
October 1996

NAIC
National Association of Insurance Commissioners
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**Draft Template for State Implementation of the Health Insurance Portability and Accountability Act of 1996 ("the Act")**

The following template is a draft staff document prepared for NAIC member comment and revision. It is not an official NAIC document approved by NAIC members. It will be discussed and revised through the NAIC's Special Committee on Health Insurance.

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INTRODUCTION

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, P.L. 104-191, H.R. 3103 (“THE ACT”) provides a federal framework for reforms of the employer group and individual health insurance markets. Within this framework, the Act provides the states with significant latitude to go beyond federal standards. The Act retains the states’ current role as primary regulators of health insurance at the same time that it sets forth minimum federal standards and a new role for the federal government in overseeing the enforcement of these standards. As such, the Act raises a number of interpretive and implementation issues for the states and state insurance regulators.

The following document attempts to assist the states in understanding the many issues and questions raised by the Act. It contains an Executive Summary and a Section-by-Section “template”. Each section of the template summarizes the Act’s provisions, highlights issues for the states and includes comparisons among the Act’s provisions and provisions within relevant NAIC models. In this comparison, the template notes where the Act’s provisions preempt or supersede state provisions based upon an NAIC model, and where the NAIC model provisions would not be affected by the Act.

The executive summary parallels the sections of the template and relates to the key provisions of the Act. It includes synopses of provisions relating to group and individual market reforms, medical savings accounts, long term care, fraud and abuse, administrative simplification, Medicare anti-duplication and additional tax-related provisions.
Key Dates for Group and Individual Health Insurance Reform

Actions by States

April 1, 1997: **Deadline** for a state to notify the HHS Secretary that the state has enacted or intends to enact any necessary legislation to provide for the implementation of an acceptable alternative mechanism for the individual market; and to provide the HHS Secretary with any information required by the Secretary to review the mechanism and its implementation or proposed implementation.

**Note:** The Act also requires states to file information about their alternative mechanisms every 3 years. The Act does not specify whether the due date is the same date as the state filed its initial notice and information, or the date on which or by which the HHS Secretary determined that the state's mechanism was acceptable.

**Note:** The Act also provides that if a state submits its notice and information about an alternative mechanism **after Jan. 1, 1997**, the mechanism shall be considered an acceptable alternative unless the Secretary makes a determination that the mechanism is not acceptable within 90 days of the date of submission. A mechanism not found unacceptable becomes effective 90 days after the end of the 90 day submission period. The Act does not contain any similar provision for automatic approval for notices submitted on or before Jan. 1, 1997.

July 1, 1997: Federal portability and renewability provisions become effective for individual health insurance unless state has implemented, or has filed notice of intent to implement, an alternative mechanism.

July 1, 1997: Portability, availability, and renewability provisions become effective for group health plans and health insurance coverage offered in connection with such plans with no respect to years beginning on or after this date.

Jan. 1, 1998: Deadline for state enactment of legislation providing for implementation of alternative mechanism in individual market, except for states where legislature does not meet within 12 months after date of enactment of this Act. (Aug. 21, 1996, is the enactment date.)

July 1, 1998: Deadline for state enactment of legislation providing for implementation of alternative mechanism for individual market in states where legislature does not meet within 12 months after date of enactment of this Act. (Aug. 21, 1996, is the enactment date.)

December 31, 2000: Deadline for the CEO of each state to submit to the HHS Secretary a report on the access of large employers to health insurance coverage in the state and the
circumstances for lack of access to coverage, if any, of large employers or classes of large employers.

Note: The Act also requires the CEO of each state to file a similar report every three years addressing the access to coverage of large employers.

**Federal Regulations**

April 1, 1997: Secretary of HHS required to issue interim final regulations for individual market.

April 1, 1997: Secretaries of Treasury, Labor, and HHS required to issue interim final regulations for group market.

**Other Key Dates**

July 1, 1996: Covered people generally begin accumulating creditable coverage.

June 1, 1997: Health plans and issuers required to begin issuing certifications of prior creditable coverage for both group and individual markets.

Jan. 1, 1998: Earliest date that the Act would permit an enforcement action against a group health plan or health insurance issuer, as long as the plan or issuer was trying to comply in good faith with the law's requirements. If regulations are not issued by April 1, 1997, no enforcement action can be taken until the regulations are issued, even if they are issued after Jan. 1, 1998.

**I. Executive Summary**

**Group and Individual Market Reforms:** The Act establishes federal standards for the large group, small group, and individual private insurance markets.

**Group coverage:** The Act requires health insurance carriers participating in the small group market to issue policies at the option of the small employer, subject to specified exceptions. For all group plans, both large and small, the Act requires guaranteed renewability (subject to certain exceptions), establishes maximum preexisting condition exclusion periods, and requires the issuer to give credit against the exclusion for prior creditable coverage.

State laws regulating group health insurance coverage are NOT preempted EXCEPT to the extent that any state standard or requirement prevents the application of a requirement of H.R. 3103. However, there is a different test for determining whether state laws affecting preexisting condition limitations are preempted. H.R. 3103 does supersede any provision of State law which establishes a standard or requirement.
applicable to a preexisting condition as defined in the Act and which differs from the standards or requirements for preexisting conditions specified in the Act. However, there are several exceptions to this general rule for preexisting conditions, and these exceptions permit states to retain laws that are more generous to insureds than the federal requirements in many important areas, including the length of preexisting condition exclusions.

The Act provides that the states may enforce the provisions of the Act for all group health insurance issuers licensed in the state. However, if the Secretary of the U.S. Department of Health and Human Services ("HHS Secretary") determines that a State has failed to substantially enforce a provision or provisions of the Act with respect to health insurance issuers in the State, the HHS Secretary will enforce the provisions against the issuers. The Secretary of the U.S. Department of Labor will enforce the group plan provisions of the Act for ERISA plans.

**Individual coverage:** The Act includes requirements for improving the availability of individual health insurance. States are given the option of implementing their own reforms which meet minimum federal requirements, if they submit the requisite notice and information on such program to the HHS Secretary and the Secretary does not find that the state program fails to meet the federal requirements. In the absence of acceptable state reforms, the Act imposes minimum federal requirements which require health insurance issuers participating in the individual insurance market to offer a choice of at least two policies to qualified individuals as defined in the bill without any preexisting condition exclusion. The law also requires issuers participating in the individual market to guarantee the renewal of an individual policy at the option of the individual, subject to certain exceptions described below.

An individual is eligible to be issued coverage in the individual insurance market if the individual has had previous insurance coverage of the type specified in the law for the prior 18 months, most recently under a group plan or other specified plan, and has not let that coverage lapse for any period exceeding 63 days.

**Scope:** The Act generally does NOT impose any rating restrictions on group or individual health insurance polices. Nor will it provide increased availability of coverage for individuals who do not have previous qualifying coverage in the individual market.

The Act applies to both ERISA plans and to state-regulated insurance plans. It achieves these reforms by a set of parallel amendments to both ERISA and the Public Health Service Act with respect to group health plans, and by amendments to the Public Health Service Act implementing the reforms of the individual insurance market. It also amends the Internal Revenue Code.

For purposes of determining a state's compliance with these provisions of H.R. 3103, the most relevant NAIC models are: the 1992 Small Employer Health Insurance Availability Model Act; the 1995 Small Employer Health Insurance Availability Model Act; the 1996
Small Employer and Individual Health Insurance Availability Model Act; the 1996 Individual Health Insurance Portability Model Act; and the Model Health Plan for Uninsured Individuals Act. A more detailed discussion in the body of this text explains the issues raised for those states that have adopted any of these models, and identifies the changes to these models that may be required for compliance with the Act.

**Medical Savings Accounts/High Deductible Policies**

The Act amends the Internal Revenue Code to provide, on a pilot project basis, for favorable federal tax treatment of medical savings accounts (MSAs) - a trust established to pay qualified medical expenses - for eligible individuals covered by a high deductible health plan sponsored by a small employer or held by a self-employed individual. The Act defines high deductible health plan, and qualified medical expenses, for which deposits to the MSA may be spent without penalty, and delineates who may be a trustee. The MSA pilot is intended to be limited to 750,000 participants through the year 2000. The Secretary of the Treasury is required to monitor the number of participants and the reduction in revenues to the federal government as a result of MSA participation. If Congress does not specifically extend the program after the year 2000, those participants with MSAs will be allowed to keep them, but without favorable tax treatment. Studies will be conducted during the life of the pilot program by the General Accounting office (GAO) to determine the effect of MSAs in a number of areas.

**Long-Term Care**

The Act amends the Internal Revenue Code to provide for favorable tax treatment for certain long term care policies. The Act provides definitions for a federally tax qualified long-term care contract, a qualified long-term care service, and a chronically ill individual. Pursuant to these provisions, and within certain parameters, premiums and unreimbursed expenses for qualified long-term care services are treated the same as medical expenses under the Internal Revenue Code for the purpose of itemized deductions, and benefits received under a long-term care policy are excludable from income.

For a long-term care insurance contract to be considered qualified, there are a number of requirements that must be met: the only insurance protection provided under the contract must be for “qualified long-term care services”; the contract cannot pay or reimburse for expenses that are reimbursable under Medicare; the contract must be guaranteed renewable; the contract cannot provide a cash surrender value; any refund of premium or policyholder dividends must be used to reduce future premiums or to increase future benefits; and the policy must comply with specified consumer protection provisions.

The Act states that the NAIC will be asked by the Chair of the House of Representatives’ Ways and Means Committee and the Chair of the Senate Committee on Finance to formulate, develop, and conduct a study to determine the marketing and other effects of per diem limits on certain types of long-term care insurance.
Fraud and Abuse

The Act requires the HHS Secretary to establish a national health care fraud and abuse control program. This program is charged with conducting investigations, audits, evaluations and inspections relating to the delivery of and payment for health care in the United States. Individuals convicted of felonies for health care fraud offenses and other specified offenses will be excluded from participation in Medicare or any state health care program for five years. The Secretary is further required to establish a database on all final adverse actions against health care providers, suppliers or practitioners. While the provisions of the Act pertain primarily to federal health care programs, state health care programs supported by Medicaid, and the federal maternal and child health services block grants, the Act does call for coordination between state and federal enforcement activities related to health plans. The Act provides for enhanced federal penalties for health care fraud offenses, which may be of interest to fraud units in state insurance departments.

Administrative Simplification

The Act requires the HHS Secretary to adopt data standards for specified administrative and financial transactions, including the data elements for the transactions, to enable health information to be exchanged electronically. The HHS Secretary may also adopt data standards for any additional, unspecified transactions that the Secretary determines are appropriate and consistent with the goals of improving the operation of the health care system and reducing administrative costs. Data standards specify the type and format of health information that will be required to be transmitted electronically.

The Act preempts any contrary provisions of state law relating to data standards. However, the Act’s requirements do not supersede any provision of state law that the Secretary determines is necessary for any of five reasons: to prevent fraud and abuse; to ensure appropriate State regulation of insurance or health plans; for State reporting on health care delivery or costs; or for other purposes; or that addresses controlled substances. The provisions of the Act are also not to be construed to invalidate or limit “any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.” In addition, there is an exception stating that nothing in the part shall limit the ability of a State to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.

The Act also directs the HHS Secretary to submit recommendations to Congress with respect to privacy standards within 12 months of the law’s enactment. Privacy standards establish rules for the collection and disclosure of confidential health information. The law requires Congressional action on privacy standards within 36 months of enactment, or in its absence, Secretarial action within 42 months of enactment. However, any regulation promulgated by the Secretary will not supersede a contrary provision of state
law if that provision imposes requirements, standards, or implementation specifications that are more stringent than those imposed under the regulation.

Medicare Anti-Duplication

Prior to the enactment of the Act, and subject to specified exceptions, federal law prohibited the sale of health insurance policies which duplicated Medicare benefits. The exceptions allowed for the sale of policies that paid benefits without regard to what Medicare paid and provided consumers a disclosure statement as part of the application for coverage. Thus, prior federal law prohibited the sale of any policy that coordinated its benefits with Medicare, including long-term care policies.

The Act amends prior federal law so that long-term care insurance policies are not considered to duplicate Medicare benefits if they meet certain conditions; and policies that pay without regard to other coverage are no longer considered to duplicate Medicare. The Act also modifies the disclosure statements to comport with the change.

Additional Tax-Related Provisions

A. Viatical Settlements

The Act sets forth requirements pursuant to which a chronically or terminally ill individual may receive life insurance policy benefits before dying without incurring a tax penalty. The Act provides an exclusion from gross income for: (1) amounts received under a life insurance contract and (2) amounts received for the sale or assignment of a life insurance contract to a qualified viatical settlement provider if the insured is either terminally ill or chronically ill. For a chronically ill individual, such funds are only excluded from income if the payment is for the costs incurred for long-term care services not reimbursed by insurance or otherwise. Whoever makes such payments must report those payments to the Internal Revenue Service.

B. Deductions for Self-Employed

The Act increases the deductions that self-employed individuals are allowed to claim for the amounts paid during the taxable year for health insurance for the taxpayer, his or her spouse and dependents. The increase in deductions will be phased in over a 10-year period. The Act also clarifies that payments that are received through arrangements other than traditional commercial insurance arrangements which have the characteristics of an insurance arrangement, such as self-funded arrangements, are treated the same under this provision as a traditional commercial insurance arrangement.
II. Group Market Reforms

A. Provisions Relating to Preexisting Condition Exclusions

1. Summary: A group health plan or health plan issuer may only impose a preexisting condition exclusion if it relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on enrollment date. Such preexisting condition exclusion is limited to 12 months, or 18 months for late enrollees.

The 12 (or 18) month preexisting condition period must be reduced by periods of “creditable coverage”. A group health plan shall count a period of creditable coverage, without regard to the specific benefits covered under such plan, unless the group health plan or health insurance issuer elects to credit it based on coverage of benefits within several classes or categories of benefits specified in regulations. (These will be federal regulations for all plans; the states could enforce the federal requirements for insurers). A 63-day lag time between coverage periods is allowed before prior coverage no longer counts as “creditable.”

Group health plans and health insurance issuers must provide certification of prior coverage to a requesting plan or issuer at the time an individual ceases to be covered under the plan. HMOs can use affiliation periods of 2 months in lieu of preexisting condition exclusions; they also may use an “alternative method to address adverse selection”, as approved by the state insurance commissioner or designated state officials.

Interestingly, the Act defines “preexisting condition exclusion” more broadly than it is actually allowed to be used. It defines the term as a “limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.” However, as noted above, an exclusion can only be used if it relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date.

The Act states that “genetic information” is not to be treated as a condition in the absence of a diagnosis of the condition related to such information. In addition, a group health plan may not impose preexisting condition exclusions relating to pregnancy nor for newborns or adopted children who are covered within 30 days of birth or placement for adoption.
2. Issues for the States:

a. What laws does the state currently have relating to preexisting condition exclusions?

(E.g., any small group reform legislation, other rules or regulations that might limit exclusions).

b. If the state laws are based upon the NAIC Small Employer Availability Model Act adopted in 1992 ("the NAIC 1992 small group model"), please consider the following issues:

**Definition of preexisting condition:** The NAIC 1992 small group model limited the length of preexisting condition exclusions to 12 months for "(a) conditions that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; (b) a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or (c) a pregnancy existing on the effective date of coverage."

This requirement differs from the federal requirement and states may wish to consider the deletion of sections (a) and (c) in order to comport with the federal requirement. As long as the reference to the effective date of coverage is equivalent to the enrollment date, section (b) is consistent with the federal requirement. In addition, states may wish to consider the need to add requirements excluding the use of pregnancy as a preexisting condition and containing the federal requirement with respect to genetic information.

**Late enrollee:** The federal definition of late enrollee is similar to, but not identical to, the NAIC’s 1992 and 1995 definition, which are the same. (In 1995, the NAIC amended the Small Employer Health Insurance Availability Model Act; this will be referred to as the 1995 small group model). Several of the categories within the NAIC definition are contained within the description of permissible special enrollment periods in the Act. To the extent that the NAIC definition is more expansive than that within the Act, these requirements are not preempted because they do not “prevent the application of” the federal requirement (the Act’s “test” for preemption). In addition, the Act explicitly allows for the addition of categories of special enrollment.

Thus, for example, a state law based upon the NAIC model might not have to add the new ERISA section 701(f)(1)(B) under “special enrollment periods” in the Act which requires employees to provide notice of the reason they did not accept coverage. A state law which did not require this could be considered more generous in its definition of late enrollee because it would include employees who did and did not provide this notice. However, the Act lists some conditions, such as legal separation and a reduction in the hours of employment, where an enrollee is not to be considered “late,” and states may
wish to consider adding these conditions to the state definition in order for it to comport with the federal requirements.

The 1992 and 1995 NAIC models specify that the eligible enrollment period must be at least 30 days long. The Act does not contain this specification except with respect to the “special enrollment periods.” In the absence of an explicit federal requirement for the length of the eligible enrollment period, the NAIC requirement, by providing a minimum period for enrollment, could be viewed as more generous than the Act. Section 704(b)(2)(vi) of the Act allows states to have additional special enrollment periods; thus, state law based on the NAIC requirement in this area would not appear to be preempted.

