12/12 preexisting condition limitation exclusion, but for a person who had qualifying previous coverage, that person would have 30 days from termination of the prior policy to obtain a guaranteed issue product. There was further discussion by the task force members, clarifying that no decisions had been made at this point and that this was for drafting purposes only. **1995 Proc. 2<sup>nd</sup> Quarter 586-587.**

A regulator mentioned the current draft would not allow someone into the individual market if that person was eligible for group coverage. He stated that the result would be locking people into group coverage and if that coverage was not very good, that person did not have an option to enter the individual market. He stated that certain precautions could be taken to protect against anti-selection. **1995 Proc. 2<sup>nd</sup> Quarter 587.**

The chair noted that the draft would require the same standard and basic packages for both markets. A regulator stated that the plans were slightly different in his state between the markets, mostly because of the issue of mental health benefits. An industry representative noted that deductibles tend to be higher in the individual market. An interested party asked the task force to consider the approach where only four or five products were offered in the individual market. Those products had the same benefits, and differed only in the amount of deductible and coinsurance. A regulator opined that such an approach addressed anti-selection issues. **1995 Proc. 2<sup>nd</sup> Quarter 587.**

An interested party stated that there should be a broad base of insurance and the task force should not burden just the small group market. He stated the task force should not miss the opportunity to tap into the self-insured market. **1995 Proc. 3<sup>rd</sup> Quarter 792.**

A regulator suggested that the model as recommended by the task force provided alternatives to states; the model did not mandate guaranteed issue, but merely provided it as an alternative. The regulator believed it was sound public policy to provide alternatives to states. **1995 Proc. 4<sup>th</sup> Quarter 792.**

A regulator stated that his state strongly objected to any guaranteed issue requirements and adjusted community rating and stated the price implications would have negative affects in the marketplace. He opined that the model represented a governmental intrusion into a marketplace that worked reasonably well. **1995 Proc. 4<sup>th</sup> Quarter 792.**

The chair indicated that another option was guaranteed issue standard and basic only, while underwriting other plans. Also, there was the option of having a high-risk pool with a cost-spreading mechanism. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

Some regulators opined that if the model did not accomplish guaranteed issue in the individual market, it gutted the three models adopted earlier on purchasing alliances (the Regional Health Care Voluntary Purchasing Alliance Model Act, the Single Health Care Voluntary Purchasing Alliance Model Act, and the Private Health Care Voluntary Purchasing Alliance Model Act). The third option with regard to a high-risk pool already existed in an NAIC model law regarding high-risk pools. Other regulators also opined that their states wanted to get rid of their high-risk pools and believed that addressing a high-risk pool as a third option in this draft model would send the wrong signal with regard to individual reform. Some regulators saw high-risk pools as a step backwards, because the existence of such pools ran contrary to the purpose of the model, which was to prevent segmentation of the market based on health risk. Some regulators also opined that perhaps the task force should think of high-risk pools as a transitional place for people to be in between the group and individual markets, not a permanent place. It was noted, however, that there always needed to be a penalty for those who procrastinated in obtaining insurance. An industry representative stated that the high-risk pool was some states' answer to availability. **1995 Proc. 3<sup>rd</sup> Quarter 792-793.**

An interested party indicated that her organization would support a third option and spreading the cost across all groups and the self-funded. The drafting group determined not to include a third option. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

Regulators indicated the parent committee should re-examine the high-risk pool model, and that this vote did not mean the regulators were not concerned about those issues. **1995 Proc. 3<sup>rd</sup> Quarter 793.**



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An interested party had raised the issue of rate setting in the two markets. A regulator stated that different companies were in each market and that insurers argued that small employers were unfairly burdened when combined with the individual market. He suggested a drafting note be added that a state might want to consider it. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

A regulator clarified the assumption that the individual market burdens the small group market. In one state, there was evidence that the small group products are under-priced and in fact the individual market has been picking up the slack. Another regulator suggested allowing companies to write in both markets but everyone participates in the assessment mechanism, which was thereby reflected in the rates spread across the individual and small group markets. It was agreed that the issue could be revisited as part of a discussion on the New Jersey model and spreading assessment costs. **1995 Proc. 3<sup>rd</sup> Quarter 793.**

