June 20, 2003

Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance

Based on NAIC Model Acts and Regulations
TO: All NAIC Members and Other Interested Parties in Small Employer and Individual Health Insurance Rate Filings

FROM: Michael Batte, Chair
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Life and Health Actuarial Task Force

DATE: November 2003


Attached is the latest version of the compliance manual for use in the review for small employer and individual health insurance policies. The manual was produced under the direction of the Accident and Health Working Group of the Life and Health Actuarial Task Force.

The manual was initially produced to provide assistance to the states in their rate review activities for small employer health insurance. The 1997 version was expanded to include guidance for various NAIC small employer models as well as NAIC models for individual health insurance. The 2003 version has now been expanded to include reference to the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

It should be emphasized that this manual is intended only to provide guidance as to reasonable interpretations of the model acts and regulation as they pertain to rating issues, and that it is not in any way intended to be binding on any state.

The working group welcomes comments on the manual. Those comments should be forwarded to the attention of Dennis Hare, Associate Life/Health Actuary, NAIC at the Kansas City address or dhare@naic.org.
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I. INTRODUCTION

This manual is intended to be used to evaluate compliance with the rating aspects of the following:

NAIC Model Acts

- Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups;
- Small Employer Health Insurance Availability Model Acts (Prospective Reinsurance With or Without an Opt-Out and Allocation With or Without an Opt-Out (1993 and 1995 versions)
- Small Employer and Individual Health Insurance Availability Model Act
- Individual Health Insurance Portability Model Act

Model Regulation

- Model Regulation to Implement the Small Employer Health Insurance Availability Model Act (1993 version)

The direct application of this rating guidance manual is limited to those states which have passed one of the Model Acts without modification. However, many aspects of the manual may apply to states which have modified the Model Acts, and other portions may be readily adaptable to fit such modifications. No attempt will be made in this manual to describe such modifications, however. Of course, in cases where any portion of this manual is inconsistent with an actual law or regulation of a state, such law or regulation would prevail.

Under the Model Acts, health insurance carriers are required to make an annual filing to the insurance department. In addition, they are required to maintain certain documentation which is not to be filed with the department in order to maintain confidentiality reflecting the proprietary nature of the information. For the purposes of verifying compliance, it is assumed that the examiner will have both sets of information available.

While the manual is written for the examiner of an insurance department, it is anticipated that insurance carriers will review this material in order that they may maintain appropriate information to make the compliance verification process as expeditious as possible. Therefore, the examiner should not be surprised if a carrier follows the manual directly. Of course, the examiner must be alert for practices or documentation which seem to be designed to circumvent the Model Acts, Model Regulations or this manual.
OVERVIEW OF REVIEW PROCESS

The rating requirements and review can be divided into 3 parts:
1. Procedural requirements
2. Allowable rating design
3. Accurate implementation of rating design into rates

This manual addresses each of these areas.

1. Procedural requirements

The sections on documentation, disclosure, and actuarial certifications deal with these issues. Not only must the rates be within applicable limits but the carrier may be required to have evidence that these rates are based on accepted actuarial practices and sound actuarial principles. Analysis of the methods used to determine the rates can be very useful to prevent “gaming.”

2. Rating design

Each section on the specific model details the allowable rating design for each model. One important factor for the examiner to consider is the scope of the rating law. The examiner should test that all policy forms have been analyzed for inclusion or exclusion under the rating laws. A reconciliation of annual statement premiums to coverages may be useful in detecting business inappropriately excluded from the rating analysis.

3. Accurate implementation of rating design into rates

Sufficient sampling should be done to ensure that the actual rates charged are in agreement with the documentation. The examiner should also review the rate quoting process to ensure that excessive rate quotes are not made that would be outside the allowable rating limits.