**Coverage gap:** The 1992 and 1995 NAIC small group model allows for a coverage gap of 90 days before coverage is no longer considered “continuous” for purposes of crediting prior coverage. The Act allows for 63 days but specifically allows states to have longer periods for lapses in coverage. Thus, state provisions on coverage gaps based upon the NAIC model need not be changed. State laws with a period shorter than 63 days, however, would be preempted.

Section 8C(2) of the 1992 NAIC small group model requires crediting coverage for services when qualifying previous coverage provided benefits with respect to such services. The Act calls for the promulgation of regulations for “classes” or “categories of benefits” under which issuers may elect to credit prior coverage. These regulations would preempt state laws that include the NAIC requirement because the NAIC requirement relates to the imposition of a preexisting condition exclusion, unless the regulations were written to allow for portability of individual services. As such, it is superseded under the preemption clause of PHSA Section 2723(b) (Section 102) and ERISA Section 704(b) (Section 101).

**Qualifying Coverage:** The Act defines “creditable coverage” to include a group health plan as defined in the law, health insurance coverage as defined in the law, and names several federal programs that qualify, including Medicare and Medicaid. The Act’s definition also includes “a State health benefits risk pool” and a “public health plan (as defined in regulations).”

The 1992 NAIC small group model defines “qualifying previous coverage” and “qualifying existing coverage” to include Medicare; Medicaid; an employer-based health insurance or health benefits arrangement that provides benefits similar to the benefits specified under the basic health benefit plan developed as specified in the model; and an individual health insurance policy that provides benefits similar to those included in the basic health benefit plan, provided that the individual policy has been in effect for at least one year.

States whose laws are based on the 1992 NAIC model may therefore wish to consider expanding the list of federal public programs that qualify, or include the umbrella term...
from the NAIC 1995 small group model discussed below, in order to conform to the federal requirement.

The 1995 NAIC small group model defines “qualifying previous coverage” and “qualifying existing coverage” slightly differently from the 1992 model. In addition to naming Medicare and Medicaid, it also specifies the Civilian Health and Medical Program for Uniformed Services (CHAMPUS), the Indian Health Service program, “or any other similar publicly sponsored program.” Because of this umbrella phrase, states that have adopted the 1995 NAIC model arguably do not have to amend their laws to specify each federal program named in the Act in order to avoid federal preemption of state law.

Both the 1992 and the 1995 NAIC models contain drafting notes suggesting that states may wish to grant the commissioner rulemaking authority to define the coverage that falls within the definition of “qualifying previous coverage” and “qualifying existing coverage.” Under the models, states that have adopted such a provision have the option of conforming their definitions to the Act by promulgating conforming regulations instead of enacting legislation.

**Affiliation Periods:** The 1992 and 1995 NAIC models allow carriers to impose a sixty (60) day affiliation period in lieu of a preexisting condition limitation. The Act allows HMOs to have a two month affiliation period, but PHSA section 2723(b)(2)(vii) (Section 102) and ERISA section 704(b)(2)(vii) (Section 101) also permit states to have shorter time periods. The NAIC’s slightly shorter time period is therefore not preempted. However, the Act does not specify that non-HMOs could use such affiliation periods, as do the NAIC models. Thus, it would appear that the state law provisions allowing use of an affiliation period by non-HMOs are preempted by the Act, unless the “non-HMOs” under state law fall within the federal definition of HMO.

The Act defines HMO to include a federally qualified HMO, an organization recognized under state law as a health maintenance organization, or “a similar organization regulated under State law for solvency in the same manner and to the same extent as a health maintenance organization.” Thus, the federal definition includes entities which, though regulated like HMOs, may not be denominated HMOs under state laws. Such entities, as HMOs under the Act, also have the option of using affiliation periods.

In contrast, the NAIC models permit other carriers in addition to HMOs to use affiliation periods. Both models define “carrier” to include essentially any entity that offers health benefits or health insurance and that is subject to the jurisdiction of the state insurance commissioner. HMOs are explicitly covered in the definitions of carrier. Because affiliation periods relate to the preexisting condition exclusions, the provisions within the NAIC models on this point cannot differ from the Act and are not saved by one of the Act’s explicit exceptions. These provisions of the NAIC models relating to carriers that do not meet the federal definition of HMO are preempted.
If a state law is based upon the 1995 NAIC Small Employer Availability Model Act ("NAIC 1995 small group model"), please consider the following issues:

The 1995 NAIC model limitation on preexisting condition exclusions follows section (b) of the old model as noted above. States ought to consider the need to add the same clarifications to this section noted above (re: pregnancy and genetic information). Although the 1995 NAIC model limits the length of the exclusion period to 6 months, this provision would not be preempted as it falls within one of the exceptions to the federal preemption clause relating to state preexisting condition requirements.

The 1995 NAIC small group model requires the crediting of prior coverage without specifying that the particular service had been covered. As with the 1992 model, these provisions would be preempted by the federal regulations relating to classes or categories of benefits.

See discussion of late enrollee definition above under the 1992 NAIC small group model. The only difference in the 1995 model is the addition of Section P(1)(5) which is already contained within the federal requirement that individuals enroll during the periods in which they are eligible. A state law containing this section should not be preempted.

See discussion on the 1992 model relating to coverage gaps; provisions are the same within the 1995 model.

3. If there are no state laws in this area, or if state laws fall short of the federal standards, please consider the following issues:

If a state’s laws fail to contain the minimum federal requirements and the requirements relate to the imposition of a preexisting condition exclusion governed by Section 701 of the Act, the state law would likely be preempted unless it falls into one of the specified exceptions. If the law relates to another area, and falls short of the federal requirement, it may be preempted as “preventing the application of” the federal requirement.

In addition, it appears that, if a state law is preempted by the federal law, a state could not enforce the federal standards unless they are enacted at the state level. The only exception to this case would be a state whose laws grant its insurance regulatory authority broad powers, including the powers to enforce federal laws. Otherwise, it appears that a state could only enforce its own laws. Under the Act, the Dept. of HHS is granted the authority to enforce whatever standards are not substantially enforced at the state level. Hence, state laws which are not revised to meet the federal requirements could potentially result in the state’s loss of enforcement authority.

If states have no provisions at all in the area, the minimum federal requirements would apply and, as described above, would be enforced at the federal level.
4. If the state laws relate to preexisting condition limits and include the federal standards and/or maybe go further in the areas permitted by the Act, it appears that the state need not revise its standards. In addition, if the state laws relate to other areas governed by the Act and do not “prevent the application of” the federal requirement, they would not be preempted.

5. The following implementation questions have been raised by some states with respect to preexisting condition exclusion periods. [Note: We have included NAIC staff’s initial responses/interpretations, which are subject to member comment and revision]:

Q: Does the reference to genetic information in Section 701(b)(1)(B) of the Act permit the use of genetic information to exclude coverage or prohibit it unless the condition is diagnosed? (Wisconsin)

A: The Act states that such information shall not be treated as a condition in the absence of a condition for which there was a diagnosis; hence, it appears that the use of genetic information to exclude coverage is prohibited in the absence of a diagnosis relating to the genetic information.

Q: How does the preexisting condition limit apply to the case in which medical advice or treatment is given but not for the ultimately diagnosed disease. E.g., treatment for a migraine when the condition is brain cancer or, as in the Anderle case, treatment for flu and merely observing one episode of double vision, which turns out to be a predecessor of a stroke? (Wisconsin)

A: The Act does not clarify this question but states that the preexisting condition exclusions must relate to a condition for which there was medical diagnosis or treatment. Presumably, a case could be made that any treatment for a migraine, without a simultaneous diagnosis for the cancer, should only be treated as relating to the migraine, until such time as the cancer, the condition in dispute, was diagnosed.

Q: May states authorize HMOs to have an “alternative” anti-adverse selection provision that addresses MSA dumping? (Wisconsin)

A: The Act allows states to provide that HMOs can have a mechanism, other than affiliation periods or preexisting condition limitations, to address adverse selection. This provision does not distinguish between such selection by type of policies but presumably could include provisions relating to “MSA dumping”.

Q: Is COBRA coverage considered creditable coverage for purposes of the portability provisions of the Act? (Pennsylvania)

A: Yes, COBRA coverage qualifies for purposes of both the individual and group market portability provisions.
B. Provisions Relating to Availability of Coverage

Summary: Pursuant to the Act, health issuers offering coverage in the small group market in a state must accept all small employers (defined as 2-50 employees) applying for coverage and must accept every eligible individual who applies during the period in which such individual first becomes eligible under the terms of the group health plan, in accordance with the terms of the plan and state law.

An issuer can deny health insurance coverage in connection with a group health plan if it does not have the financial reserves necessary to underwrite additional coverage and is applying the paragraph uniformly in the small group market consistent with state law. Health issuers denying coverage under this section may not offer coverage in the state for 180 days or until the issuer has demonstrated to state authority, under applicable state law, that it has sufficient reserves, whichever is later.

Issuers offering coverage through network plans may limit coverage to small employers with eligible individuals residing or working in the service area. Such issuers may also deny coverage to such employers if the issuer has demonstrated to the applicable State authority that it will not have the capacity to deliver services adequately to enrollees of additional groups and it is applying this paragraph uniformly without regard to claims experience of the employer, employees and dependents or health status-related factors of employees or dependents. Issuers so denying coverage are suspended from offering coverage for 180 days.

Health insurance issuers can establish employer contribution rules or group participation rules as allowed under state law. An employer contribution rule is a requirement relating to the minimum level or amount of employer contribution toward the premium of participants and beneficiaries. A group participation rule is a requirement relating to the minimum number of participants that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

The guaranteed issue requirement does not apply to health insurance issuers who make coverage available in the small group market only through one or more “bona fide associations.”

The Act provides that the chief executive officer of each state submit, by 12/31/2000, and every 3 years thereafter, a report on the access of large employers to health insurance coverage in the State and the circumstances for lack of access of large employers to such coverage. Based upon these state reports, the HHS Secretary must submit triennial reports to Congress on this topic. The bill also requires GAO to submit a report on this topic within 18 months of the date of enactment.
Issues for the states:

1. What laws does the state currently have relating to small group reform? (i.e. identify state statutes affecting the small group market)

2. If state laws are based on an NAIC Model, please consider the following issues:

If a state has adopted the NAIC 1992 small group model, the Act requires the offering of a standard and basic health benefit plan in each “class of business.” Section 16 of the 1992 model also allows for denial of coverage to an employer based on health status or claims experience as long as the carrier offers the small employer the opportunity to purchase a basic and standard benefit plan. The Act does not allow for distinctions based upon class of business nor does it limit its guaranteed issue requirement to two packages. It would appear that state laws based on the provisions of the NAIC 1992 small group model would “prevent the application of” the broader federal requirement and would therefore be preempted.

Definition of small employer: The Act’s definition of “small employer” differs from that contained in both the NAIC 1992 and 1995 small group models. The Act covers “an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.”

The NAIC models set different maximums and minimums and compute employer size differently from the Act. For example, the 1992 NAIC model covers a small employer “that, on at least fifty (50%) percent of its working days during the preceding calendar quarter, employed no more than twenty-five (25) eligible employees, the majority of whom were employed within this state.”

The 1995 NAIC model sets no maximum number of eligible employees but does specify that the term “small employer” includes a self-employed individual. It also requires eligible employees to have a “normal work week of thirty (30) or more hours,” and specifies that the small employer cannot be an entity “formed primarily for purposes of buying health insurance” and that there must be a bona fide employer-employee relationship. The provisions of the 1995 NAIC model for computing the number of eligible employees are identical to those of the 1992 model.

It should also be noted that the definition of “small employer” contained in the Act’s provisions addressing medical savings accounts differs from the definition applicable elsewhere in the Act. (See discussion in Section IV below on Medical Savings Accounts.)

Because the definition of “small employer” is critical to the applicability and implementation of the Act, states will need to consider conforming their laws so that they include all employers captured by the Act’s range of two to fifty employees, pursuant to
its method of computing these numbers. State laws which apply to a broader range of employers (i.e. 2-100, or groups of one) would not be preempted by the federal requirement because they would not “prevent the application of” the federal requirement.

The Act allows for states to set requirements with respect to minimum participation and contribution so state laws based upon the NAIC model’s provisions relating to this would not be preempted.

The provisions of Section 8(D) of the NAIC 1992 small group model setting forth conditions for certain carriers to be excepted from the requirement to offer coverage would not appear to be preempted except that, according to the Act, only network carriers could limit the offering of coverage to those employers without employees in the service area. Section 8D(1)(a), which allows carriers not to offer to employers not located in the carrier’s service area, therefore, would appear to prevent the application of the federal requirement and may therefore be preempted. Section 8(D)(1)(b) of the NAIC 1992 small group model would more closely mirror the federal requirement if amended to read that a small employer carrier shall not be required to offer coverage to an “employer whose employees do not reside within the carrier’s established geographic service area.” This amendment might be necessary in order to avoid preemption because the Act does not explicitly allow for a carrier to deny an employee coverage but rather allows it for employers who meet the federal criteria.

Finally, Section 8(D)(1)(c) of the NAIC 1992 small group model does not include the requirement from Section 2711(c)(1)(B)(ii) that requires carriers to apply that paragraph’s requirements uniformly without regard to claims experience or health status-related factors of employers, employees or dependents. This requirement should probably be added to state laws in order to avoid preemption or a finding of noncompliance.

Section 8(D)(2) of the NAIC 1992 small group model prevents carriers that have been excepted from the issuance requirements from offering coverage in the small or large group market for a specified time period. The size of the small employer group size would need to be changed to comport with the federal requirement. However, the NAIC 1992 model provisions limiting carriers ability to offer either large group or small group coverage when they fail to offer small group coverage under the law’s exceptions could stand because they go beyond, but do not prevent the application of, the federal requirements.

**Network Plans:** The Act contains special requirements for network plans. A “network plan” is defined as “health insurance coverage of a health insurance issuer under which the financing and delivery of medical care...are provided, in whole or in part, through a defined set of providers under contract with the issuer.”

The 1992 NAIC model (Section 8D), the 1995 model (Section 7D) and the 1996 Small Employer and Individual Health Insurance Availability Model Act (Section 7G) permit carriers not to offer coverage in cases where the small employer, employee, or eligible
person is not physically located in the carrier’s geographic service area or does not work or reside in the carrier’s service area. Because this exemption is broader than the Act’s provision, which applies only to network plans, it may prevent the application of the federal requirements with respect to carriers who are not offering coverage through network plans. State laws based on these provisions may therefore have to be narrowed to comply with the Act.

If the state has adopted the NAIC 1995 small group act, the state law’s guaranteed issue requirement likely is unaffected by the guarantee issue requirement within the Act, as long as the state’s definition of small employer includes, at a minimum, those employers which fall within the federal definition of small employer. Since the model includes a requirement for guaranteed issue of all products, this model does not conflict with the federal requirements in the same way as the earlier model.

Section 7 of the NAIC 1995 small group model requires the offering of all products and at least two products of the carrier. This would not conflict with the federal requirement because the two product minimum adds to, but does not “prevent the application of”, the federal all-product guaranteed issue.

3. If there are no state laws in this area, or if the laws fall short of the federal standards, please consider the following issues: See discussion under Section 1(A).

4. If the state laws include the federal standards and/or maybe go further, the state’s laws would not be preempted as long as they did not “prevent the application of” the federal requirements.

5. The following implementation questions have been raised by some states. [Note: We have included NAIC staff’s initial responses/interpretations, which are subject to member comment and revision.]

Q: How does the provision which subjects multiemployer and multiemployer welfare arrangements to guaranteed renewal requirements relate to the other provisions for non-discrimination and guaranteed issue which apply to group health plans and small group insurers? Specifically, what, if any, type of guaranteed issue requirement applies to a MEWA with respect to the employers it does or does not accept? (Oregon)

A: The guaranteed issue requirement within the Act applies to small group health insurance issuers. “Group health plans” (which include any MEWAs that are employee welfare benefit plans) are specifically excepted from the definition of health insurance issuer, and hence from the federal guaranteed issue requirement. However, states are still free to include such carriers within their state guarantee issue requirements. (MEWAs which are not employee welfare benefit plans but which fall within state insurance statutes would appear to be subject to this requirement).
Q: Are fully insured MEWAs subject to the federal small group market reforms? That is, must a fully insured MEWA offer coverage to all small employer members of the MEWA or may small employer members be rejected on the basis of health status? (Oregon)

A: See above.

Q: Does the reference to "directly or through any arrangement" within the definition of small employer market include a MEWA? If so, does this lend support to an argument that the guaranteed issue requirement applicable to small employers extends to MEWAs? (Oregon)

A: While the reference to "any arrangement" within the definition of small employer, in and of itself, might be read to include MEWAs, the guaranteed issue requirement itself applies to a "health insurance issuer" that offers health insurance coverage in the small group market in a state. Even if the small group market definition is read to include MEWAs, the requirement itself is imposed on the issuers offering coverage in that market and MEWAs that are group health plans are not issuers. Once again, states can choose to extend guaranteed issue to MEWAs in their state.

Q: In small group, do small employer carriers have to guarantee issue all products? (North Dakota)

A: Yes. Small employer carriers which fall within the federal definition are subject to the federal guaranteed issue requirements, which includes an all-product guarantee issue.

Q: Does the law contain a requirement that an employer offer health coverage to early retirees, before they are eligible for Medicare? (Pennsylvania)

A: No, the Act includes no employer mandate to offer health coverage.