An industry letter proposed extensive anti-dumping and anti-stacking language for both options 1 and 2. There was some discussion regarding the intent of an anti-stacking provision, which some regulators thought was not to prevent a person moving from one plan to another, but to prevent a person from having multiple individual policies. A regulator noted that in his state, under the small group law, a change to another plan could only be made one time a year. Another regulator recited that in his state, there was an annual open enrollment period in which a person could upgrade coverage. A commissioner noted that there should be a provision for a commissioner to order a special open enrollment in an emergency situation such as a receivership. Staff was directed to draft language regarding an open enrollment period with a provision allowing the commissioner to create an emergency open enrollment period for good cause. It was suggested that the Health Maintenance Organization Model Act has a similar provision currently, as does the Life and Health Insurance Guaranty Association Model Act. **1995 Proc. 3<sup>rd</sup> Quarter 789.**

Discussion evolved regarding the under 65 disabled Medicare population being unable to obtain Medicare supplement insurance and, therefore, they should have access to an individual market guaranteed issue product. There was some question as to whether Medicare would be primary or secondary under such a scheme. There was also some confusion among the task force members as to whether recent amendments to the Medicare supplement insurance law mandated a guarantee issue of Medicare supplement insurance to the under 65 disabled Medicare population. **1995 Proc. 3<sup>rd</sup> Quarter 789.**

An issue regarding whether employees with coverage should be counted as participating with regard to the minimum participation requirement was raised. Task force members noted tracking was a practical problem because the situation became very fluid, particularly with spouses. **1995 Proc. 3<sup>rd</sup> Quarter 789.**

An interested party suggested the use of a rating surcharge not to exceed 50% of the rate permitted under Section 5 for a period not to exceed 12 months, an affiliation period, or any other reasonable term or condition which was actuarially equivalent. A regulator noted that actuarially the 50% might not work because it is an impossible calculation. The interested party representative mentioned the 50% would not necessarily cover the expenses but it was an acceptable compromise to the interested party. It was noted that the third alternative, any other reasonable term or condition not exceeding the actuarial value of a 12-month preexisting condition limitation, was a nightmare for regulators to enforce. The task force agreed that with the deletion of the latter option, the interested party suggested language should be placed in the model for review. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

The task force discussed minimum participation requirements. A regulator had suggested that employees with coverage should be counted as participating with regard to those minimum requirements. It was noted that this language had just been adopted last March by the NAIC membership when it adopted the revisions to the Small Employer Health Insurance Availability Model Act, and perhaps those minutes would give some insight as to the change. **1995 Proc. 3<sup>rd</sup> Quarter 729.**

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An interested party suggested including a risk pool option. In the past, predecessor companies had supported small group reform. However, the all markets approach followed in Utah, is alarming for his company. He believes it is bad policy for the NAIC to adopt an untested model. Also, there is tremendous administrative expense in developing products and field staff for the individual market, which his company has no experience in writing. He requested that the task force seriously consider withdrawal of Option 1, since forcing insurance companies to write business in an area with which they were unfamiliar was bad policy. **1995 Proc. 3<sup>rd</sup> Quarter 730.**

A regulator indicated that his state had dealt with this concern and did not force carriers to write in markets in which they do not normally write. **1995 Proc. 3<sup>rd</sup> Quarter 730.**

An interested party stated that the Utah and New Jersey models had been adopted before the Travelers decision. She stated the individual and small group markets are fundamentally different and it would be unprecedented for regulators to force carriers to do something at which they have no experience. The interested party had proposed language regarding a broad assessment base through a hospital tax, which goes beyond the insured market. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

An interested party stated that he believed that if there were no forced writing in the individual market, then individual carriers should be allowed to have separate rating pools for guaranteed issue products and underwritten products. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

A commissioner stated she did not believe community rating was an essential element of reform and that in fact it may cause harm. She pointed out that the small group model recognizes options in rating and for those states that wish to proceed slowly, some latitude regarding experience rating is helpful. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