CAVEAT

While this manual is intended to be reasonably comprehensive, it is impossible to anticipate every possible set of circumstances. Therefore, it must be emphasized that this manual is only one of a number of tools and source references which should be used in testing compliance with the Model Acts. The appropriate Model Act itself and any related laws and regulations are critical source references with which the examiner must be familiar. Another important reference is the actuarial certification, which will be discussed in detail in Section III of this manual. An important resource is the examiner’s judgment. The reader of this manual should keep in mind that appropriate judgment is an important element of each and every step of the tests discussed herein. In particular, there are certain to be circumstances wherein a guideline requirement may not apply. This manual should not be considered to be a limit on other appropriate actuarial methodologies. On the other hand, a major concern in the regulation of health insurance is what is commonly referred to as “gaming,” that is, the insurer operating strictly within the letter of the law, but pushing the limits and definitions beyond common sense. The examiner should be aware
of the potential for such gaming, and evidence of gaming should be investigated thoroughly. The examiner should look for consistent rules applied in a consistent manner.

Section II provides a description of the health insurance environment. Section III concerns the evaluation of the actuarial certification. Sections IV-VI discuss the analysis of the required documentation, disclosure of the carrier’s rating practices, and other data required to verify compliance. General issues are discussed in Section VII. Following that are Sections VIII - XI which address the specifics of the various models. Appendix A contains copies of the Model Acts. Appendix B contains copies of the Model Regulations. Appendix C is a chart summarizing the rating provisions of the various models.
II. HEALTH INSURANCE ENVIRONMENT

A. THE SMALL EMPLOYER HEALTH INSURANCE MARKET

Historically, the small employer health insurance market was defined as encompassing the market from three employees through twenty-five. Some carriers issued group coverage to employers with as few as one employee; conversely, some of the techniques used in the small employer market were often used with groups up to 50 or even 100 employees. The Federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) defines a small employer group to be one having between two and fifty employees. Some states have passed laws that extend the definition of a small employer to those that have as few as one employee and to those that have as many as 100 employees. (See Section II.D for additional information concerning HIPAA.)

The line between individual and group coverage is not always clear, with some individual products sold on a group basis and some group policies sold to individuals. The Model Acts apply to insurance sold to employers of certain size categories, however, and therefore are independent of the actual insurance vehicle used.

Carriers should implement some means for periodically determining that individual health policies are not being inappropriately incorporated into small employers’ health plans. While it is unreasonable to expect the carrier to prove 100% certainty that no individual policy is being incorporated into a group health plan, the examiner should be satisfied that a “good faith” effort is being made on the carrier’s behalf. “Good faith” efforts by the carriers might include such things as annual questionnaires included in the billings asking whether or not insureds are aware if their policy is being incorporated into an employer’s health benefit plan. Also, periodic questionnaires sent to agents might be a sign that the carrier is making a reasonable attempt to comply with statutory requirements. In the end, the examiner may have to exercise a great deal of personal judgment in deciding what constitutes acceptable efforts by the carrier.

Scope

The Model Acts apply to any insurance offered under a health benefit plan, including traditional indemnity plans, pre-paid service plans, and HMOs, that provides coverage to the employees of a small employer if any of the following conditions are met:

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

It is possible that individual policies sold to small employers could be subject to the Model Acts. It should also be noted that, with the exception of certified HMOs, carriers that are affiliated companies are to be treated as one carrier in application of the Model Act provisions.

**Marketplace**

The predominance of small employer health insurance is sold through multiple employer trust (MET) vehicles. This means that a master contract is issued to a trust, and that the employers buying through the trust do not receive separate group contracts. The MET market is characterized by large third party administrators (TPAs) who often perform much of the administration of the product such as billing and collection of premium and claims adjudication and often do much of the marketing, at least to brokers who then sell to the groups.

The small employer market is also serviced by carriers who sell to members of certain business associations. These products tend to be sold to a mini-group market (less than five employee lives). While the MET vehicles usually offer comprehensive coverage policies, the association group policies often offer catastrophic hospital/surgical coverage with optional outpatient medical riders.

Following the implementation of HIPAA there was a dramatic decline in the number of carriers participating in the small employer health insurance market.

**Maternity**

A key benefit which varied considerably in the small group market was maternity coverage. The presence of maternity coverage and/or the limitations imposed on the benefit were highly correlated to employer group size. Federal law mandated that maternity be treated the same as any illness for employers with 15 or more employees. For groups of 14 and fewer employees, the coverage was usually an optional benefit and often was very limited, such as having a waiting period before coverage was effective or placing a maximum cap on the benefits (e.g., $2,500). For mini-groups of under 5 employees, maternity coverage was not always available. However, this began to change as states adopted small group access laws that required maternity coverage as part of the basic and standard plans which carriers were required to make available on a guaranteed issue basis. Additionally, HIPAA does not allow insurance carriers to offer and accept some employers for certain products and not others. (See Section II.D for additional information concerning HIPAA.)