Q: On page 42, the guaranteed issue requirement is to a small employer who applies for coverage. This appears to allow the sale of individual policies "through" a small employer with underwriting, thus leaving the door open for cherry picking?

A: Health insurance issuers offering health insurance coverage in the small group market in a state are subject to the guaranteed issue requirements of the Act. The Act defines small group market to include the health insurance market under which individuals obtain coverage on behalf of themselves through a group health plan maintained by an employer. This section would seem to be intended to include any coverage obtained through an employer, yet individual policies obtained through an employer would not be a group health plan and hence technically would appear to fall outside of the requirement. This might be an unintended loophole. The NAIC
1995 model, Section 4 (D) specifically states that the model act applies to any health benefit plan *marketed to individual employees through an employer*. State laws containing such a provision would appear to guard against the possible loophole within the Act, without being preempted by the federal requirement.

Q: Can a state require that carriers only guarantee issue basic and standard plans in the small group market?

A: No. The Act does not distinguish among the products but requires that health insurance issuers offering health coverage in one state accept every small employer applicant. Hence, they cannot accept employers for certain products and not others. However, a state may require that basic and standard plans be among the products issued by the small group carrier.

C. Provisions Relating to Renewability of Coverage

Summary:

Under the Act, health issuers are required to renew coverage except for nonpayment, fraud and other specified reasons, including an employer’s membership ceasing in an association in the instance of association-only group coverage.

If an issuer decides to discontinue a “particular type of coverage” offered in the small or large group market, coverage may be discontinued if the issuer provides at least 90 days notice, provides employers with the option to purchase other health insurance coverage offered by the issuer in this market and that issuer acts uniformly without regard to health status-related factors relating to covered or eligible participants. If a health issuer discontinues all health insurance coverage in the large and/or small group market, this discontinuance must be in accordance with applicable state law, the issuer must provide at least 180 days notice and all health insurance issued in that market in the state may not be renewed. There is a 5 year prohibition on market reentry for issuers who terminate coverage pursuant to this provision. However, a health issuer may modify the health insurance coverage for a product offered to a group health plan in the large group market or in the small group market if, for coverage other than association coverage, such modification is consistent with state law and effective on a uniform basis among group health plans who have purchased that product.

Multiemployer plans or MEWAs may not deny an employer continued access to the same or different coverage other than for the following reasons: fraud, nonpayment, noncompliance with material plan provisions, ceasing to offer in a geographic area, no individual resides in service area of network plan, or failure to meet terms of an applicable collective bargaining agreement.
Issues for the States:

1. What laws does a state currently have in this area?

2. If state laws are based on the NAIC 1992 small group model, the Act contains similar, but not identical, provisions with respect to renewability of coverage. Section 7(A) of the NAIC model, and Section 2712 of the Act both allow for nonrenewability for nonpayment of premiums or fraud. The Act is more specific and states that nonrenewal is permissible if the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely payments. The NAIC model simply allows for nonrenewal in instances of nonpayment of required premiums. A state law with this broader standard would not appear to "prevent the application of" the federal standard but since the federal requirement amplifies the NAIC requirement, and might be read to allow for nonrenewal only in a narrower range of circumstances; such a state may wish to consider adding these details to the state requirement so as not to run afoul of the preemption clause.

The Act sets a higher threshold with respect to the type of misrepresentation that can justify nonrenewal. It requires that the plan sponsor have performed fraud or made an intentional misrepresentation of material fact under the terms of the coverage before a carrier can nonrenew. (The italicized section is not within the NAIC model which requires that the small employer have committed fraud or misrepresentation with respect to the coverage of insureds or their representatives). Since the Act therefore excepts a narrower range of circumstances from the renewal requirement, a state law with a broader exception (misrepresentation included, for example) would potentially be found to "prevent the application" of, and possibly be out of compliance with, the federal requirement.

The Act also does not contain the specification that the fraud or misrepresentation be with respect to insureds or their representatives. It is not clear if this element prevents the application of the federal requirement. If it is found that the federal requirement encompasses a broader range of parties with respect to the fraud, the NAIC requirement on this point may need to be deleted.

The provision within the NAIC 1992 Act allowing nonrenewal in instances of misuse of a provider network provision is not contained within the Act and therefore conflicts and should be deleted. The provisions within the Act (Secs. 2712(b)(5) and (6)) which allow for nonrenewal when there is movement outside the service area and cessation of association membership are not contained within the NAIC model and would likely need to be added in order for a similar state law to comport with the Act. However, provision 7(C) within the NAIC model which limits the applicability of these rules to a carrier's service area might be found to be essentially equivalent to the federal requirement on movement outside the service area. In such a case, the NAIC model provision would suffice.
With respect to a carrier election to discontinue all its small group or large group coverage, the Act addresses both markets; the NAIC model only addresses the small group market. Hence state laws based on the NAIC model would have to add provisions relating to large group coverage in order to comport with the federal requirement.

With respect to the small group requirements, the Act specifically requires compliance with applicable state law; thus, more stringent state laws with additional notice or other requirements (such as NAIC model requirements that commissioner be notified 3 days before employers in Section 7(A)7) would not appear to conflict with the federal requirements. However, the Act requires notice to participants and beneficiaries as well as employers. This additional requirement would appear to need to be added to the NAIC model act in order to avoid noncompliance.

The NAIC model also provides the commissioner with the discretion to make a determination that the continuation of coverage is not in the policyholders’ interest or could impair the carrier’s ability to meet its contractual obligations. While it would appear that the inclusion of this requirement, along with the other federal requirements, would not conflict with the Act, the NAIC model provides that this could be a separate reason for nonrenewal, independent of the federal requirements, and such an option would likely be found to “prevent the application of” the federal requirement.

Section 703 of the Act sets forth separate renewability requirements for MEWAs and multiemployer plans. These requirements are slightly different from the requirements for issuers. Interestingly, under the Act, group health plans (and hence MEWAs that are group health plans) are not considered “health issuers”, upon whom the states enforce the requirements. The law therefore contemplates that the states would not enforce these renewability requirements for MEWAs that are group health plans, even if they are licensed under state MEWA or insurance statutes. (This seems to apply to self-funded MEWAs since the issuers providing coverage to fully insured MEWAs would be subject to the renewability requirements for issuers). However, it would appear that states could continue to enforce requirements relating to renewability and MEWAs, as long as they did not prevent the application of the federal renewability requirements.

The 1992 and 1995 NAIC small group models include drafting notes that indicate that MEWAs should be added to the list of carriers in states with separate certificates of authority for such arrangements and that otherwise such arrangements (when self-funded) should be treated as unauthorized insurers if unlicensed. States wishing to enforce additional renewal requirements upon MEWAs that are group health plans would need to make sure that the relevant provisions of the NAIC models, as applied to such MEWAs, do not prevent the application of these separate federal requirements.

The Act includes a provision allowing for termination of particular coverage in accordance with specified requirements, along with state laws. The states are explicitly given the ability to place requirements or conditions upon the extent to which and how a health issuer may discontinue health insurance coverage for a product offered to a group.
health plan or for all products offered in the market. The NAIC model does not include these provisions so they would appear to need to be added. However, the state law could also include additional requirements.

If a state has adopted the 1995 model, the above comments also apply. The only difference in the renewability section of the models is that the 1995 model does not include Section 7(A)(5) of the 1992 model relating to misuse of provider network provision; however, as noted above, that provision would likely need to be deleted from a state law in order to comply with the Act.

3. If there are no state laws in this area, or if the laws fall short of the federal standards, please consider the following: As in the other areas discussed above, states with laws that do not, at a minimum, include the federal requirements in this area run the risk of preemption and the possibility of federal enforcement of the federal standards. See discussion in section 1(A) herein. In the instance of exceptions to the renewability requirements, additional state exceptions could be read to “prevent the application of” a broader federal renewability requirement, as noted above.

4. If the state laws include the federal standards and/or go further, the state laws are likely to stand without violating the law. With respect to the renewability requirements, it would appear that a state could impose additional notice or other requirements for a carrier that is not renewing as long as the requirement wouldn’t result in fewer carriers being subject to the renewal requirements (such an event might be found to “prevent the application of” the federal requirement). Hence it would appear that state laws that added categories of excepted carriers probably would be held to conflict with the federal requirement. However, additional requirements placed upon the carriers that meet the federal categories, such as any additional notice requirements within Section 7(A)(6)(b) of the 1992 model, would likely not conflict, especially since the Act explicitly requires discontinuance of all, or particular, coverage to occur in conformance with state laws.

5. The following implementation questions have been raised by some states. [Note: We have included NAIC staff’s initial responses/interpretations, which are subject to member comment and revision.]

Q: On page 16, what is meant by the reference to a MEWA offering “different coverage”? I assume this means equivalent coverage and this is intended to deal with the obsolete policy form issue. Why is the Multiemployer and MEWA provision necessary? Is it in some way an exception from the provisions otherwise applied to group health plans? (Wisconsin)

A: It is not clear why MEWAs were added to the multiemployer plan renewability provisions since these entities are primarily regulated by the states, whereas multiemployer plans are regulated at the federal level. While the provision likely was intended to address the obsolete policy form issue, as noted above, it does not so
specify. However, it would appear that states are free to require the offering of similar coverage by MEWAs in such circumstances since the law does not amend the ERISA provisions which clarify state jurisdiction over MEWAs ("the Erlenborn amendments"). The renewability provisions for MEWAs and multiemployer plans are drafted somewhat differently from the provisions applicable to group health plan issuers.

D. Anti-Discrimination Provisions

Summary:

A group health plan and a health insurance issuer offering group coverage in connection with a group health plan may not establish rules for eligibility for any individual to enroll under the plan (including continued eligibility) based on health status-related factors which include: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

A group health plan and health issuer offering coverage in connection with a group health plan, may not require any individual to pay any premium or contribution that is greater than that for a similarly situated individual enrolled in the plan.

With respect to health insurance issuers, it appears that states could add additional factors upon which insurers could not deny eligibility, as long as the list of prohibited reasons for exclusions included the list specified by the Act.

The conference report language explains that the reference to "similarly situated individuals" was intended to allow a plan or coverage to vary coverage or premiums for different groups of employees, such as full-time versus part-time employees or employees in different geographic locations or different benefit schedules for different collective bargaining units. This provision does not prevent a whole group from being charged more but is intended to prevent the singling out of individuals. In addition, the report explains that plans can exclude coverage for conditions or place caps on coverage as long as this is not directed at individuals.

The report also explains that the prohibition on discrimination based upon "evidence of insurability" was intended to clarify that discrimination based on activities such as skiing, motorcycling etc. is prohibited.

Issues for the States:

1. What laws does a state currently have relating to nondiscrimination in employer-sponsored insurance? (E.g. provisions within small group act, Unfair Trade Practices Act).
2. If a state law is based upon the NAIC 1992 small group model, please consider the following issues: Section 16(B)-(I) of the NAIC 1992 small group model amplifies or builds upon the anti-discrimination and/or guarantee issue requirements of the Act without preventing their application; hence they are not preempted.

The federal requirements prohibit an insurer or employer from establishing discriminatory eligibility criteria for individual employees (within certain categories of workers; i.e. full-time or part-time). Section 8(C)(5)(a) of the NAIC 1992 small group model requires the offering of coverage to all eligible employees without singling out certain individuals. Section 8(C)(5)(b) prohibits the modification of a health benefit plan with respect to a small employer or any eligible employee or dependent to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered under the plan. These NAIC requirements are broader than the federal anti-discrimination language, as it applies to employers as well as employees, but it should not be preempted because it does not prevent the application of the narrower federal requirement.

If your laws are based upon the NAIC 1995 small group act, the Act raises the following issues: Section 7(C)(5)(a) and (b) of the NAIC 1995 small group model mirrors Section 8(C)(5) of the 1992 model, described above. Hence, as with the 1992 model, these provisions do not appear to be preempted. Section 16 of 1995 model (Standards to Assure Fair Marketing) also amplifies or builds upon the federal guaranteed issue and anti-discrimination provisions without preventing their application; hence they are not preempted.

3. If there are no state laws in this area, or if the laws fall short of the federal standards, the state’s options are as follows: As in other areas of the Act, if the state requirements do not include the federal requirements, they would be preempted as “preventing the application of” the federal requirements. States which fail to include these requirements in their laws, or which do not enforce them, risk losing their enforcement authority if they are found to fail to “substantially enforce” a provision or provisions of the Act.

4. If the state laws include the federal standards and/or go further, the state’s laws should not be preempted unless they would “prevent the application of” the federal requirements.

5. The following implementation questions have been raised by some states. [Note: We have included NAIC staff’s initial responses/interpretations, which are subject to member comment and revision.]

Q: Do the reforms in Section 702 and 2702 mean that a whole group cannot be rejected on the basis of health status-related factors, or just individual members of the group? (The whole group rationale might follow this logic. If an individual within a group cannot be rejected for health status, then it follows that all of the individuals within
the group cannot be rejected because of the health status of one or more members of the group. See also the conference report comment on page 11; “these provisions preclude insurance companies from denying coverage to employers.”) But, if you believer that whole groups cannot be rejected on the basis of health status, how does that mesh with the separate treatment of the large group market in Section 2711? (Oregon)

A: The conference report emphasizes that the nondiscrimination provisions are intended to prevent a plan or coverage from “singling out” an individual based on health status or health status related factors. In addition, benefits within an employer plan are only to be permitted to vary for “similarly situated” employees (i.e. employees that are full-time vs. part-time). While it is true that page 11 discusses precluding issuers from denying coverage to employers, this likely was intended to address small employers, or the denial of coverage to any employer based on the health status of a single employee. The enforcement of this provision may be tricky since an individual’s health status could significantly affect that of a group and the law clearly prevents carriers’ denying coverage based on individuals’ health status. Overall, however, the structure of the law, in which small employers are subject to a separate guaranteed availability section, indicates that large employers were not to be subject to as stringent of a guaranteed issue requirement. Once again, however, states could choose to incorporate large employers within their guaranteed issue requirements.

Q: Are fully insured MEWAs subject to non-discrimination requirements of Sections 702 and 2702? If so, how does that mesh with the more limited requirement for MEWAs in Section 703? (Oregon)

A: The non discrimination requirements are imposed upon group health plans and health insurance issuers. Hence, MEWAs which are employee welfare benefit plans, and hence “group health plans” under the Act, would be subject to the Act’s nondiscrimination requirements. As discussed above, it is not clear why Section 703 sets forth separate renewability provisions for MEWAs.

Q: May a benefit provision be challenged under the discrimination provision (page 14 sec 702) on the basis that it was adopted with the specific purpose of limiting benefits because of utilization of one or more individuals? (Wisconsin)

A: Yes, as discussed above, the discrimination provision is targeted at prohibiting discriminatory benefit provisions targeted at particular individuals. However, since the bill does not mandate particular benefits it may not always be easy to prove such discrimination. Perhaps, if the provision was offered until particular individual(s) used it heavily, or was offered to other employees within the same category of employees, this may be one way to demonstrate violation of the Act.
E. Definitions

Several of the definitions were discussed in the preceding analyses. We have received the following additional questions from states concerning particular definitions in the Act:

Q: Does a self-employed individual or a partner count as an “employee”? Note the act says they are “participants” but not that they are employees. Does this mean that there must be three or more employees aside from the self-employed individual for the restrictions to apply? Are the self-employed merely entitled to coverage without being counted for the purpose of determining whether the group health plan provisions apply? (Wisconsin)

A: The Act defines “employee” as such term is defined under section 3(6) of ERISA. The definition of small employer, to which the guarantee issue requirements apply, includes employers with an average of two but no more than 50 employees and hence would not include the self-employed. However, other provisions of the Act apply to group health plans generally and do not appear to have a size limitation.

Q: How does the definition in ERISA of “employee welfare benefit plan” apply in the context of these provisions? (Wisconsin)

A: The Act defines “group health plan” as an employee welfare benefit plan that provides medical care to employees or dependents directly or through insurance, reimbursement or otherwise.

Q: What is a plan year for the purpose of determining whether there are two or more employees? (Wisconsin)

A: The Act refers to a preceding calendar year; it also includes a method of calculation for employers not in existence in the preceding year.

Q: A “partner” is defined as an eligible participant in a group health plan. Does this open the door to pseudo “partnership” sold on a mass marketing basis—a new form of the MEWA scam? (Wisconsin)

A: The definition of “partner” does not include any clear safeguards against such an operation; although it does not appear to have been its intention. Perhaps this could be clarified by regulation.

Q: What restriction, if any, applies to modifications of association plans? (Wisconsin)

A: The Act does not require a health insurance issuer to guarantee issue group coverage if the issuer offers coverage in the small group market only through one or more
“bona fide associations.” (PHSA Section 2711(f)/Section 102.) In general, the Act defines bona fide association consistently with the definition of “professional association” contained in the 1996 NAIC Availability and Portability Models. Moreover, the Act explicitly permits states to include additional criteria in defining associations.

This provision enabling states to expand on the federal requirements for an association will enable a state to limit the entities that meet the definition of association. A narrow definition of association will in turn limit the number of health insurance issuers who escape the requirement to guarantee issue in the small group market on the grounds that they offer such coverage only to associations.

The Act does contain one criterion in its definition not contained in the NAIC models: the requirement that the association “does not make health insurance coverage offered through the association available other than in connection with a member of the association.” States may want to consider adding such a provision to ensure compliance with the federal requirements.