A consumer advocate stated that the market has been moving away from risk factors and experience as a way to compete. The connection between the individual and small group markets exists, and some states, while not forcing carriers to write individual insurance, had recognized the dual responsibility. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

A regulator explained the problem with separating guaranteed issue from underwritten policies with regard to rating. The bad risks would all wind up in the guaranteed issue products and the insurance would become unaffordable. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

A commissioner stated that she did not believe that community rating was an essential element of reform and in fact could cause harm. She pointed out that the small group model recognized options in rating and, for those states that wished to proceed slowly, some latitude regarding experience rating was helpful. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

A regulator reminded the task force of what had brought the task force to this point in the draft model in the first place, which was an outcry against abusive rating practices and the unavailability of insurance. He suggested that the task force should look at broad based subsidies that might ameliorate some of the problems. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

A regulator suggested a third option to add: an individual not eligible for a guaranteed issue product must reside in the high-risk pool that is as broadly funded as possible for a certain period of time, then move to the individual market. If the person is then continuously insured he is in the system; if he leaves the market, he must then re-enter the high-risk pool to obtain coverage. Another regulator offered a substitute suggestion. He believed there was a wide divergence of opinion at the state level and an alternative model should be considered. He believed models should reflect the wide variety of approaches such as high-risk pools, guaranteed issue and open enrollment, which have been taken from the states. He suggested that the task force should complete the work on the present draft and then begin work on a model based on the alternative approach. **1995 Proc. 3<sup>rd</sup> Quarter 731-732.**

The next item under consideration was the broad-based funding mechanism in the form of a hospital tax proposed by a regulator. She indicated that the hospital tax approach is based on several states with laws that tax hospital surcharges only. The task force members indicated they supported the concept of broad-based funding sources in general and would be willing

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to list several ways to achieve that funding in a drafting note. Regulators were reluctant, however, to insert any language into a model recommending any sort of tax. There was some discussion among the members regarding listing the mechanisms within the draft under an option vs. listing them in a drafting note. **1995 Proc. 3<sup>rd</sup> Quarter 732.**

The Task Force determined that a cap on the number of high risk individuals required to be accepted by a carrier should be allowed. **1995 Proc. 4<sup>th</sup> Quarter 888.**

With regard to phasing in loss ratios, the task force determined that a phase-in period of three years, such as occurred with Medicare supplement insurance, should be allowed in Section 3 Option 1. **1995 Proc. 4<sup>th</sup> Quarter 888.**

There was some discussion of association plans. An interested party expressed some concerns that carriers writing professional association business not be subject to the guaranteed issue requirements of the model for all applicants who were not members of the association. Regulators expressed some sympathy for the position, but also expressed some concern about opening loopholes on the model. **1995 Proc. 4<sup>th</sup> Quarter 888.**

An interested party requested that carriers be allowed to keep existing individual business separate. The task force determined to have the next draft reflect that concept. **1995 Proc. 4<sup>th</sup> Quarter 888.**

A regulator stated that his state opposed guaranteed issue in the individual market and pure community rating as related in the model draft. He believed there were reasonable alternatives for the task force to pursue. He moved to table the draft model, indicating that he would like to look at other approaches. After further discussion, the motion failed. **1995 Proc. 4<sup>th</sup> Quarter 818.**

A consumer advocate raised the issue of separate spouses being precluded from obtaining a guaranteed issue product when the separated spouse was eligible for group coverage under the spouse's policy but was not covered by the spouse's group plan. She proposed language, but regulators expressed concern with the language insofar as it attempted to compare premium rates between the employer plan and the individual market. **1995 Proc. 4<sup>th</sup> Quarter 820.**

A drafting note was added to reflect that if a state did not adopt Options 1 or 2 in Section 7 with respect to guaranteed issue, it should also not adopt the section relating to converted policies. **1995 Proc. 4<sup>th</sup> Quarter 821.**

