

As adopted by the Health Insurance and Managed Care (B) Committee, Nov. 22, 2010.

MODEL LANGUAGE FOR PROHIBITION ON RESCISSIONS OF COVERAGE

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Section 1. Definitions.

- A. “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.
- B. “Group health plan” means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in subsection G, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
- C. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Patient Protection and Affordable Care Act (Affordable Care Act) uses the term “health insurance coverage.” The definition of “health benefit plan” is intended to be consistent with the definition of “health insurance coverage” contained in HIPAA. Paragraphs (2), (3), (4), and (5) below track the language of HIPAA that addresses “excepted benefits,” i.e., those benefits that are excepted from the requirements of the Affordable Care Act.

- (2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
- (3) “Health benefit plan” does not include:
 - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
 - (a) Limited scope dental or vision benefits;

- (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
 - (5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
 - (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
 - (6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
 - (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
 - D. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
- Drafting Note:** The Affordable Care Act uses the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” is consistent with the term “health insurance issuer.”
- E. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for the covered person’s responsibility for copayments, coinsurance or deductibles.
 - F.
 - (1) “Individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance.
 - (2) For purposes of this subsection, a health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.
 - G. “Medical care” means amounts paid for:
 - (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to medical care referred to in paragraph (1); and
 - (3) Insurance covering medical care referred to in paragraphs (1) and (2).

- H. (1) “Rescission” means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.
- (2) “Rescission” does not include:
 - (a) A cancellation or discontinuance of coverage under a health benefit plan if:
 - (i) The cancellation or discontinuance of coverage has only a prospective effect; or
 - (ii) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or
 - (b) When the health benefit plan covers only active employees and, if applicable, dependents and those covered under continuation coverage provisions, the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative record-keeping.

Drafting Note: The definition of “rescission” is derived from the interim final regulations on rescissions published in the *Federal Register* June 28, 2010.

Section 2. Applicability and Scope

- A. These sections apply to any health carrier providing coverage under an individual or group health benefit plan.
- B. (1) These sections apply to grandfathered plan coverage.
- (2) For purposes of this subsection, “grandfathered plan coverage” means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with federal regulations.

Section 3. Prohibition on Rescissions of Coverage.

- A. (1) A health carrier shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:
 - (a) The individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud; or
 - (b) The individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.
- (2) For purposes of paragraph (1)(a), a person seeking coverage on behalf of an individual does not include an insurance producer or employee or authorized representative of the health carrier.
- B. A health carrier shall provide at least thirty (30) days advance written notice to each plan enrollee or, for individual health insurance coverage, primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection A regardless of, in the case of group health insurance coverage, whether the rescission applies to the entire group or only to an individual within the group.
- C. The provisions of this section apply regardless of any applicable contestability period.

Drafting Note: States may have additional consumer protections in their laws or regulations related to rescissions of coverage determinations. The Affordable Care Act’s preemption standards permit States to impose more stringent, consumer protection requirements.