Q: Can the definition of “bona fide association” be read as prohibiting health status rating?

A: While the definition might initially indicate that, the conference report clearly indicates that insurers can charge employer groups more based on health status. However, it is not clear whether associations can do so.

Q: The Act does not deal with the stop-loss issue. The language of the Act is such that it probably would be difficult for HHS to adopt an interpretation of group health plan which includes stop-loss coverage. It is difficult to predict how the Act will affect pending litigation. It probably can be used to argue either side. (Wisconsin)

A: The Act does not appear to clarify the stop loss issue in any fashion. It is unclear whether any regulations would address this issue.

F. Enforcement/Timeline

Q: How does the Act apply to policies issued prior to June 30 and renewed after that date? (Wisconsin)

A: The Act does not appear to distinguish between issuance and renewal and therefore likely applies to policies issued prior to June 30.
III. Individual Market Reforms

A. Minimum Federal Requirements

Guaranteed Availability in the Individual Market

Summary: Individuals with 18 or more months of "creditable coverage" whose most recent coverage was under a group health plan, governmental plan or church plan can obtain individual coverage without the imposition of a preexisting condition exclusion. The bill provides for guaranteed issue of all products to eligible individuals. However, in states which have not implemented an acceptable alternative mechanism (test for this described below in Section B on state flexibility), health insurance issuers may elect to limit the coverage offered as long as they offer at least two different policy forms which:

1) are designed for, made generally available to, actively marketed to and enroll both eligible and other individuals; and

2) a) are the policy forms with the issuer's largest and next to largest premium volume in the state or applicable marketing area in the individual market; or

   b) are the lower level and higher level policy forms which include benefits substantially similar to other individual health insurance coverage offered by the issuer in that State and each of which is covered under a method described in section 2744(c)(3)(A)(relating to risk adjustment, risk spreading, or financial subsidization)

   (Higher level coverage is 15% greater than between 100% and 120% of weighted average; lower level coverage is between 85%-100%)

   Weighted average is the average actuarial value of benefits provided by all health insurance coverage issued either by the issuer or all issuers in the state.)

The issuers' elections (about whether to limit coverage and offer the most popular policy forms or the actuarial average plans described above) are effective for policies offered by the issuer for at least 2 years from the date of election.

Guaranteed Renewability in the Individual Market

A health insurance issuer providing individual health insurance coverage to an individual must renew or continue coverage at the individual's option. There are specified exceptions to this rule (which parallel guaranteed renewability requirements in the group market). In the instances of individual coverage offered within the association, there is an
exception to the guaranteed renewal rule when an individual’s membership ceases, as long as the paragraph is applied uniformly without regard to any health-status related factor. For carriers that only offer individual coverage through associations, the guaranteed renewal requirements are imposed with respect to the association coverage, rather than the individuals within such associations.

At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form as long as the modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

**Issues for the States:**

1. **What laws does a state currently have in this area?**

2. **If the state laws are based on an NAIC Model, the Act raises the following issues:**

   States that have adopted the *Small Employer and Individual Health Insurance Availability Model Act* (as it relates to individual insurance) (the “1996 NAIC Availability Model”) or the *Individual Health Insurance Portability Model Act* they would largely be in compliance with the federal requirements, although a state would still need to provide the requisite notice and comply with the requirements for an “alternative state mechanism” described in Section B herein. A more detailed discussion of acceptable alternative mechanisms and the role these models play in that mechanism occurs in Section B herein. [Note: a later draft will include a more detailed discussion of the provisions within these NAIC models which do not exactly comport with the Act and which a state would need to add in order to meet the requirements for an alternative state mechanism.]

3. **If there are no state laws in this area, or if the laws fall short of the federal standards, please consider the following issues:**

   The section described above describes the “minimum federal requirements” which apply if a state chooses not to implement an “acceptable alternative mechanism” as described below. If a state does not implement an alternative mechanism and its laws do not include the minimum federal requirements, they would likely be preempted. If a state has no individual market laws and wants these minimum federal requirements to apply, as discussed in the group market section, it appears that some state action is still necessary if the state wishes to enforce the requirements. In the absence of state implementing statutes and/or regulations, it would appear that the state insurance regulatory official may not have authority to enforce the requirements and the HHS Secretary could find that a state was failing to “substantially enforce” the federal requirements, and would therefore move to enforce the requirements from the federal level.

   The 1996 NAIC Availability Model Act contains a definition of “qualifying previous coverage” or “qualifying existing coverage” that differs slightly from the definitions in
both the 1992 and 1995 small group acts. The Availability Model definition is the same as the definition in the 1995 small group model with respect to group coverage and therefore raises the issues discussed above for the 1995 small group model. In addition the 1996 Availability Model contains the limitation that “qualifying previous coverage” and “qualifying existing coverage” do not include self-funded ERISA plans unless those plans have the same preexisting exclusion limitations as those contained in the Availability Model. This provision makes it optional for a state to include coverage under a self-funded ERISA plan and places conditions on that coverage. In contrast, the Act mandates that coverage under a self-funded ERISA plan is qualifying coverage. States should consider clarifying that these provisions must comport with Act.

4. If the state laws include the federal standards and/or go further, please consider the following issues:

It is important to note that pursuant to the minimum federal requirements, in states with no acceptable alternative mechanism, carriers are given the option to limit the plans they offer (i.e. not guarantee issue all products) to either the two most popular plans, or the two plans valued according to their “actuarial value” as described above. It appears that if a state chooses to go beyond or vary from these requirements, i.e. with a broader guarantee issue, or limit the choice to the two most popular plans and not give the carriers the option to choose the actuarial value option, the state would be implementing an “alternative mechanism” and would have to comply with the requirements for such mechanisms described in Section B herein.

B. State Flexibility in Individual Market Reforms

The federal requirements for individual reform described above shall not apply with respect to individual health insurance coverage offered in the individual market in the State so long as a State is found to be implementing an acceptable alternative mechanism in which:

1. all eligible individuals are provided a choice of coverage;
2. no preexisting condition exclusion is imposed;
3. the choice includes at least one policy form that is
   (a) comparable to comprehensive coverage in the individual market in the state, or
   (b) comparable to the standard plan under small group or individual laws;
4. the state is implementing
   (a) one of the NAIC model laws on individual market reform,
   (b) a qualified high risk pool, or
   (c) (i) a mechanism providing for risk adjustment, risk spreading, or
        a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for financial subsidization to eligible
individuals, including through assistance to participating insurers; or
(ii) a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

A qualified high risk pool is defined as one that:
(1) provides coverage with no preexisting condition exclusion imposed upon eligible individuals, and
(2) provides for rates and benefits consistent with standards set forth in the *NAIC Model Health Plan for Uninsurable Individuals Act*.

Process for Implementing “Acceptable Alternative Mechanism”

A state is presumed to be implementing an acceptable alternative mechanism as of 7/1/97 if, by no later than 4/1/97, the chief executive officer of the State notifies the HHS Secretary that the state has enacted or intends to enact legislation to provide for the implementation of a mechanism “reasonably designed” to be an acceptable alternative mechanism as of 1/1/98. In the case of a state that does not have a legislature that meets within the 12 months after enactment, the state has until 4/1/98 to notify the HHS Secretary that the state intends to enact and implement an alternative mechanism by 7/1/98. The state must provide the Secretary with such information as the Secretary may require to review the mechanism and its implementation or proposed implementation under this section and must update this every 3 years. If a state submits the required notice after January 1, 1997, the state plan is considered acceptable unless the Secretary makes a finding, as described below, that the plan is not acceptable within 90 days.

If the Secretary finds that a state’s mechanism is not an acceptable alternative or is not being implemented, after consultation with the chief executive officer and chief insurance regulatory official, the Secretary shall notify the State of its preliminary determination and permit the state a reasonable opportunity to modify the mechanism. If the state fails to implement an acceptable alternative, the minimum federal requirements shall apply to the health insurance coverage offered in the individual market in that state.

Issues for the States:

While the general effective date for the individual reform section is 7/1/97, in states implementing an alternative mechanism, the deadline for implementation of such a mechanism is actually 1/1/98, or 7/1/98 in states whose legislatures do not meet within the 12 months after the law’s enactment. Such states, however, must comply with the notice requirements and deadlines noted above. One open question is whether the state’s legislation must already be drafted by the time the state notifies the Secretary of its intent to implement an alternative mechanism. The law specifies that the state must provide the Secretary with information to review the mechanism and its implementation; it does not
specify the level of detail that will be required, whether it might include the proposed legislation itself and, if so, what happens if this language changes before adoption. The law is unclear on this point.

C. Enforcement/Timeline

Each state may require that health insurance issuers that issue, sell, renew or offer health insurance coverage in the State in the individual market meet the requirements established under this part with respect to such issuers. If a State fails to substantially enforce the requirements of this part, the HHS Secretary shall enforce them.

Preemption

Nothing in the part governing individual market reform is to be construed to prevent a State from establishing, implementing or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of this part.

Issues for the States:

The preemption clause noted above is identical to the clause in the group market reforms section. It emphasizes that states can go beyond the minimum federal requirements. However, for the individual market section, the most important provision for the purposes of understanding the bill’s preemptive effect seems to be the section setting forth the requirements for an alternative state mechanism, rather than the “preemption clause”. For example, were it not for the flexibility accorded the states within the alternative mechanism section, state standards which differed from the minimum federal standards (i.e. which only allowed for a broad guarantee issue requirement) might be found to “prevent the application of” the federal requirements because they did not contain the same range of options for carriers. However, as long as a state mechanism meets the requirements of the alternative state mechanism section, the state standards can stand, irrespective of whether they might otherwise be considered to “prevent the application of” the federal standard.

5. The following implementation questions have been raised by some states. [Note: We have included NAIC staff’s initial responses/interpretations, which are subject to member comment and revision.]

Q: Can a carrier impose a preexisting condition exclusion for pregnancy if the policy is issued to someone other than an eligible individual? (Wyoming)

A: Yes, the bill’s prohibition against imposing any preexisting condition exclusion only applies to eligible individuals (those with 18 months prior coverage, the most recent of which is group coverage).
Q: What is the time limit under the individual guaranteed issue requirement for applying for coverage (p. 71)? Is the time limit the 63-day “gap” rule which terminates creditable service? If so what “tolls” the 63 days? What if an insurer simply does not process the application within 63 days? Does filing the application “toll” the 63 days? (Wisconsin)

A: The bill requires that persons with 18 months prior creditable coverage (most recently under group or governmental plan) be guaranteed issued an individual product. Creditable coverage in the group and individual market is not counted if there is more than a 63-day gap. The law does not clarify what “tolls” the 63 days, yet it would appear to thwart the intent of the bill if the insurer could circumvent that process by not having acted on the application. Federal regulation could make clear that filing an application tolls the 63 days or a state could clarify this in its laws.

Q: What is a policy form for the purpose of applying the premium volume criteria for identifying individual policies which must be guarantee issued? (Wisconsin)

A: The law does not define policy form and therefore appears to defer to definitions in state law or regulation unless otherwise defined by federal regulation.

Q: May HHS adopt regulations which interpret the requirement that the higher and lower level guaranteed issue coverage must include certain benefits if the insurer offers them otherwise in the marketplace based on the requirement that they have “benefits substantially similar to other individual health coverage offered in the market”? For example, if the insurer offers maternal coverage in the underwritten market may the insurer be required to include this coverage in the higher level plan? More generally can HHS use this provision to categorize benefit level to limit gaming by benefit design? (Wisconsin)

A: The concerns you raise would seem to be well within the parameters of the bill, and thus able to be addressed by HSS in its regulation.

Q: Am I correct that the actuarial value policies may be used only if there is a state-enacted risk adjustment or subsidy mechanism? (Wisconsin)

A: No. In a state which has no acceptable alternative mechanism, the issuer may elect to guarantee issue two policy forms. If the issuer chooses the actuarial value policies, those policies must be covered under a risk spreading mechanism, which can be among issuers (which would require state action) or policies of an issuer (which the issuer can accomplish without state action).

Q: On page 80 of Title I, is (D) an additional option or an additional qualification for the alternative mechanism? (Wisconsin)
A: It is an additional qualification; the acceptable alternative mechanism has four requirements, one of which is (D) on page 80 of Title I. To fulfill (D), a state gets three choices (and if choosing number 3 gets two alternatives): (1) adopt one of the NAIC models on individual market reform; (2) implement a qualified high risk pool; or (3)(a) have a mechanism providing for risk adjustment, risk spreading, or a risk spreading mechanism (among issuers or policies of an issuer), or (b) have a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

Q: If a state high risk pool has a lifetime maximum of $300,000, will the high risk pool qualify as an acceptable alternative mechanism? (Wyoming)

A: It might not. The Act’s intent is to provide eligible individuals with health insurance that is comparable to comprehensive coverage. The HHS Secretary might determine that a high risk pool with a lifetime benefit limit of $300,000 is not an acceptable alternative mechanism.

Q: If a state high risk pool has a $3,000 deductible for maternity, will the high risk pool qualify as an acceptable alternative mechanism? (Wyoming)

A: Again, it might not. Since the Act’s intent is to provide eligible individuals with health insurance that is comparable to comprehensive coverage (as opposed to catastrophic), and the Act also defines high deductible plans as those with between $1,500 and $4,500 (depending on single or family coverage), the HHS Secretary might determine that such a high risk pool is not an acceptable alternative mechanism.

Q: Do the guaranteed renewability requirements of the Act apply to policies in force on the effective date? (Indiana)

A: Yes. There is no carveout from any of the Act’s provisions for policies in force on the law’s effective date.

Q: Can a state use a high risk pool only as an acceptable alternative mechanism (i.e., carriers do not have to guarantee issue any products in the individual market?) (North Dakota)

A: Yes, the Act contemplates that a high risk pool alone may be an acceptable alternative mechanism, providing that it is a qualified high risk pool and meets the federal standards set forth to be qualified (no preexisting condition exclusion applicable to eligible individuals and premiums and benefits comparable to the NAIC high risk pool model), along with the additional applicable requirements for alternative state mechanisms.
Q: Would coverage under a self-funded ERISA plan count as qualifying previous coverage for the purposes of the individual market reform requirements of the statute?

A: Yes, the individual market section uses the same definition of “creditable coverage” as does the group market section, and includes ERISA plans. The section also specifies that the most recent coverage must be group coverage or a governmental or church plan for purposes of the individual market availability provisions.

IV. Medical Savings Accounts/High Deductible Policies

A. Standards for High Deductible Policies

Summary: Beginning January 1, 1997, the Act provides tax incentives for a limited number of “medical savings accounts” (MSAs): trusts established to pay for qualified medical expenses. These tax incentives are to be made available in conjunction with MSAs offered to eligible individuals who are covered by a high deductible health plan sponsored by a small employer or self-employed individual. The participating eligible individual receives a tax deduction of no more than 65 percent of the annual deductible for individuals and 75 percent of the annual deductible for families for contributions that have been paid into the medical savings account by the individuals for that taxable year. Payments made to a medical savings account by the small employer are excludable from gross income unless made through a cafeteria plan. If an employer has made a contribution to the MSA, no contributions by the individual account holder are deductible.

A small employer is an employer that has employed an average of 50 or fewer employees on business days during the entirety of either of the two preceding calendar years, or if recently established, by the average number of employees the employer reasonably expects to employ during the current calendar year. This definition differs from the definition of small employer in the group insurance reform section of the Act, which limits the definition to those employers with the specified number of employees during the preceding calendar year (not 2 years).

Except under certain circumstances, the individual (or his/her spouse) cannot also be covered under another health plan that provides coverage for any benefits covered under the high deductible health plan. However, an individual is still eligible for a medical savings account if the individual has coverage (through insurance or otherwise) for accidents, disability, dental care, vision care, and long-term care, or certain “permitted insurance” coverages. These coverages include Medicare supplemental insurance and insurance substantially related to liabilities incurred under workers’ compensation laws, tort liabilities, liabilities relating to ownership or use of property, such other similar liabilities as the Secretary may specify by regulations, insurance for a specified disease or illness, or insurance paying a fixed amount per day (or other period) of hospitalization. If
the individual is self-employed, he/she cannot be covered by a high deductible health plan established or maintained by any employer of the individual (or his/her spouse).

The Act requires that high deductible health plans have an annual deductible between $1,500 and $2,250 for individual coverage and between $3,000 and $4,500 for family coverage. Out-of-pocket expenses may not exceed $3,000 for individual coverage and $5,500 for family coverage. Payment of the high deductible plan premium does not count toward this maximum.

The conference report language states that, as is the case under existing law, it is the responsibility of state insurance commissioners to oversee high deductible health plans issued in conjunction with MSAs. The conferees also state in the report that states may impose additional consumer protections and that it is intended that the NAIC will develop model standards for high deductible health plans. The NAIC is not mentioned in this regard in the bill, however.

Under the Act, plans are not high deductible health plans if their coverage is substantially for accidents, disability, dental care, vision care, and long-term care, or the “permitted insurance” coverages. These include: Medicare supplemental insurance and insurance substantially related to liabilities incurred under workers’ compensation laws, tort liabilities, liabilities relating to ownership or use of property, such other similar liabilities as the Secretary of the Treasury may specify by regulations, insurance paying a fixed amount per day (or other period) of hospitalization, or insurance for a specified disease or illness.