A regulator stated she was proposing language that would allow carriers with professional association business to elect whether to be in the individual market or all group market. An industry representative stated that he had some professional association carrier language that has more consumer protections. The chair indicated that the NAIC, through its Special Committee on Health Care Reform, was on record that it did not favor carve-outs for association plans. A regulator wondered whether the draft could make association plans conform to the dictates of small group laws but not make them a small group carrier. An interested party said that the problem was the association carrier had two choices: either be in the individual market or in the small group market. **1995 Proc. 4<sup>th</sup> Quarter 818.**

A regulator requested that the last sentence of the drafting note, which directly followed Section 7 on availability of coverage, be deleted because he did not remember that the working group, in adopting the alliance models, discussed an assumption that small group guaranteed issue provisions of the act would be in place. **1995 Proc. 4<sup>th</sup> Quarter 819.**

An interested party stated that her association would like to see old individual business subjected to minimum standards: (1) the same preexisting condition limitations; (2) the same limitations on riders for specific body parts; and (3) the ability to assess the old business for reinsurance purposes. Some regulators questioned the need to have such minimum standards since people in those policies were eligible for a guaranteed issue product at the renewal date. **1995 Proc. 4<sup>th</sup> Quarter 819.**

A commissioner stated that both models have provisions exempting persons otherwise eligible for guaranteed issue if the person is covered or is eligible for coverage under other private or public health benefit arrangements, specifically including Medicare. The commissioner noted that this provision is in the Small Employer and Individual Insurance Availability Model

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**Section 7 (cont.)**

Act and in the Individual Health Insurance Portability Model Act. However, the latter provision refers to Medicaid when, instead, it should refer to Medicare. The task force voted to modify the sections in each model, so that they read the same. **1996 Proc. 1st Quarter 30.**

A commissioner mentioned a drafting note in the Small Employer and Individual Health Insurance Availability Model Act that says that a state has the option of not using the guaranteed issue approach. **1996 Proc. 1st Quarter 31.**

One commissioner stated that his state has had individual and small group laws requiring portability, guaranteed issue, guaranteed renewability and modified community rating for nearly four years, adding that these provisions have been successful in increasing the availability of health insurance. **1996 Proc. 1st Quarter 32.**

A commissioner stated that NAIC model laws are merely samples for use by states and should not be confused with uniform laws for which there is a strong argument for uniformity among the states. Another commissioner stated that he understood those distinctions and that he was concerned that the guaranteed issue approach increases costs. The commissioner explained that insured's may be priced out of the market because of the higher cost of guaranteed issue insurance and then become unable to obtain coverage because of health conditions. **1996 Proc. 1st Quarter 32.**

Language was added to the drafting note to clarify that any exemptions to guaranteed issue provided to certain individual health benefit plans may not be applied with respect to HIPAA-eligible individuals. Language was added to clarify that late enrollees were entitled to the same reduction in any period of a preexisting condition exclusion for any periods of creditable coverage as those individuals who enrolled in the health benefit plan in a timely manner. **1999 Proc. 4th Quarter 941.**

An interested party commented that requiring health benefit plans to accept late enrollees was not in compliance with HIPAA. He stated that HIPAA did not require late enrollees to be accepted. Another interested party echoed the interested party's comments. The chair disagreed; he stated that HIPAA provisions regarding the acceptance of late enrollees are ambiguous. The chair further stated that requiring health benefit plans to accept late enrollees was permissible under HIPAA. By stating clearly that late enrollees must be accepted, this requirement would be consistent with the model act's original intent. Another regulator suggested that the task force ask for clarification on whether HIPAA required health benefit plans to accept late enrollees. **1999 Proc. 4th Quarter 941.**

E. The chair next questioned the drafting note for Subsection E(7), which outlined the special enrollment rights for specified employees. He stated that Appendix A, entitled "Model Description of Special Enrollment Rights" should not be adopted as part of the model act. Instead, states should adopt the appendix by regulation. There was no objection to the chair's suggestion. **1999 Proc. 4th Quarter 942.**

Amendments were made to comply with various HIPAA provisions that were not in the model act, such as the amendments for concerning network plans and association plans. She also pointed out technical amendments made in various sections of the model act, including the Standards to Assure Fair Marketing section as a result of adding a definition of "health status-related factor." **1999 Proc. 4th Quarter 942.**