**Underwriting**

On the administrative side, a critical function for keeping premiums competitive has typically been underwriting. Because of the risk of adverse selection to carriers operating in this market, underwriting or risk selection was generally performed carefully. Clearly, with a group of three
employees there was a much greater deviation from expected levels if one of the employees was unhealthy than in a group of 1,000 employees with one unhealthy employee. In addition to the initial underwriting, when a claim came in, a carrier may have looked for a pre-existing condition or inaccurate information on the employee application. When significant application irregularities were found, a practice known as rescission may have been exercised. This means that coverage was rescinded from issue. Premiums were refunded less any claims which had already been paid and the contract was considered null and void from inception.

The degree of underwriting in the small group market varied, depending upon the size of the group, carrier practice and the existence of guaranteed issue requirements. For the mini-group market, detailed individual employee applications were usually required requesting such information on medical conditions and medical history of each person to be insured to allow the carrier to accept, reject, or issue with substandard limits or rate-ups each group and individuals within the group. Like individual insurance, some mini-group carriers also required Attending Physician Statements (APS) and used the Medical Information Bureau (MIB) to verify the application declarations. As employee group size increased the underwriting requirements often tended to be less stringent, moving from what was essentially individual underwriting to case underwriting where the entire case was either accepted or rejected, and the health status of individual employees was not considered. The types of underwriting varied from full medical (as is common for very small groups) to guaranteed issue. Short form underwriting was in between the two extremes and was more typical as group size increased.

Under the guaranteed availability provisions of HIPAA, which became effective July 1, 1997, carriers are not allowed to reject groups or individuals within the group nor rate individuals within the group differently. (See Section II.D for additional information concerning HIPAA.) Underwriting is still used. Underwriting now might focus on participation requirements, e.g. minimum employer contribution requirements or minimum employee participation requirements.

**Rating Practices**

Because pre-existing condition exclusions and initial underwriting tended to reduce claim costs in the early policy years, carriers were able to reduce rates for new business to very low levels relative to that required for a mature book of small group business. This practice generated strong competition based on price. In fact, the small employer marketplace was quite price sensitive. As a result, carriers tended to use durational rating. That is, a new case received a lower rate than a case that had been on the books for two or three years, unless the group was re-subjected to underwriting and pre-existing condition exclusions. If a group stayed with the same carrier for a number of years, its rates increased with duration for the first two or three years even above medical cost trends.

Another practice commonly used in the small group market was tier rating. Under this practice, the level of claims of a particular group established the tier in which the group’s rates fell. While there were many appropriate uses of this technique, it was used in certain instances to give exorbitantly high rate increases to groups with significant claims, particularly where claims were expected to be ongoing. In such instances, carriers were accused of trying to run off bad business.

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**Impact of HIPAA on Rating Practices**

In addition to prohibiting underwriting individual insureds at issue, HIPAA prohibits carriers from imposing a pre-existing condition waiting period or other similar exclusion on insureds with prior credible coverage. Therefore, since the advent of HIPAA, claim costs are much flatter by policy year duration.

**Intent of Rating Requirements**

Excessive durational and tier rating came to be recognized by regulators and the public, and even by most carriers, as contrary to public interest. However, carriers were almost forced to pursue these practices because of the stiff competition for new business and the adverse selection implications which would have otherwise occurred on business in force. The intent of the rating requirements is to limit the spread between the lowest rates offered and the highest rates which can be offered. While it is recognized that this will have the tendency to increase new business rates, it should also increase the stability of year-to-year increases relative to the average increase, thereby achieving a broader pooling of risks.