The Act creates a “safe harbor” for policies that do not apply a deductible for preventive care pursuant to state law. When state law prohibits a deductible for preventive care, a plan will still be treated as a high deductible health plan because of a state law requirement.

**Issues for States:**

1. **What laws does the state currently have relating to high deductible health plans coupled with a medical savings account?** (State laws governing accident and health policies, medical savings account laws etc.).

2. **If your state has a law in this area, please consider the following issues:**

The Act provides certain specific requirements for the accompanying high deductible plan in order for an MSA to receive favorable tax treatment. For example, the Act has established parameters for the annual deductible levels of high deductible health plans issued in conjunction with MSAs. States which have laws requiring higher annual deductibles for catastrophic policies, whether or not offered in connection with MSAs, may wish to take action to accommodate the availability of these policies to their citizens for the purposes of obtaining an MSA with favorable federal tax treatment.
Additionally, states may wish to, but do not appear to be required to, incorporate other federal provisions such as the forms of insurance which are not considered high deductible health plans, irrespective of the level of deductible associated with the plan, and which may be held by an MSA participant in addition to a high deductible health plan (i.e., coverage substantially for accidents, disability, dental care, etc.). If a state does not incorporate these provisions, the excepted plans still would not be considered to be high deductible plans for purposes of MSA federal tax deductible.

3. If there are no state laws in this area, or if a state’s law falls short of the federal standards, please consider the following issues:

As with other forms of health insurance, the conference report notes that states have regulatory oversight for high deductible health plans. The report also specifically allows that states may require additional consumer protections regarding high deductible health plans. However, states do not need to adopt any laws regarding MSAs in order for MSAs to receive favorable tax treatment.

4. If your state’s laws include the federal standards or go further, your state need not take any addition action unless state standards for MSAs and/or high deductible plans conflict with federal standards in a fashion which would prohibit the sale of qualified policies and the state wishes to amend its laws to comport with federal requirements for favorable tax treatment.

5. The following implementation questions have been raised: [Note: We have included NAIC staff’s initial responses/interpretation, which are subject to member comment and revision].

Q: HHS may define categories of benefits based on deductibles and copays. Could this be used to address the MSA adverse selection issue? (Wisconsin)

A: Yes. The law states that a health carrier may determine creditable coverage periods based on several classes or categories of benefits as specified in regulations of DHSS. According to the conference report, the conferees intended that significant differentials in deductibles could be considered differences in classes of benefits. Thus, DHSS by regulation, could alleviate the potential adverse selection problem with MSAs by allowing health carriers to disallow MSA coverage as prior creditable coverage with regard to the individual or group market guaranteed issue requirements.

In this regard, the law states that the carrier would be required to display prominently in any disclosure statements that such a method of determining qualifying coverage was being used and the efforts of such a determination. The report does not mention any such disclosure requirement on carriers selling the high deductible plans. States may wish to require that carriers disclose to employers and employees that MSAs/ high deductible plan coverage may not qualify as creditable coverage if the employee later seeks

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individual coverage, and that preexisting condition exclusions may then be imposed (if the regulations contain such limitations).

B. Use of MSA by Account Holders

Summary: Amounts paid out of the MSA for qualified medical expenses are not included in gross income for federal tax purposes. Qualified medical expenses are amounts paid for medical care (as defined in section 213(d) of the Internal Revenue Code, which is the section of the Code dealing with deductibility of medical expenses) for the account holder, his/her spouse or dependents. These expenses may not be compensated for by insurance or otherwise and generally, the account may not be used to purchase insurance. An exception is made for qualified long term care insurance, health care continuation coverage purchased pursuant to Act, and health coverage while receiving unemployment compensation under federal or state law.

The legislation includes disincentives against the use of the accounts for expenses which are not qualified medical expenses. Amounts paid or distributed from the MSA for purposes other than qualified medical expenses are included in gross income and will be assessed a 15 percent penalty. Exceptions are provided for those expenses made for disability, death, or after the account holder becomes eligible for Medicare.

Please note, however, that the federal legislation does not indicate what expenses counts toward a deductible. The resolution of this particular issue and the relationship between the deductible and qualified medical expenses may have discrete ramifications for state insurance departments. For instance, if the expenses which count toward the deductible are tied to the catastrophic plan benefits, consumers may wind up with medical expenses that do not count toward satisfaction of the catastrophic deductible, even if the MSA could be used for these expenses because the expenses fell within the federal tax definition of “medical expenses”. Alternatively, the consumer may pay charges which are in excess of the insurer’s allowed charge, also resulting in paid charges not counting toward fulfillment of the deductible. In any event, this issue could result in consumer complaints to state Insurance Department over what qualified medical expenses count toward the deductible in a MSA/catastrophic plan scheme.

Issues for States:

1. What laws does the state currently have relating to the use of medical savings account contributions?

2. If the state has a law in this area, please consider the following issue:

If the state law allows the accountholder to use the contributions to pay for insurance (other than specified exceptions), the taxpayer may lose the benefit of the favorable tax status.
3. If there are no state laws in this area, or if the state's law falls short of the federal standards, states need not develop a law but may want to ensure that any current laws do not conflict with the Act if they want to facilitate favorable state and federal tax treatment for state residents.

4. If a state's laws include the federal standards or goes further, the state does not have to revise its laws as long as it does not prevent policies from meeting the requirements necessary for federal tax deductibility.

5. What is the relationship between state laws related to MSAs and other state laws?

The Act may interact with certain state laws. For instance, the law permits the use of MSA funds to purchase qualified long term care insurance, health care continuation coverage purchased pursuant to Act, and health care coverage during a period in which the individual is receiving unemployment compensation under federal or state law. States may wish to explore the extent to which state laws accommodate this use. The use of MSAs by participants in the federal program may have an impact on state reform activities. States may wish to explore the impact of MSAs on their efforts to encourage comprehensive health care reform.

C. Responsibilities of MSA Trustees

Summary: The medical savings account is defined as a trust established solely to pay the qualified medical expenses of the account holder.

The trustee may be:

- a bank;
- an insurance company;
- another person approved by the HHS Secretary.

The trustee may not invest the MSA funds in life insurance contracts or commingle the funds with other property except in a common trust fund or common investment fund. The interest of the individual in the balance in his account must be nonforfeitable to quality as an MSA.

By August 1 of 1997, 1998, and 1999, the trustee of an MSA must make a report to the IRS on the following items:

- the number of medical savings accounts established before July 1;
- the name and TIN of the account holder; and
- the number of MSAs which are accounts of previously uninsured individuals.
Trustees of accounts established before May 1, 1997 must make a similar report by June 1, 1997 with respect to those accounts for which the organization served as a trustee. The law imposes a $50 penalty for each failure to report properly unless the failure to report is due to reasonable cause.

**Issues for States:**

1. **What laws does the state currently have relating to trustees of medical savings accounts?**

2. **If the state has a law in this area, please consider the following issues:**

   The definition of who may be a trustee under this Act may have an impact upon the states. Although the bank or insurance company which serves as the trustee may be required to comply with state laws, the statute does not explicitly require that the trust be organized in accordance with state law. The language also provides that the Secretary of the Treasury may approve a person other than a bank or insurance company as trustee if the Secretary is satisfied that the trust will be administered properly. The legislative language resembles that used in the federal statutes and regulations governing individual retirement accounts. In addition to the regulations developed for this piece of legislation, states may want to be familiar with the relationship between their laws governing trusts and the federal standards regarding trusts for individual retirement accounts.

   Also, the federal legislation prohibits certain activities such as the commingling of MSA account funds with some other funds and the investment of MSA funds in life insurance contracts. Again, this language mirrors the federal regulatory provisions governing individual retirement accounts. State laws may not conflict with these prohibitions if the states wish favorable tax treatment.

3. **If there are no state laws in this area, or if your state's law falls short of the federal standards,** states need not develop a law but may want to ensure that any current laws do not conflict with Act to ensure favorable tax treatment for state residents.

4. **If your state's laws include the federal standards or goes further,** your state does not have to revise its laws unless state laws conflict with the Act.

5. No implementation questions received to date.

**D. Enforcement/Timeline**

**Summary:** The trustee's reports will be used, in part, to determine whether the maximum number of eligible persons have benefited from a MSA contribution during the years 1997 through 2000. Generally speaking, once the annual threshold levels have been reached, no additional persons and employers will be permitted to participate for that taxable year.
After the year 2000, the tax incentives will no longer be provided for MSA participants unless Congress extends the life of the program. Additionally, if the Treasury Secretary determines that the numerical limitation for a year prior to the year 2000 has been exceeded, the incentives will only be available for any month during that year for individuals who already own MSAs and employers who have already established them for their employees. The annual threshold levels are as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/30/97</td>
<td>375,000</td>
</tr>
<tr>
<td>6/30/97</td>
<td>525,000</td>
</tr>
<tr>
<td>1998</td>
<td>600,000</td>
</tr>
<tr>
<td>1999</td>
<td>750,000</td>
</tr>
</tbody>
</table>

Previously uninsured individuals are not included in the annual threshold determinations.

The Treasury Secretary is required to monitor the number of participants and the reduction in revenue as a result of MSA participation.

The GAO is charged with entering into a contract with an appropriate organization to study the effects of medical savings accounts in the small group market on selection, health costs, use of preventive care, consumer choice, scope of coverage of high deductible health plans, and other relevant items. The report is to be submitted to Congress no later than January 1, 1999.

Issues for States:

1. What is the role of states in the enforcement of the provisions of this Act?

   The federal legislation does not explicitly discuss the role of the states in the enforcement of the provisions of this Act. States generally have no role in enforcement of federal tax laws.

2. Will states want to develop state laws explicitly to accommodate a temporary federal program?

   The length of the federal MSA program is limited to four years, absent legislation extending the program further. States may want to consider the degree of changes that they want to make to state laws to accommodate a program which may be temporary.
V. Long Term Care

A. Issues Relating to Tax Deduction

Summary: The section of the law addressing long-term care insurance amends the Internal Revenue Code. Unreimbursed expenses for qualified long-term care services are treated as medical expenses for the purpose of itemized deductions for medical expenses, subject to the floor of 7.5% of adjusted gross income. Long-term care insurance premiums are also treated as medical expenses for the purpose of itemized deductions for medical expenses, with a cap as to the amount that can be claimed. This is a variable amount based upon the age of the individual (with older individuals having a greater tax deduction). The premium amounts are to be indexed to account for inflation.

Proceeds from a long-term care insurance contract are excludable from taxable income, subject to a cap of $175 per day, or $63,875 annually, on per diem contracts. If the aggregate amount of periodic payments exceed the cap, the excess payments are excludable only to the extent they represent actual costs for long-term care services during the period. An employer-provided long-term care contract is generally treated as an accident and health plan. However, employer-provided coverage under a long-term care insurance contract is not excludable if provided through a cafeteria plan, and expenses for long-term care services cannot be reimbursed under a flexible spending plan.

Self-employed individuals may now deduct premiums for long-term care insurance in the same manner they have deducted premiums for health insurance (which will be increased pursuant to Section 301 of this law.) Insurance carriers must use the prescribed NAIC federal income tax reserve method. This method currently prescribed is the one-year full preliminary term method. COBRA continuation rules do not apply to long-term care insurance contracts.

1. What laws does your state currently have relating to long-term care insurance (i.e., long term care insurance laws and regulations, laws and regulations governing the accelerated use of life insurance proceeds for long-term care)?

2. If your laws are based upon the NAIC Long-Term Care Insurance Model Act and Regulation, the Act raises the following issues:

Again, this section of the law only addresses the federal income tax treatment of long-term care insurance contracts. States are under no obligation to change their state tax laws. Furthermore, this section does not appear to raise any issue under the NAIC model which would cause states that have adopted the NAIC model to risk losing federal tax deductibility.

3. If there are no state tax laws in this area, or if the state tax laws fall short of the federal standards, these sections place states under no obligation to amend existing statutes or regulations.

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4. If the state tax laws include the federal standards and/or go further for state tax deductibility, the state need not revise its standards in order for residents to be able to take advantage of the tax deduction.

5. The following implementation questions have been raised by some states. We have included NAIC staff's initial responses and interpretations, which are subject to member comment and revision:

   a) How are premiums treated that are paid on behalf of someone else, i.e., a child who pays the premium of a policy that insures a parent? (Iowa)

While we defer to others to interpret or apply the Internal Revenue Code, we offer the following: In reading the section of the Act that discusses eligible long-term care insurance premiums, it states that the term means the amount paid during a taxable year for any qualified long-term care insurance contract covering an individual. (Emphasis added) The term includes any amount paid which does not exceed the stated limits of premium paid. It does not appear to specify that the person paying premiums and receiving the tax deduction be the beneficiary under the contract.

B. Definition of Qualified Long-Term Care Contracts

Summary: The Act provides definitions for a federally tax qualified long-term care contract, a qualified long-term care service, and a chronically ill individual. Pursuant to these provisions unreimbursed expenses for qualified long-term care services as well as premiums for qualified long term care contracts are treated the same as medical expenses under the Internal Revenue Code. (See details in Section A herein).

The federal definitions are interrelated. In order for a long-term care contract to be considered qualified, the only insurance protection it can provide is for qualified long-term care services.

For a long-term care insurance contract to be considered qualified, there are a number of requirements that must be met. These are: the only insurance protection provided under the contract can be for "qualified long-term care services", the contract cannot pay or reimburse for expenses that are reimbursable under Medicare; the contract must be guaranteed renewable; the contract does not provide a cash surrender value; any refund of premium or policyholder dividends must be used to reduce future premiums or to increase future benefits; and the policy must comply with the required consumer protection provisions.

"Qualified long-term care services" are defined as a variety of necessary services or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care provider. For services to
be considered qualified long-term care services, the recipient must be considered a chronically ill individual.

A "chronically ill individual" is defined as an individual who has been certified by a licensed health care practitioner as: (a) one who is expected, for a period of at least 90 days, to be unable to perform at least two (2) activities of daily living due to a loss of functional capacity, (b) having a level of disability similar to a person who is expected, for a period of at least 90 days, to be unable to perform at least two activities of daily living, according to regulations that will be prescribed by the Treasury Secretary (in consultation with the HHS, or, (c) requiring substantial supervision due to severe cognitive impairment. The activities of daily living (ADLs) are the same as is in the current NAIC model regulation: eating, toileting, transferring, bathing, dressing, and continence. Insurers are required to take into account at least of five (5) of the six (6) ADLs when making a determination as to whether or not an individual is chronically ill.

The Act states that any contract issued before January 1, 1997 which meets state long-term care insurance requirements will be considered a qualified long-term care contract. Any rider to a life insurance policy which provides long-term care benefits is treated the same as a long-term care contract, as if such coverage was a separate policy.

The Act states that the NAIC will be asked by the Chair of the House of Representatives’ Ways and Means Committee and the Chair of the Senate Committee on Finance to formulate, develop, and conduct a study to determine the marketing and other effects of per diem limits on certain types of long-term care insurance.

1. What laws does the state currently have relating to long-term care insurance? (i.e., long term care insurance laws and regulations, laws and regulations governing the accelerated use of life insurance proceeds for long-term care).

2. If the state laws are based upon the NAIC Long-Term Care Insurance Model Act and Regulation, please consider the following issues:

There are no requirements in the Act that make any of the provisions mandatory for LTC contracts. States may adjust or maintain their LTC statute and regulation as they desire. However, this may result in the states’ LTC statutes and regulations conflicting with the federal standards for a qualified contract. This raises the following issue for the states: Does the state wish to allow the sale of qualified long-term care insurance contracts? In other words, does the state wish to change its standards in some areas in order to enable the insurance consumers of their state to avail themselves of the federal tax deductibility allowed in the Act?

If a state has laws and regulations similar to the NAIC model law and regulation and wants its laws to work within the federal requirements for qualified long-term care contracts, there are changes that need to be made to the NAIC model provisions.
The Act only states that a nonforfeiture benefit be offered. (see Section B herein for a discussion on nonforfeiture benefits). This differs from the inclusion of required nonforfeiture benefits within the NAIC Model. However, the NAIC model provision does not conflict with the federal standard.

Further, the Act designates the type of nonforfeiture benefits that are permissible, none of which provide a cash surrender value. NAIC model provisions would need to clarify that nonforfeiture benefits could not conflict with these federal requirements. The Act provides that a cash surrender value cannot be part of the contract if that cash surrender value can be paid, assigned, used as collateral for a loan, or borrowed. If the policy provides for a refund of premium or dividend, that value can only be applied as a reduction in future premiums or an increase in future benefits. If a policyholder dies, the qualified long-term care contract may provide a refund which must be no more than the aggregate premiums paid under the contract. If a qualified long-term care contract is surrendered or lapsed, any refund will be included in gross income to the policyholder to the extent that any deduction or exclusion of the premiums paid were allowable.

The Act states that a carrier must consider at least 5 (of the 6) activities of daily living, whereas the NAIC model states that a carrier must take into consideration all 6 ADLs when determining whether or not an individual is eligible for benefits. This requirement does not directly conflict with the federal requirements and therefore need not be changed.