A provision outlined the conditions under which a small group carrier may impose an affiliation period. This provision would limit the use of affiliation periods to HMOs. This amendment was made in accordance with a provision in HIPAA that provided for such a limitation in the small group market. The existing language in the availability model that allowed any small group carrier under specified circumstances, including an HMO, to impose an affiliation period would not be preempted under HIPAA because the operation of this provision would not prevent the application of the HIPAA provision. **2000 Proc. 1st Quarter 168.**

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**Section 7 (cont.)**

Section 7E(7) outlined special enrollment rights for certain employees and their dependents. The drafting note was revised to make clear to states that, when adopting the model act, the NAIC does not intend that a state adopt the appendices that are attached to the availability model as part of the model. Instead, states should adopt the appendices by regulation. **2000 Proc. 1<sup>st</sup> Quarter 168.**

A drafting note to Section 7C(2)(b) and (d) raised an issue concerning whether HIPAA would permit a carrier to impose a waiting period. A regulator stated that he did not believe that HIPAA would permit a carrier-imposed waiting period. An interested party stated that this was an issue that would be addressed in the final HIPAA regulations. References to a carrier-imposed waiting period were deleted. **2000 Proc. 2<sup>nd</sup> Quarter 173.**

**Section 8. Certification of Creditable Coverage**

Task force members noted that the continuation/conversion treatment regarding guaranteed issue needed to be discussed further. **1995 Proc. 2<sup>nd</sup> Quarter 587.**

A regulator noted that there should be the need for a definition of preexisting conditions clarifying that if an individual becomes ill while in previous coverage, but may have been covered for less than 12 months, that person would not be excluded under the preexisting condition limitation of the new policy. He also noted a similar concept with regard to affiliation periods needs to be clarified in the model. **1995 Proc. 2<sup>nd</sup> Quarter 587.**

A provision related to the imposition of affiliation periods by carriers in the individual market noting that the same amendment restricting the imposition of affiliation periods to HMOs was included. Unlike the small group market, HIPAA had no such provision involving the imposition of affiliation periods in the individual market; therefore. After discussion, the task force decided to retain the language that allowed an individual carrier to impose an affiliation period if the carrier did not use preexisting condition limitations. **2000 Proc. 1<sup>st</sup> Quarter 168.**

**Section 9. Individual Market Risk-Spreading Mechanisms**

The task force discussed whether the small employer model act should be amended to include the individual market or whether a separate document was preferable. Some members of the task force questioned whether other model acts were already in existence that might apply, and NAIC staff was directed to determine if there were other applicable models. Some members indicated that since some states addressed individual insurance and group insurance in different parts of their statutes, it might be easier to have a separate product. **1995 Proc. 1<sup>st</sup> Quarter 573.**

Some task force members believed minimum loss ratios were a vehicle to keep premiums down, while others believed that a viable, competitive marketplace would accomplish the same result without the use of loss ratios. **1995 Proc. 2<sup>nd</sup> Quarter 586.**

The task force then discussed the issue of risk-spreading mechanisms. One state reported that it had recently passed legislation providing for guaranteed issue in the individual market, but using an enrollment cap for carriers, and also mandating that small group carriers participate in the individual market. Another state said that it used an assessment and loss reimbursement mechanism and also mandated small group carrier participation in the individual market. Various task force members noted that the reinsurance mechanism of the Small Employer Health Insurance Availability Model Act (Prospective Reinsurance With or Without an Opt-Out) was not utilized throughout the states to any large degree, and in fact very few lives were reinsured. Task force members noted that depending on the guaranteed issue approach taken, it would affect how the risks would be spread. Task force members also indicated interest in the Academy discussion regarding the net effect of the various options. **1995 Proc. 2<sup>nd</sup> Quarter 587.**

A regulator indicated his concern was with the suggested bright line test that clearly distinguished group from individual coverage association plans and that many association plans could not afford to pay 10% of the premium, thus making those plans individual plans. However, there was some concern that, with regard to true small employers; the intent of the model

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**Section 9** (cont.)

was to place those plans into small group coverage if the employer contributed any portion of the premium. The regulator indicated he would try to narrow the focus of the proposed amendment. **1995 Proc. 3<sup>rd</sup> Quarter 730.**