The Act also differs from the NAIC model in the determination as to when benefits are triggered. The model states that an individual must be deficient in no more than 3 of the 6 ADLs in order to qualify for benefits under this trigger, while the Act states that the individual must be deficient in at least 2 of the ADLs in order to trigger benefits in a qualified long-term care contract. This provision, too, does not directly conflict with the federal standard. However, the NAIC model provision could allow for a trigger of one ADL; this is not allowed by the Act. Hence, states may wish to consider adding the phrase “at least two” to the provisions of the NAIC model. Otherwise, a contract would provide for the triggering of services more readily than the Act and would conflict with the Act.

Further, the Act and conference report state the individual must be expected to be unable to perform those ADLs for at least 90 days in order to trigger benefits. This is not a waiting period. If a licensed health care provider certifies that the individual will be unable to perform at least 2 ADLs for an expected period of at least 90 days, the individual would be considered chronically ill. This 90-day timeframe is not mentioned or required in the NAIC model. It appears that the 90 day requirement would have to be added to the NAIC model in order to comply because the NAIC model otherwise would provide for the triggering of services in a wider range of cases than those permitted for “qualified” policies.
Another area in the Act that differs from the NAIC model regarding benefit triggers is the definition and application of cognitive impairment and its triggering of benefits. The NAIC model regulation (Section 5E) defines cognitive impairment as a deficiency in a person's short or long term memory, orientation as to person, place, or time, deductive or abstract reasoning, or judgment as it relates to safety awareness. The model regulation states that the determination of a deficiency as a condition of payment of benefits (Section 24D(2)) shall not be more restrictive, in regard to cognitive impairment, than supervision or verbal cueing by another person that is needed in order to protect the insured or others. The Act, however, is more restrictive in this area. It states that an individual must require substantial supervision to protect him or herself from threats to health and safety due to severe cognitive impairment. (Emphasis added) The stated concern of the conference committee was that the eligibility for the medical expense deduction not be diagnosis-driven; hence, the more restrictive federal language was included. The NAIC model does not require the degree of supervision or depth of cognitive impairment in order for benefits to be triggered in this manner. Nonetheless, in these two areas, the less onerous NAIC requirements do conflict with the federal definition because the NAIC model would result in triggering of additional benefits and the federal definition requires that qualified long-term care contracts only provide qualified long term care services.

3. If there are no state laws in this area, or if the laws fall short of the federal standards, please consider the following issues:

States are not forced by the new Act to adopt the definitions if the state does not have statutes or regulations already codified. However, lack of these definitions in the insurance code or insurance regulations leaves the U.S. Department of Treasury as the sole enforcer of these requirements. The existence of state law provisions enables states to enforce the requirements as part of their insurance code, and to handle consumer complaints concerning non-compliance with the state requirements.

4. If the state laws include the federal standards and/or go further in most areas (see Section B herein), the state need not revise its standards. However, if a state law conflicts with the Act in a definitional requirement, as noted above, policyholders likely will not be able to avail themselves of federal tax deductibility.

5. The following implementation questions have been raised by some states: Note: We have included NAIC staff's initial responses and interpretations, which are subject to member comment and revision.

   a) What occurs when a carrier wishes to sell a non-qualified plan? (Iowa)

   A carrier may sell any long-term care insurance policy in a state, as long as the policy conforms to state statute and regulation. A policy does not have to be a qualified policy as defined in the Act, in order to be marketed.
b) If state statutes are changed to reflect the federal requirements of a qualified long-term care insurance contract, may a carrier sell a long-term care insurance product that is not qualified? (North Dakota)

A carrier cannot sell a product in a state that does not conform to the state insurance code. If the state law includes the federal requirements, a non-qualified policy would also violate the state law.

C. Consumer Protection Standards

Summary: The consumer protection standards that have been placed in the Act follow most of the provisions that are in the NAIC Long-Term Care Insurance Model Act and Regulation as in place in January, 1993. The three consumer protection areas that must be included in a policy are: (1) the requirements taken from the January, 1993 NAIC models, (2) an additional disclosure requirement, and (3) the requirements relating to nonforfeiture. The Act provides that if a state imposes any policy requirement which is more stringent than similar requirements in the law, the requirement imposed by the Act is deemed to have been met if the state requirement has been met.

The first, and largest, consumer protection section lists the provisions in the policy that must exist in order for the contract to be considered a qualified LTC contract. These required provisions were taken from the January, 1993 model act and regulation, which are attached. Many of these provisions have not been subsequently amended by the NAIC. The Act states that section 6C (regarding preexisting conditions) and 6D (relating to prior hospitalizations) of the 1993 model act are required to be in a qualified LTC contract. The Act also requires the provisions set forth in Section 7A (relating to guaranteed renewability or noncancellability) and the corresponding requirement found in Section 6B of the model act, Section 7B (relating to prohibitions on limitations and exclusions), Section 7C (relating to extension of benefits), Section 7D (relating to continuation or conversion of coverage), and Section 7E (relating to discontinuance and replacement of coverage). Also required from the January, 1993 model are Section 8 (relating to unintentional lapse), Section 9, except Section 9F (relating to disclosure), Section 10 (relating to prohibitions against post-claims underwriting), Section 11 (relating to minimum standards), and Section 12 (relating to the requirement to offer inflation protection), except that the signature rejecting such offer can be either on the application or on a separate form.

A qualified LTC contract shall include the provisions of Section 23 (relating to the prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

Qualified LTC contracts must meet the requirements of Section 6F (relating to the individual's right to return the policy, except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial), Section 6G (relating to the outline of coverage), Section 6H (relating to requirements for...
certificates under group LTC plans), Section 6I (relating to policy summaries and benefits paid from life insurance policies), Section 6J (relating to monthly reports on accelerated death benefits in life insurance policies), and Section 7 (relating to incontestability period). From the January, 1993 model regulation, the qualified LTC contracts must meet the requirements set forth in Section 13 (relating to application forms and replacement coverage), Section 14 (relating to reporting requirements, except that the issuer shall also now report annually the number of claims denied, other than denials due to failure to meet the waiting period or because of any applicable preexisting condition), Section 20 (relating to filing requirement for marketing and marketing materials), Section 21 (relating to standards for marketing, Section 22 (related to appropriateness of recommended purchase), Section 24 (relating to a standard format outline of coverage), And Section 25 (requirement to deliver the NAIC Shopper’s Guide to Long-Term Care Insurance).

The next provision required is additional disclosure. This provision states that if a carrier intends for the long-term care insurance contract to be considered as a qualified long-term care insurance policy, that fact must be disclosed in the policy and in the outline of coverage.

The final consumer protection provision states that the issuer must offer, with any level premium policy, a nonforfeiture provision. This provision can be in the form of reduced paid-up insurance, extended term insurance, a shortened benefit period, or other similar offerings approved by the Secretary of the Treasury.

1. **What laws does the state currently have relating to long-term care insurance** (i.e., long term care insurance laws and regulations, laws and regulations governing the accelerated use of life insurance proceeds for long-term care)?

2. **If the state laws are based upon the NAIC Long-Term Care Insurance Model Act and Regulation, please consider the following issues:**

For the purposes of federal tax deductibility, states are not precluded from having more stringent consumer protections, as long as they do not conflict with the definitions (see above). The Act provides that if the states’ requirements are more stringent than those set forth in the Act, the consumer protection requirements that are needed to be considered a qualified long-term care insurance contract are deemed to be met.

The consumer protection section in the Act requires the offering of nonforfeiture benefits, and allows states to have more stringent “analogous” requirements. Since mandatory nonforfeiture benefits, as found in the NAIC model, is more stringent than the Act requirement, this section need not be changed. However, it does appear that the Act constrains the type of nonforfeiture benefits. It limits the nonforfeiture benefits to reduced paid-up insurance, extended term insurance, a shortened benefit period, or other similar offerings approved by the Secretary of the Treasury. In addition, as discussed in section B herein, the definition section states that a qualified long-term care contract cannot provide a cash surrender value that can be paid, assigned, pledged as collateral, or
3. If there are no state laws in this area, or if the laws fall short of the federal standards, please consider the following issues:

States are not forced by the new Act to adopt the definitions if the state does not have statutes or regulations already codified. However, lack of these definitions in the insurance code or insurance regulations leaves the U.S. Department of Treasury as the sole enforcer of these requirements. The existence of state law provisions enables states to enforce the requirements as part of their insurance code, and to handle consumer complaints concerning noncompliance with the state requirements.

4. If the state laws include the federal standards and/or go further in any area that does not conflict with the definitions described in Section A (see above), the state need not revise its standards in order for residents to be able to avail themselves of the federal tax deductibility.

5. The following implementation questions have been raised by some states:
No questions received to date.

D. Enforcement/Timeline

Summary: The change in the reserve method in the Act applies to contracts issued after December 31, 1997. After the date of enactment, and before January 1, 1998, if a contract providing long-term care coverage is exchanged solely for a qualified long-term care insurance contract, no gain or loss shall be recognized on the exchange. All other provisions of the law are effective for taxable years beginning after December 31, 1996.

The U.S. Department of Treasury is the federal agency that is responsible for determining whether or not a long-term care contract is qualified. As such, that agency is also responsible for enforcement of the tax provisions. States are still responsible for the enforcement of consumer protections that are in the states’ insurance code. Interestingly, however, the Act allows more stringent state consumer protections to replace the federal standards. Therefore, the Department of Treasury will need to make determinations as to whether state laws are at least as stringent as the federal consumer protection standards in order to determine compliance with the federal tax requirements.

1. What laws does your state currently have relating to long-term care insurance (i.e., long term care insurance laws and regulations, laws and regulations governing the accelerated use of life insurance proceeds for long-term care)?

2. If your laws are based upon the NAIC Long-Term Care Insurance Model Act and Regulation, please consider the following issues:
States need to be aware of the timelines in that they will begin receiving policy filings that will be created to conform to the Act’s requirements of a qualified long-term care contract.

3. If there are no state laws in this area, or if the laws fall short of the federal standards, please consider the following issues:
These sections place states under no obligation to amend existing statutes or regulations.

4. If the state laws include the federal standards and/or go further, the state need not revise its standards.

5. The following implementation questions have been raised by some states:
No questions on these provisions have been received to date.

VI. Fraud and Abuse

Summary: The fraud and abuse provisions of the Act pertain primarily to federal health care programs, state health care programs supported by Medicaid, and the federal maternal and child health and social services block grants. These programs generally are not administered in state insurance departments. However, some provisions apply to a broader range of government agencies and private entities.

The Act requires the HHS Secretary through the Inspector General, and the Attorney General to establish a national health care fraud and abuse control program. The program includes a variety of activities, including the coordination of federal, state and local fraud and abuse enforcement activities with respect to health plans. Health plans are defined as a plan or program that “provides health benefits through insurance or otherwise.” Health plans include health insurance policies, contracts of service benefit organizations, and membership agreements with health maintenance organizations (HMOs) or other prepaid health plans. The legislation does not specify the nature of federal and state interaction under this provision. However, the Attorney General and Inspector General are charged with issuing guidelines for the fraud and abuse control program.

A Health Care Fraud and Abuse Control Account has also been established as part of the Federal Hospital Insurance Trust Fund. The expenditure account is available to finance the activities of the national health care fraud and abuse control program. Funds for the account will come from gifts, penalties, fines, and amounts resulting from property forfeitures. The Act does not allocate any monies from the trust fund to the states for fraud and abuse control activities.

The fraud and abuse control program is also charged with conducting investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States. To this end, the law establishes a Medicare Integrity Program. Under this program the HHS Secretary enters into contracts with private entities to perform a number of functions which include reviewing the activities of health care
service providers and other individuals and entities providing items or services under the Medicare program and auditing cost reports. Additionally, the law requires the Secretary to provide an explanation of benefits for each item or service for which payments were made under the Medicare program and to establish a program that encourages individuals to report to the Secretary nonfrivolous information about individuals or entities that are engaging in activities that constitute grounds for sanctions, including fraud and abuse, against the Medicare program.

Under the Act, the Secretary is required to issue written advisory opinions within 60 days in response to inquiries regarding whether certain transactions would violate the 1987 Medicare and Medicaid anti-kickback law. The advisory opinions would be binding on the Secretary and the party requesting the opinion. Additionally, any person may ask the Inspector General to issue a special fraud alert regarding practices which may be of concern to the Medicare program or a state health care program.

The enforcement of health care fraud and abuse statutes is also a responsibility of the health care fraud and abuse control program. Individuals convicted, under federal or state law, of felonies for health care fraud offenses which occurred after the enactment of this statute or offenses relating to controlled substances will be excluded from participation in Medicare or any state health care program for five years. The Secretary can exclude individuals convicted of misdemeanor offenses related to the delivery of health care or any act or omission in a health care program operated by or financed by any federal, state, or local government agency. The Secretary can also exclude individuals convicted of any other criminal fraud offenses related to any program operated by or financed by any federal, state, or local government agency. Individuals who have an ownership or control interest in sanctioned entities who know or should know of the action constituting the basis for the sanction or exclusion may also be excluded from program participation.

Additionally, under the Act, Medicare HMO organizations may be fined intermediate sanctions or their contract with Medicare may be terminated if they fail to live up to the terms of their Medicare contracts. Congress also provided additional safe harbors from the anti-kickback penalties for certain risk-sharing arrangements. The HHS Secretary is required to solicit proposals for additional safe harbors, modifications to existing safe harbors, advisory opinions, and special fraud alerts. The Act also prohibits individuals from knowingly and willfully disposing of assets in order to qualify for Medicaid.

The law enhances civil monetary penalties, makes health care fraud a crime independent of other crimes such as federal mail and wire fraud or the False Claims Act, and extends its reach beyond public sector health care programs. The law sets the standard of intent required for federal health care fraud as “knowingly and willfully” executing or attempting to execute a scheme to defraud a health care benefit program. Health care benefit program is defined as “any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.” Additionally, the law
establishes criminal penalties for theft or embezzlement, false statements, obstruction of criminal investigations relating to health care offenses, and laundering of funds. It also provides for injunctive relief, authorizes certain investigative demand procedures, and contains forfeiture provisions.

Of further interest to the states, the Secretary is required to establish a database on all final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners. Each government agency and health plan is required to report on a monthly basis any adverse actions taken against a health care provider, supplier, or practitioner. The definition of “government agency” includes state law enforcement agencies, Medicaid fraud control units, and state agencies responsible for the licensing and certification of health care providers and licensed health care practitioners. The information in the database would be available to federal and state agencies and health plans. A fee schedule may be established for disclosure of information in the database to individuals or agencies other than federal agencies. This provision is to be implemented in a manner that does not duplicate the reporting requirements of the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986.

A. Issues for the States:

1. What laws does your state currently have relating to health care fraud and abuse?

2. How do these provisions directly impact state insurance departments?

Most of the fraud and abuse provisions apply to agencies with responsibility for Medicare, Medicaid, and programs funded by federal maternal and child health and social service block grants. State insurance departments which have some responsibility for the state’s Medicaid program may need to comply, or work with other relevant state agencies to comply with these provisions.

However, state insurance departments which are not responsible for Medicaid activities are still affected by these provisions. While the fraud and abuse provisions of the Act may not require explicit changes in state insurance law, the law does call for coordination between state and Act enforcement activities related to health plans. While further information is required regarding the breadth and depth of this coordination effort, it should be noted that the term health plans is not defined in the law to be limited to those plans contracting with federal and state health programs. Additionally, the scope of this coordination is not made explicit in this statute.

The database effort required by the law will also impact state insurance departments. Certain state agencies are required to provide information on a monthly basis. Entities that state insurance departments are investigating may be reported to the database by state law enforcement agencies. State insurance departments may also benefit from the
information which will be contained in the database relating to adverse actions taken against providers, suppliers, and practitioners.

Fraud units of state insurance departments should also be aware of and may benefit from the enhanced federal penalties for health care fraud offenses, both in the public and private sector, and the resources available to the federal government to combat health care fraud.

VII. Administrative Simplification

Summary

In the Act, the subtitle’s stated purpose is to improve the Medicare and Medicaid programs, and the efficiency and effectiveness of the health care system, by establishing standards and requirements for the electronic transmission of certain health information. It adds a new “Part C - Administrative Simplification” to Title XI of the Social Security Act. (42 U.S.C. 1301 et seq.)

Most of the law’s provisions address the topic of data standards. Data standards specify the type and format of the health information that will be required to be transmitted electronically. There is a single section addressing privacy standards. Privacy standards establish rules for the collection and disclosure of confidential health information.

Privacy Standards: Instead of giving the HHS Secretary authority to develop privacy standards, (as was in the House bill), the Act directs HHS to submit recommendations to Congress with respect to such standards within 12 months of enactment. The law requires Congressional action on privacy standards within 36 months of enactment, or in its absence, Secretarial action within 42 months of enactment. However, any regulation promulgated by the Secretary will not supersede a contrary provision of state law if that provision imposes requirements, standards, or implementation specifications that are more stringent than those imposed under the regulation.

Data Standards: The HHS Secretary is charged with adopting standards for specified transactions, including the data elements for the transactions, to enable health information to be exchanged electronically. The transactions include specified financial and administrative transactions and any other financial and administrative transactions that the Secretary determines are appropriate and consistent with the goals of improving the operation of the health care system and reducing administrative costs.

One set of standards to be adopted would provide for a “standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system.” The standards adopted must specify the purposes for which a unique health identifier may be used.
The Secretary is also charged with adopting standards for: code sets; security standards for health information; standards specifying procedures for the electronic transmission and authentication of signatures; and standards for the transfer of information among health plans. The Secretary is to promulgate these standards within 18 months of the adoption of the Act, except for standards relating to claims attachments, which must be promulgated within 30 months of the Act’s enactment.

Any standard adopted under Part C applies to health plans, health care clearinghouses, and health care providers when those providers transmit information in electronic form in conjunction with specified transactions (including claims). “Health plans” are defined to include group health plans and health insurance issuers as defined in the Public Health Service amendments within the Act employee welfare benefit plans established for the employees of two or more employers, and other specified types of health policies.

Any standard adopted by the Secretary must have been developed, adopted, or modified by a standard setting organization. The Secretary is authorized to adopt her/his own standard if no standard setting organization has adopted a relevant standard. The Secretary is also authorized to adopt a different standard from one developed by a standard setting organization if the Secretary’s standard will reduce administrative costs and is promulgated as a rule.

Effect on state law: The subtitle contains broad preemption language but this has been narrowed from the provisions in the House bill (see italics below for added state savings clauses). It now states that any provision, requirement, standard or implementation specification contained in this new Part C or adopted pursuant to its provisions supersedes any contrary provision of state law, including any provisions of state law that require medical or health plan records to be maintained or transmitted in written rather than electronic form. The records affected explicitly include billing information. However, the Act’s requirements do not supersede any provision of state law that the Secretary determines is necessary for any of five reasons: to prevent fraud and abuse; to ensure appropriate State regulation of insurance or health plans; for State reporting on health care delivery or costs; or for other purposes; or that addresses controlled substances. The provisions of this new part C are also not to be construed to invalidate or limit “any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.” In addition, there is a new exception stating that nothing in the part shall limit the ability of a State to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.

In implementing this Part C, the Secretary is to rely on the recommendations of the National Committee on Vital and Health Statistics.
The bill contains criminal penalties against any person for obtaining or disclosing individually identifiable health information or a unique health identifier in violation of the new Part C.

Issues for the States:

A. Covered Transactions

The law specifies the following transactions as those for which the Secretary must adopt standards, including data elements:

(1) Health claims or equivalent encounter information;
(2) Health claims attachments;
(3) Enrollment and disenrollment in a health plan;
(4) Eligibility for a health plan;
(5) Health care payment and remittance advice;
(6) Health plan premium payments;
(7) First report of injury;
(8) Health claim status;
(9) Referral certification and authorization.

In addition to these specified transactions, the Secretary may adopt standards, including data elements, for “other financial and administrative transactions determined appropriate by the Secretary, consistent with the goals of improving the operation of the health care system and reducing administrative costs.”

The list of specified transactions raises two issues. First, the language does not direct the Secretary to adopt uniform data standards for patient medical record information and the electronic exchange of such information. Elsewhere in the bill the National Committee on Vital and Health Statistics is explicitly charged with studying “the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;” and with reporting its recommendations and legislative proposals for such standards and electronic exchange to the Secretary not later than four years after the date of enactment. Those knowledgeable about the financial and administrative transactions named above, however, have questioned whether uniform standards can be established for the specified transactions without also specifying standards for patient medical record information. Such information is often attached to the claims submission or incorporated into the claim.

With respect to data standards for patient medical record information, therefore, the states may have flexibility to impose their own requirements, at least until the above-described report is received. On the other hand, if “health claims or equivalent encounter information” or “health claims attachments” are interpreted to include the relevant patient medical record information, state law may be superseded by the standards and implementation specifications adopted by the HHS Secretary. However, the general
preemption section is subject to a number of exceptions, as specified above. In addition, any state law relating to patient medical record information would most likely relate to the privacy of individually identifiable information, and would therefore be protected by the preemption rule that permits a more stringent state law to remain in effect.

Second, the language makes clear that any transactions (other than those specified in the bill) for which the Secretary promulgates standards must be chosen with the goal of both improving the operation of the health care system and reducing administrative costs. These criteria are important to payers who fear that, without these limiting criteria, the Secretary might both choose transactions and set standards that serve the interests of health researchers but impose high costs.

B. Implications for State Insurance Departments and Data Reporting Agencies

The first step is to inventory the laws and regulations of your state to identify any that establish standards for the electronic transmission of health information. If your state has enacted standards for the electronic submission of any of the transactions specified in the Act, those standards will have to be at least consistent with, if not identical to, any standard ultimately adopted by the HHS Secretary, unless the exemptions contained in the preemption section apply. States may wish to notify HHS directly of any existing state standards for the electronic submission of the transactions specified in the Act. States may also wish to provide information about such standards to the NAIC staff.

C. Confidentiality

As noted above, the law directs the HHS Secretary to submit “detailed recommendations on standards with respect to the privacy of individually identifiable health information” to the Congressional committees having jurisdiction over health care issues by Aug. 21, 1997 (the date that is 12 months after the law’s enactment date). Congress is charged with enacting legislation “governing standards with respect to the privacy of individually identifiable health information transmitted in connection with the [specified] transactions” within 36 months of the enactment date (i.e., by Aug. 21, 1999). If Congress fails to act, the HHS Secretary is directed to promulgate final regulations containing such standards within 42 months of the law’s enactment date. These regulations must, at a minimum, address: (1) the rights that an individual who is a subject of individually identifiable health information should have; (2) the procedures that should be established for the exercise of such rights; and (3) the uses and disclosures of such information that should be authorized or required.

The law specifies that any “regulation” promulgated under the law shall not supersede a contrary provision of State law, “if the State law imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications imposed under the regulation.”
Until the federal privacy standards are promulgated in either legislation or regulation, it is impossible to advise states with any specificity about the impact of the Act on existing state law. However, as an initial step, states could inventory their existing laws and regulations, if any, protecting the confidentiality or privacy of health information in any context. States may want to consider taking action in this area, especially in the absence of federal standards. Ultimately the specific language of these statutes and regulations will have to be compared to federal standards, which are due to be established sometime within the next 42 months.

A number of states have adopted the NAIC’s Insurance Information and Privacy Protection Model Act. This model does set privacy standards governing the release of personal or privileged information about an individual collected or received in connection with an insurance transaction. These standards apply to insurance institutions, agents, or insurance support organizations. An insurance institution is defined to include health maintenance organizations, medical service plans, and hospital service plans. The model also establishes the right of an individual to have access to recorded personal information and to request the correction, amendment, or deletion of this information.

The requirements of this model will be affected by any federal standards adopted with respect to the privacy of individually identifiable information. Until the promulgation of the federal standards, however, it is impossible to say whether the standards contained in the NAIC’s Insurance Information and Privacy Protection Model Act will be judged “more stringent.” States that have adopted this model may ultimately need to amend it to conform to federal requirements. In addition, the NAIC’s Health Plan Accountability Working Group is developing a confidentiality model that would apply more specifically to health information.

D. Enforcement/Timeline

The HHS Secretary is charged with adopting and enforcing the data standards promulgated pursuant to this law. This exclusively federal role contrasts with the legislation’s provisions implementing small group and individual market reform, which provide for state enforcement unless the Secretary determines that a state “has failed to substantially enforce” a provision of the law.

The federal enforcement role does not, however, extend to provisions of state laws addressing data that are saved by the exceptions to preemption specified in the Act. Provisions of state law that are contrary to the Act are NOT preempted if the HHS Secretary determines that they are necessary for any of these purposes: (1) to prevent fraud and abuse; (2) to ensure appropriate state regulation of insurance and health plans; (3) for reporting on health care delivery or costs; or (4) for other purposes. Nor are state laws preempted if the HHS Secretary determines (5) that the provision addresses controlled substances.
In addition there is a sixth exception to preemption for state data standards, and it does not involve Secretarial discretion. This exception is for any provision of state law that “relates to the privacy of individually identifiable information” and is more stringent than the requirements imposed by the federal regulation(s).

Moreover, the Act provides that the data preemption section is limited in two ways: (1) It cannot be construed to limit or invalidate “the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.” (2) In addition the data preemption section cannot “limit the ability of a State to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.”

Taken together, these are potentially broad exceptions to the broad general preemption of state laws addressing data standards or implementation specifications.

The enforcement of the privacy standards will presumably be articulated when those standards are promulgated. States would continue to enforce any state law requirements or standards that are more stringent than the federal privacy requirements.

5. The following implementation questions are raised by the language of the law:

Q: Is the HHS Secretary required to do rulemaking for all standards that are adopted by HHS pursuant to the law, or just for those standards that have not been developed, adopted, or modified by a standard setting organization?

A: Although the legislation is ambiguous on this point, the Secretary will probably do rulemaking for all standards, and not just for those that have not been developed by a standard setting organization. The level of public interest in all the standards will undoubtedly dictate that the Secretary engage in rulemaking and provide for public comment.

Q: May a health plan require a provider to submit more information than is required by the standard specified by the Secretary for a given transaction?

A: The language of the law is not clear on this point, but permitting a health plan to require more information than is specified in the Secretary’s standard would defeat the legislation’s purpose of promoting uniform standards for the specified transactions.

Q: May a state require the submission of additional information beyond that specified in the standard promulgated by the Secretary?
With respect to state data requirements, state flexibility will depend upon how the preemption language is construed. The language provides states a broad allowance for requirements that the Secretary of HHS determines are necessary for state regulation of insurance and health plans and state reporting on health care delivery or costs. In addition, there is a fairly broad additional exception for state requirements for audits, program monitoring and evaluation, and licensure or certification. Notably, this additional exception is not subject to a Secretarial determination, which is required with respect to state laws addressing the state regulation of insurance. Therefore, states may require the submission of additional information for at least those programs which fall in the latter category. Additional state requirements affecting state regulation of insurance and health plans, or affecting state reporting on health care delivery or costs, will be subject to Secretarial discretion.

Q: May a state impose more stringent privacy requirements than those specified in federal legislation, as opposed to federal regulations?

A: Under the bill, the Secretary is given authority to promulgate regulations for “security standards” but is asked to submit recommendations for “privacy standards”. There has been criticism leveled recently about this section of the bill because the transaction standards will go into effect without accompanying federal privacy standards. State privacy laws that are more stringent than the federal regulations will be able to stand.

VIII. Medicare Anti-Duplication

Summary: Prior to the enactment of the Act, Act prohibited the sale of health insurance policies which duplicated Medicare benefits. The Social Security Act Amendments of 1994 (P.L. 103-432) provided an exception from this prohibition and allowed for the sale of certain policies that duplicated Medicare benefits, as long as the policies paid benefits without regard to what Medicare paid and provided consumers a disclosure statement as part of the application for coverage. This disclosure statement conveyed to the consumer that the policy duplicated benefits paid by Medicare.

However, until the enactment of the Act, federal law still prohibited the sale of any policy that coordinated its benefits with Medicare or other health insurance coverage (i.e. did not pay “without regard to” Medicare or other coverage), including long-term care insurance policies. These policies were not excepted from the anti-duplication prohibition. Many members of Congress, state long-term care “partnership programs” and other organizations, including the NAIC, advocated a narrow legislative change to allow long-term care policies to coordinate their benefits with Medicare and other private insurance without violating the Medicare anti-duplication prohibition.

The Act includes such an amendment, along with several other changes. Under the Act, long-term care insurance policies are not considered to duplicate Medicare benefits if
they: 1) provide health care benefits only for long-term care, nursing home care, home health care, or community based care, or any combination thereof; 2) coordinate against or exclude services available from or paid by Medicare or other health insurance; and 3) for policies sold or issued on or after 90 days from the Act’s enactment (August 21, 1996), disclose in the outline of coverage that the policy coordinates with, or excludes benefits covered by, Medicare.

In addition, the Act amends current law so that policies that pay without regard to other coverage are no longer considered to duplicate Medicare. In addition, the Act modifies the disclosure statements required by federal law (See above) to comport with this change. Hence, the disclosure statements no longer include a statement that the policies duplicate Medicare. Instead, the disclosure statements for most policies must state that some health care services paid for by Medicare may also trigger the payment of benefits under the policy. It also notes that the policy must pay benefits without regard to other health benefit coverage to which the insured may be entitled under Medicare.

The disclosure statements for long-term care insurance policies also now have additional language that states that the long-term care insurance may pay for some care also covered by Medicare. Sellers of health insurance policies subject to the disclosure statement requirement may substitute the current disclosure statements for the disclosure statements addressed in the Act. (In other words, the current disclosure statements may still be used, at the carrier’s option.)

1. What laws does the state currently have relating to Medicare supplement insurance and the duplication of Medicare benefits?

The Act mandates that state laws must equal, or be more stringent than, federal requirements.

2. If the state laws are based upon the NAIC Medicare supplement insurance Model Act and Regulation, please consider the following issues:

The Act calls for changes in the NAIC’s model Medicare Supplement Insurance Regulation. States which do not similarly amend their laws risk noncompliance with the Act provisions relating to Medicare supplement insurance. Carriers have the option to use either the new disclosure statement as amended in the Act in Title II, Subtitle G or to use the current disclosure statements.

3. If there are no state laws in this area, or if the laws fall short of the federal standards, please consider the following issues:

All states have either adopted the current disclosure statements and have received approval from the Health Care Financing Administration (HCFA) or are having their Medicare supplement program reviewed by HCFA. States that have not adopted the disclosure statements face the possibility of not having their Medicare supplement
programs approved by HCFA, in which case carriers may not sell Medicare supplement policies in their state. States that do not adopt the new disclosure statements may have their Medicare supplement program approval or conditional approval withdrawn by HCFA.

4. If the state laws include the federal standards and/or go further, the state need not revise its standards. States may impose additional disclosure requirements but may not declare or specify that policies duplicate Medicare benefits.

5. The following implementation questions have been raised by some states:

No questions received to date.

IX. Additional Tax-Related Provisions

   A. Viatical Settlements/Treatment of Accelerated Death Benefits

Sec. 331. Treatment Of Accelerated Death Benefits By Recipient.

The Act sets forth requirements pursuant to which a chronically or terminally ill individual may receive life insurance policy benefits before dying without incurring a tax penalty. A “terminally ill individual” is one who has been certified by a physician as having an illness or physical condition reasonably expected to result in death within 24 months of the date of certification. A “physician” means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action. A “chronically ill individual” is one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least two activities of daily living for at least 90 days because of a loss of functional capacity, (2) having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision because of severe cognitive impairment.

This section provides an exclusion from gross income for: (1) amounts received under a life insurance contract and (2) amounts received for the sale or assignment of a life insurance contract to a qualified viatical settlement provider if the insured is either terminally ill or chronically ill. For a chronically ill individual, such funds are only excluded from income if the payment is for the costs incurred for long-term care services not reimbursed by insurance or otherwise. Under the conference agreement, the amount excluded from income is actual expenses not reimbursed or the higher of $175 per day (adjusted for inflation after 1997) or actual expenses if paid as a per diem.

1The Joint Committee on Taxation has estimated that sections 331 and 332 may cost $762 million over five years.
Whomever makes such payments must report to the Internal Revenue Service the aggregate amount of such benefits paid to any individual during any calendar year, along with name, address, and taxpayer identification number of such individual. The recipient of such payment must receive a copy of the report by January 31 following the year of payment.

A "qualified viatical settlement provider" is any person that regularly purchases or takes assignments of life insurance contracts on the lives of terminally ill or chronically ill individuals and either (1) is licensed for such purposes in the state in which the insured resides, or (2) if the person is not required to be licensed by that state, for a terminally ill insured, meets the requirements of sections 8 and 9 of the NAIC's Viatical Settlements Model Act (Model Act) and also meets the requirements of the NAIC's Viatical Settlements Model Regulation for reasonable payments. If the insured is chronically ill, the viatical settlement provider must meet requirements similar to those of sections 8 and 9 of the Model Act and any standards promulgated by the NAIC for reasonable payments for the chronically ill.

These provisions do not apply in the case of an amount paid to any taxpayer other than the insured, if such taxpayer has an insurable interest by reason of the insured being a director, officer or employee of the taxpayer. Also, they do not apply if the insured has a financial interest in any trade or business carried on by the taxpayer.

Effective Date: This section applies to amounts received after December 31, 1996.

Sec. 332. Tax Treatment Of Companies Issuing Qualified Accelerated Death Benefit Riders.

For purposes of life insurance company taxes, a life insurance contract is treated as including a reference to a qualified accelerated death benefit rider to a life insurance contract (except in the case of any rider that is treated as a long-term care insurance contract). A "qualified accelerated death benefit rider" is any rider on a life insurance contract that provides only for payments that can be excluded from income under Sec. 331.

Effective Date: This provision takes effect on January 1, 1997.

Issues for the States:

1. What laws (e.g., the Viatical Settlements Model Act and Viatical Settlements Model Regulation or similar or related legislation or regulations) does the state currently have relating to accelerated death benefits or viatical settlements?

2. If the state laws are based upon the NAIC's Viatical Settlements Model Act and Viatical Settlements Model Regulation adopted in 1993 and 1994, respectively, the
state would probably not have to take further action to comply with these sections of the Act.

3. If there are no state laws in this area, or if the laws fall short of the federal standards, in order to be qualified, a viatical settlement provider would still have to comply with specified sections of the Viatical Settlements Model Act and Model Regulation with respect to payments for the chronically ill, and either state licensure requirements or specified NAIC requirements with respect to the terminally ill insureds. If there are no state standards, the Department of Treasury would be the sole enforcer of these requirements.