Woven throughout this discussion was some mention of the high-risk pools. A regulator noted that the task force previously had rejected the high-risk pool option in Section 7 of the model. However, with regard to Section 8, he moved that an Option 3 be created which is a reinsurance pool, which would have the broad-based funding of such a pool discussed in a drafting note with examples. After further discussion, the motion was adopted. **1995 Proc. 3<sup>rd</sup> Quarter 732.**

An interested-party suggested that the states should set a cap on the number of persons a carrier must accept from the high-risk pool. Regulators noted that dumping from the high-risk pool could be a source of unfairness to certain carriers and a calculation of a market share basis would be appropriate. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

The next comment was that all carriers should not be subject to assessment, that is, limited benefit plan or supplemental carriers should not be subject to a assessment. Regulators noted the issue went to how broadly the task force wanted to spread the assessment base, and the consensus was the broader the better. An interested party wondered whether the task force wanted to take advantage of the Travelers case and impose a provider tax. The task force members indicated they would be more than happy to review language submitted by the interested party in this regard and for now would not incorporate the suggestion of Colonial. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

A request by industry was submitted to strike language regarding the 35% of aggregate net paid losses limit on assessment liability. Another suggestion was made to replace it with a suggested drafting note. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

A comment was received suggesting that there should be no refunds before a full year's operation. The task force directed the several parties to agree on wording regarding Section 8D(2) and the suggestion that there should be no refunds before a full year's operation. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

An interested party strongly encouraged the consideration of other options, stating that the approach to individual market reforms in the states was clearly different. He also encouraged the consideration of a fourth option: the high-risk pool. He stated that the high-risk pool was the preferred approach in the states and the model needed to reflect that to be complete. He also believed the rating issue was particularly relevant and a drafting note indicated that the rating should be the same in the individual market and in the small group market. A consumer advocate agreed, stating that the area of individual market reform was still very much in flux. He believed that enrollment provisions could not be separate from rating provisions. **1995 Proc. 3<sup>rd</sup> Quarter 730.**

With regard to individual reform, the chair anticipated that ultimately the task force would break out individual coverage into a separate model at the end of the process. **1995 Proc. 3<sup>rd</sup> Quarter 790.**

A regulator stated that the task force should look at alternatives; he believed a separate and distinct model deserved some discussion. **1995 Proc. 3<sup>rd</sup> Quarter 730.**

The interested party who previously suggested the forth option also suggested reviewing the high-risk pool model for language regarding the broad based assessment. **1995 Proc. 3<sup>rd</sup> Quarter 731.**

Some task force members opined that all options should be left in the model and the all markets approach should not be deleted. Industry representatives reiterated their arguments that such an approach should be rejected on principle. A regulator stated that government should not force a private business into a business where it does not want to be. An interested party said he did not support the all markets approach, but if it were to be abandoned, the task force should allow risk-spreading mechanisms to be separated because if not, some specific plans of that particular company, which often are the only carriers in both markets, are at a severe disadvantage. **1995 Proc. 3<sup>rd</sup> Quarter 732.**

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**Section 9** (cont.)

The draft was clarified so that the reference to 5% included old business and was related to individual health benefit plans. **1995 Proc. 4<sup>th</sup> Quarter 820.**

A consumer representative expressed concerns about the reference to conditions associated with high claims costs. She believed the reference should be more definitive. Regulators responded this issue would be considered when a regulation was drafted. **1995 Proc. 4<sup>th</sup> Quarter 820.**

**Section 10. Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier**

**Section 11. Application to Become a Risk-Assuming Carrier**

**Section 12. Small Employer [and Individual] Carrier Reinsurance Program**

The task force voted to restore the reinsurance mechanism to the draft with regard to the individual market and apply the assessment mechanism against both the individual and small group markets. The motion was adopted. **1995 Proc. 3<sup>rd</sup> Quarter 732.**

The definition of converted policy referenced the NAIC model on conversion coverage. That model began by referencing plans issued “in the state.” The interested party said that if the conversion plan were issued in another state, then the carriers have the same problem of being forced into being an individual carrier by virtue of issuing conversion policies. **1995 Proc. 4<sup>th</sup> Quarter 819.**

**Section 13. Special Rules Relating to Converted Policies**

A drafting note stated that if a state did not wish to enact guaranteed issue in the individual market, the state should not adopt certain sections of the draft. The chair suggested that the task force still needed to address the issue of conversion policies in the draft. **1995 Proc. 3<sup>rd</sup> Quarter 789.**

The task force determined that the draft should reflect the following: carriers must offer the basic and standard plans as converted policies; persons with converted policies issued prior to the effective date of the Act should have the right at annual renewal to elect a basic or standard plan; converted policies should be rated as if they were small group policies; and carriers should spread any losses from converted policies across their entire book of business. **1995 Proc. 4<sup>th</sup> Quarter 888.**

There was some discussion regarding the section relating to converted policies. An interested party stated that her organization would like to exempt carriers that guaranteed issued all products in both the individual and small group markets from conversion requirements. The chair stated that a person with a converted policy was not entitled to a guaranteed issue product under the present model. The chair proposed that the draft be changed so that a conversion policy qualified as qualifying previous coverage. He suggested several clarifying amendments and language, which the task force accepted. **1995 Proc. 4<sup>th</sup> Quarter 820.**

Another industry representative requested that a carrier not be required to offer a guaranteed issue product at renewal to a person with a converted policy forever into the future. The task force agreed that at the carrier's option, it could cease making such an offer and force the person to make an election if the person with the converted policy had not made an election to a guaranteed issue standard or basic plan within three years after the effective date of the act. **1995 Proc. 4<sup>th</sup> Quarter 820.**

An interested party questioned how a carrier under the section on converted policies could spread the losses of those converted policies across its entire book of business in conformance with the rating requirements of adjusted community rating. Regulators responded that it was the intention of the rating section that everyone paid the same premium. **1995 Proc. 4<sup>th</sup> Quarter 820.**

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**Section 14. Prohibited Activities**

A consumer advocate requested that the task force look at the penalty provisions of the model. He noted noting that the Unfair Trade Practices Model Act has fairly low penalty provisions with regard to monetary fines, and many states in fact had statutory authority only for very low fines. He expressed concern that such low fines were not sufficient to deter wrongdoers from violations of the Act. **1995 Proc. 2<sup>nd</sup> Quarter 587.**

**Section 15. Health Benefit Plan Committee**

The chair noted that the draft model would require the same standard and basic packages for both markets. A regulator stated that the plans were slightly different in his state between the markets, mostly because of the issue of mental health benefits. The chair also noted that some states had slightly different mandated benefits in the small group and individual markets. An industry representative noted that deductibles tended to be higher in the individual market. An interested party asked the task force to consider the approach where only four or five products could be offered in the individual market. Those products had the same benefits, and differed only in the amount of deductible and coinsurance. A regulator believed that such an approach addressed anti-selection issues. **1995 Proc. 2<sup>nd</sup> Quarter 587.**

**Section 16. Periodic Market Evaluation**

**Section 17. Waiver of Certain State Laws**

**Section 18. Administrative Procedures**

**Section 19. Standards to Assure Fair Marketing**

**Section 20. Separability**

**Section 21. Restoration of Terminated Coverage**

**Section 22. Risk Adjustment Mechanism**

**Section 23. Effective Date**



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**Appendix A Model Description of Special Enrollment Rights**

The chair suggested that Appendix A, entitled “Model Description of Special Enrollment Rights” should not be adopted by a state as part of its law, but instead should be adopted by regulation. The drafting note was drafted to make states aware of this recommendation. **1999 Proc. 4<sup>th</sup> Quarter 942.**

**Appendix B Model Certificate of Creditable Coverage Forms**

**Appendix C Model for Categories of Benefits (Alternative Method)**

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*Chronological Summary of Action*

*June 1996: Model adopted.*

*December 2000: Amended model by adding Section 8, Certification of Creditable Coverage, and the three appendices. Made significant changes to definitions section and Sections 6 and 7.*

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