4. A state with additional standards that did not conflict with the Viatical Settlements Model Act and Model Regulation need not revise its laws.

5. The following implementation question has been raised by a state. We have included the NAIC staff’s initial response/interpretation, which is subject to member comment and revisions:

Q: Does the Act contain any specification with respect to the time period over which the benefits can or must be paid?

A: A qualified viatical settlement provider must comply with applicable state law or with sections 8 and 9 of the NAIC’s Viatical Settlements Model Act.

B. Deductions for Self-Employed

Summary: The Act increases the deductions self-employed individuals are allowed to claim for the amounts paid during the taxable year for health insurance for the taxpayer, his or her spouse and dependents. The increase in deductions will be phased in over a 10-year period. The deduction is currently 30 percent. The deduction increases according to the following schedule:

<table>
<thead>
<tr>
<th>Year</th>
<th>Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>40 percent</td>
</tr>
<tr>
<td>1998-2002</td>
<td>45 percent</td>
</tr>
<tr>
<td>2003</td>
<td>50 percent</td>
</tr>
<tr>
<td>2004</td>
<td>60 percent</td>
</tr>
<tr>
<td>2005</td>
<td>70 percent</td>
</tr>
<tr>
<td>2006 and thereafter</td>
<td>80 percent</td>
</tr>
</tbody>
</table>

In addition, the Act amends the Internal Revenue Code of 1986 to clarify the kind of arrangements from which payments are received that trigger deductions. Self-employed individuals who receive payments through accident or health insurance may exclude such payment from gross income. Payments received through arrangements “having the effect of accident or health insurance” may also be excluded. In other words, payments
that are received through arrangements other than traditional commercial insurance arrangements which have the characteristics of an insurance arrangement, such as self-funded arrangements, are treated the same under this provision as a traditional commercial insurance arrangement.

These provisions apply to taxable years beginning after December 31, 1996.

**Issues for States:**

State laws do not apply to any of these provisions related to federal tax deductions for self-employed individuals.

**APPENDIX: DEFINITIONS**

The following Appendix sets forth some key definitions contained in the federal law and compares them to the identical or comparable definitions in the relevant NAIC models.

Section references refer to the relevant title of the federal law and to the relevant provision of either ERISA or the Public Health Service Act (PHSA) that is amended by the federal law. For example, Section 101/ERISA Section 701 refers to Section 101 of the law and to Section 701 of ERISA, which is the ERISA Section added or amended by the federal law.

1. **Affiliation Period**

Fed. law: Section 101/ERISA Section 701:

Affiliation Period.--
(A) Defined.--For purposes of this part, the term ‘affiliation period’ means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning.--Such period shall begin on the enrollment date.

(C) Runs Concurrently with Waiting Periods.-- An affiliation period under a plan shall run concurrently with any waiting period under the plan.

Fed. law: Section 102/PHSA Section 2701(g)(2):

Identical to ERISA Section definition.

NAIC Models: Not defined.
2. Bona Fide Association

Fed. law: Section 102/PHSA Section 2791(d):

Bona Fide Association. -- The term ‘bona fide association’ means, with respect to health insurance coverage offered in a State, an association which--
(A) has been actively in existence for at least 5 years;
(B) has been formed and maintained in good faith for purposes other than obtaining insurance;
(C) does not condition membership in the association on any health status-relating factor relating to an individual (including an employee of an employer or a dependent of an employee);
(D) 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);
(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and
(F) meets such additional requirements as may be imposed under State law.

1992 NAIC Small Employer Model

Not defined.

1995 NAIC Small Employer Model

Not defined.

1996 NAIC Availability Model Act: Sections 3BB and 3CC:

The defined terms are “professional association” and “professional association plan.”

“Professional association” means an association which 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;

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(5) Is not owned or controlled by a carrier or affiliated with a carrier;

(6) Does not condition membership in the association on health status or claims experience;

(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 regardless of health status or claims experience;

(9) Is governed by a board of directors and sponsors annual meetings of its members; and

(10) 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.

“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) 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.

1996 NAIC Portability Model

The relevant terms are “professional association” and “professional association plan.” The definition of “professional association” is identical to that in the Availability Model. The definition of “professional association plan” is essentially identical to that in the Availability Model but contains two drafting notes not in the Availability Model.

3. Creditable Coverage

Fed. law: Section 101/ERISA Section 701(b):

(1) Creditable Coverage Defined. -- For purposes of this part, the term ‘creditable coverage’ means, with respect to an individual, coverage of the individual under any of the following:
(A) A group health plan.
(B) Health insurance coverage.
(C) Part A or part B of title XVIII of the Social Security Act.
(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
(E) Chapter 55 of title 10, United States Code.
(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.
(I) A public health plan (as defined in regulations).
(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)). Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 706(c)).

(2) Not Counting Periods Before Significant Breaks in Coverage. --
(A) In General. -- 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 63-day period during all of which the individual was not covered under any creditable coverage.
(B) Waiting Period Not Treated as a Break in Coverage. -- For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

Fed. law: Sections 102 and 111/PHSA Sections 2701(c) and 2741(b).
Identical to definition in ERISA section.

1992 NAIC Small Employer Model: Section 3W

Terms used are “qualifying previous coverage” and “qualifying existing coverage.”

“Qualifying previous coverage” and “qualifying existing coverage” means benefits or coverage provided under:

(1) Medicare or Medicaid;
(2) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or
(3) An individual health insurance policy (including coverage issued by a health maintenance organization, [insert appropriate reference for a prepaid hospital or medical care plan] and [insert appropriate reference for a fraternal benefit society]) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one year.

1995 NAIC Small Employer Model: Section 3V

Terms used are “qualifying previous coverage” and “qualifying existing coverage.”

“Qualifying previous coverage” and “qualifying existing coverage” mean benefits or coverage provided under:

(1) Medicare, Medicaid, CHAMPUS, Indian Health Service program or any other similar publicly sponsored program;
(2) A group health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or
(3) An individual health insurance policy (including coverage issued by a health maintenance organization, [insert appropriate reference for a prepaid hospital or medical care plan] and [insert appropriate reference for a fraternal benefit society]) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan.

Drafting Note: It may be desirable to grant the commissioner rulemaking authority to further define that coverage which falls within the definition above.

NAIC 1996 Availability Model Act: Section 3EE

(1) “Qualifying previous coverage” and “qualifying existing coverage” mean benefits or coverage provided under:
(a) Medicare, Medicaid, Civilian Health and Medical Program for Uniformed Services (CHAMPUS), Indian Health Service program or any other similar publicly sponsored program;

(b) A group health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) An individual health insurance policy, a professional association plan or a converted policy (including coverage issued by a health maintenance organization, [insert appropriate reference for a prepaid hospital or medical care plan] and [insert appropriate reference for a fraternal benefit society]) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan.

(2) “Qualifying previous coverage” and “qualifying existing coverage” do not mean benefits or coverage provided under self-funded health plans, including plans covered under the Employee Retirement Income Security Act (ERISA), unless those plans provide for the same waiver of waiting periods applicable to a preexisting exclusion or limitation period for the period of time an individual was covered by qualifying previous coverage as required in Section 7E(2) of this Act.

**Drafting Note:** It may be desirable to grant the commissioner rulemaking authority to further define that coverage which falls within the definition above.

NAIC 1996 Portability Model Act: Section 3Z

“Qualifying previous coverage” or “qualifying existing coverage” mean benefits or coverage provided under any of the following:

(1) Medicare, Medicaid, Civilian Health and Medical Program for Uniformed Services (CHAMPUS), Indian Health Service program or any other similar publicly sponsored program;

(2) Any group health insurance, including coverage issued by a health maintenance organization, [insert appropriate reference for a prepaid hospital or medical service plan] or [insert appropriate reference for a fraternal benefit society], that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, provided that the coverage has been in effect for a period of at least one year;

(3) A self-funded employer sponsored health benefit plan that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, provided that the coverage has been in effect for a period of at least one year if:

(a) the employer has elected to voluntarily participate in the Individual Health Benefit Plan Association pursuant to Section 11 of this Act; and
(b) the employer has complied with the requirements regarding participation as set forth in the plan of operation of the Individual Health Benefit Plan Association.

(4) An individual health insurance benefit plan or a professional association plan including coverage issued by a health maintenance organization, [insert appropriate reference for a prepaid hospital or medical service plan] or [insert appropriate reference for a fraternal benefit society] that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, if the coverage has been in effect for a period of at least one year; or

(5) Any state’s coverage provided under a plan similar to the NAIC Model Health Plan for Uninsurable Individuals Act if the coverage has been in effect for a period of at least one year;

**Drafting Note:** States are strongly urged to study their high risk pools by examining the claims costs and history of the individuals residing in the pool. If the results of the study indicate that residence of longer than one year in the high risk pool is necessary to avoid potential negative effects on the private individual market, states should change the one year period above to a longer time period. States may also want to consider a transition period regarding the exit of all people eligible to leave the high risk pool at the end of the first year period, to avoid a large “dump” of potentially high claim cost individuals into the private individual market simultaneously.

### 4. Eligible Enrollment Period

Fed. law: Sec. 101/ERISA Sections 701(b)(2) and 701(d)(1):

These sections don’t explicitly define “eligible enrollment period” but make clear that the minimum period is 30 days. See Sec. 101/704(b), which references sections 701(b)(2) and 701(d)(2).

Fed. law/PHSA

Same as ERISA provisions: See Sec. 102/PHSA section 2723(b), which references PHSA sections 2701(b)(2) and 2701(d)(1).

### 5. Employer Contribution Rule

Fed. Law: Section 102/PHSA Section 2711(e)

(2) Rules Defined.--For purposes of paragraph (1)--
(A) The term ‘employer contribution rule’ means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and
(B) the term ‘group participation rule’ means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

6. Group Health Plan

Fed law: Section 101/ERISA Section 706:

Group Health Plan. -- For purposes of this part--

(1) In General. -- The term ‘group health plan’ means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2)) 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) Medical Care. -- The term ‘medical care’ means amounts paid for--

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and
(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

Fed Law: Section 102/PHSA Section 2791:

Identical to ERISA definition.

NAIC Models: Do not use this term.

7. Health Insurance Issuer

Fed. law: Section 101/ERISA Section 706(b)(2):

Health Insurance Issuer. -- The term ‘health insurance issuer’ means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)). Such term does not include a group health plan.

Fed. law/: Section 102/PHSA Section 2791(b):
Identical to ERISA definition.

1992 NAIC Small Group Model: Section 3F:

“Carrier,” not “health insurance issuer,” is used.

“Carrier” means any entity that provides health insurance in this state. For the purposes of this Act, carrier includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

[Also contains a Drafting Note: re: MEWAs.]

1995 NAIC Small Group Model: Section 3F:

“Carrier” or “small employer carrier,” not “health insurance issuer,” is used.

“Carrier” or “small employer carrier” means all entities licensed, or required to be licensed, by the Department of Insurance that offer health plans covering eligible employees of one or more small employers pursuant to this Act. For the purposes of this Act, carrier includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

1996 NAIC Availability Model: Sections 3F and 3MM:

“Carrier” and “small employer carrier,” not “health insurance issuer,” are used.

“Carrier” means any 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.

“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 sitused out of state.

[Also contains a Drafting note re: MEWAs.]
1996 NAIC Portability Model: Sections 3G and 3R:

“Carrier” and “individual carrier,” not “health insurance carrier,” are used.

Definition of “carrier” is essentially identical to the definition in the Availability Model, except that “carrier” is defined to include the phrase “health carrier.”

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

8. Health Maintenance Organization

Fed. law: Section 101/ERISA Section 706

Health Maintenance Organization.--The term ‘health maintenance organization’ means--
(A) a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),
(B) an organization recognized under State law as a health maintenance organization, or
(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Fed. law: Section 102/PHSA Section 2791(b)(3)

Identical to ERISA definition.

The NAIC small employer and individual models do not define “health maintenance organization.” It is defined in the NAIC’s Health Maintenance Organization Model Act.

9. Health Status-Related Factor

Fed. law: Section 101/ERISA Section 702

(a) In Eligibility to Enroll (sic)
(1) In General.--Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:
(A) Health status.
(B) Medical condition (including both physical and mental illnesses).
(C) Claims experience.
(D) Receipt of health care.
(E) Medical history.
(F) Genetic information.
(G) Evidence of insurability (including conditions arising out of acts of domestic violence).
(H) Disability.

10. Late Enrollee

Fed. law: Section 101/ERISA Section 701(b)

Late Enrollee.-- The term ‘late enrollee’ means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during--
(A) the first period under which the individual is eligible to enroll in the plan, or
(B) a special enrollment period under subsection (f).

Fed. law: Section 101_/ERISA Section 701(f)

Special Enrollment Periods.--
(1) Individuals Losing Other Coverage.--A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:
(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.
(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.
(C) The employee’s or dependent’s coverage described in subparagraph (A)--
(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or
(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.
(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For Dependent Beneficiaries.”
(A) In General.--If-
(i) a group health plan makes coverage available with respect to a dependent of an individual,
(ii) the individual is a participant under the 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
(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,
the group health plan 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 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 such spouse is otherwise eligible for coverage.
(B) Dependent Special Enrollment Period. -- A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin 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 (as the case may be) described in subparagraph (A)(iii).
(C) No Waiting Period.--If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become 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 such birth; or  
(iii) in the case of a dependent’s adoption or placement for adoption, the date of such adoption or placement for adoption.

Fed. law: Sec. 102/PHSA Section 2701(b):

Identical to ERISA provisions.

1992 NAIC Small Employer Model: Section 3Q:

“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. However, an eligible employee or dependent shall not be considered a late enrollee if:
(1) The individual meets each of the following:  
(a) The individual was covered under qualifying previous coverage at the time of the initial enrollment;  
(b) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse or divorce; and  
(c) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage;
(2) 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; or
(3) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee’s health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

1995 NAIC Small Employer Model Act: Section P:

“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. However, an eligible employee or dependent shall not be considered a late enrollee if:

(1) The individual meets each of the following:

(a) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(b) The individual lost coverage under qualifying previous coverage as a result of cessation of employer contribution, termination of employment or eligibility, involuntary termination of the qualifying previous coverage, or death of a spouse or divorce; and

(c) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage or the change in conditions that gave rise to the termination of coverage.

(2) Where provided for in contract or where otherwise provided in state law, the individual enrolls during the specified bona fide open enrollment period;

(3) 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;

(4) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee’s health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order; or

(5) 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.

1996 NAIC Availability Model Act: Section 3V:

Identical to the 1995 Small Employer Model.
Not defined because not applicable.

11. Network Plan

Fed. Law: Section 102/PHSA Section 2791(d):

Network Plan.--The term 'network plan' means health insurance coverage of a health insurance issuer 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 issuer.

The NAIC small employer and individual models do not define "network plan."
The draft Managed Care Plan Network Adequacy Model Act defines "network" and "managed care plan."

12. Preexisting Condition Exclusion

Fed. Law: Section 101/ERISA Section 701(b):

(A) In general. -- The term 'preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of Genetic Information. -- Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

Fed/ Law: Section 102/PHSA Section 2701(b):

Identical to ERISA definition.

Fed Law.: Section 111/PHSA Section 2741

References PHSA Section 2701(b)(1)(A).

1992 NAIC Small Employer Model

Not defined, but Section 8C provides:
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 twelve (12) months following the effective date of the individual’s coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

(a) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;

(b) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or

(c) A pregnancy existing on the effective date of coverage.

1995 NAIC Small Employer Model

Not defined, but Section 7C(1) and (3) provide:

(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 effective date of the individual’s coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

(3) A health benefit plan may exclude coverage for late enrollees for preexisting conditions for a period not to exceed twelve (12) months.

1996 NAIC Availability Model: Section 3Y:

“Preexisting condition” means a 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 effective date of coverage. A condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held qualifying previous coverage and that was a covered benefit under the plan shall not be considered a preexisting condition, provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage.

1996 NAIC Portability Model: Section 3T:
"Preexisting condition" means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months preceding the effective date of coverage. A condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held qualifying previous coverage and that was a covered benefit under the plan shall not be considered a preexisting condition, provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of coverage.

13. Small Employer

Fed. Law: Section 102/PHSA Section 2791(d):

Small Employer.--The term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

Small Group Market.--The term 'small group market' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

1992 NAIC Small Employer Model: Section 3BB:

“Small employer” means any person, firm, corporation, partnership or association 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 twenty-five (25) eligible employees, the majority of whom were employed within this state. 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 state taxation, shall be considered one employer.

Drafting Note: States may wish to consider a different threshold number of employees for the purposes of defining “small employer,” depending on the underwriting and marketing practices in the state and other relevant factors.

1995 NAIC Small Employer Model: Section 3CC:

“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, 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.

Drafting Note: 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, such as renewability unlimited by size related eligibility standards, or extending the employer's right to renew to its second plan anniversary date following the date the small employer no longer meets the size requirements of that definition.

1996 NAIC Availability Model: Section 3LL:

"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 3K, 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.]

Drafting Note: 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, such as renewability unlimited by size related eligibility standards, or
extending the employer’s right to renew to its second plan anniversary date following the date the small employer no longer meets the size requirements of that definition.

1996 NAIC Portability Model

Not defined because not applicable.