**B. THE INDIVIDUAL HEALTH INSURANCE MARKET**

**Definition**

In this guide and the corresponding Model Acts, individual health insurance means insurance against medical and hospital expenses offered to individuals. As such, it encompasses a range of coverages provided by different types of entities through various types of marketing and sales arrangements. An individual can obtain coverage from an insurance carrier, a Blue Cross organization, health maintenance organization or some other type of organization. The coverage itself can be based on fee-for-service compensation to any provider, full capitation to a network of providers, or something which falls between these two arrangements. The types of coverages available range from short-term medical insurance to high deductible coverages.

**Underwriting**

Underwriting has historically been used in individual insurance to determine if coverage should be offered, and to determine the appropriate premium to charge in light of the applicant’s medical history and current medical status. Compared to group insurance, individual underwriting has traditionally been more stringent, requiring more information and more verification of information than has been the case with group insurance. This has been necessary to minimize any possible anti-selection on the part of applicants, a greater likelihood with individual insurance.
Marketplace

Over the last three decades the market for individual health insurance has changed substantially. New types of entities now provide coverage to individuals, and the benefits provided have changed markedly as well. Benefits are now more comprehensive, both in the types of services that are covered and in the amounts that are paid for services. For example, lifetime maximum benefits of $2 million dollars are now available, while annual out-of-pocket maximums are also now common.

Like group insurance, the individual health insurance market has been markedly affected by the large increases in health care costs experienced from the 1970’s through the early 1990’s. These cost increases exerted upward pressure on premiums while at the same time decreasing the profitability of this line of business for many insurance companies. Insurers and the insured have responded in various ways. The insurers have introduced cost control measures, such as treatment pre-certification and the establishment of preferred provider networks. More rigorous underwriting has also been a response. The insureds have responded by moving toward managed care coverages, or to coverages with higher copayments and deductibles.

Also at least a partial result has been a reduction in the size of the market for individual health insurance, both in terms of the number of companies offering it, and in terms of the proportion of persons covered by individual insurance.

Scope

Two of the Model Acts address individual health insurance matters: The Small Group and Individual Health Insurance Availability Model Act, and the Individual Portability Model Act. The Availability Act requires insurers to issue any benefit plan they offer to any individual who applies for the plan, provided the individual is not eligible for other public or private coverage (except conversion plans). A “basic” or “standard” plan must be offered to the individual, but they are not limited to buying such plans. The form and level of benefits for available plans are to be recommended by an appointed Health Benefit Plan committee, composed of representatives from carriers, small employers and employees, individuals eligible for guaranteed issue, and health providers. For “basic” and “standard” plans, the Committee is further required to develop recommendations for coverage limitations and cost sharing levels. These recommendations for “basic” and “standard” plan coverages are to be submitted to the commissioner for approval.

The provisions of the Portability Act are somewhat limited. The Act requires insurers to issue a “basic” or “standard” health benefit plan to individuals previously covered under private insurance, government programs, a self-insured employer plan, or a high risk pool who are not eligible for any other coverage (private or public), and who apply for coverage within 31 days after losing the previous coverage. The individual may choose between these two plans, except if his previous coverage had lesser benefits than the “standard” plan. In that case, only the “basic” plan is required to be offered. The form and level of coverage for “basic” and “standard” plans are set by the commissioner, subject to the requirement that benefits be similar to those required...
under the NAIC Small Employer Health Insurance Availability Act, adjusted to reflect the circumstances of the individual market.

**Intent of Rating Requirements**

The intent of the Model Acts with regard to individual health insurance premiums is similar to the intent for small employer group insurance: to limit the spread between the lowest and highest rates offered. The specific provisions for limitations on premiums differ between the Availability Act and the Portability Act. These will be discussed in the Sections dealing specifically with these Acts.

**C. DIFFERENCES AMONG MODEL ACTS**

Several models have been developed over the years addressing small employer health insurance. What is commonly referred to as the Rating Model Act (Model 115) was approved by the NAIC in December 1990. A year later, the two Access Model Acts (Models 116 and 118) were approved. These Access Model Acts incorporated rating requirements similar, but not identical, to those of the Rating Model Act. From a regulatory standpoint, certain practices which may not be specifically excluded might be subject to a test of actuarial reasonableness under the Rating Model Act. However, under the Access Model Acts, some practices may be held to be in noncompliance because they would have the effect of limiting access. Other than that, changes made in the rating aspects of the Access Model Acts were generally intended to clarify the intent under the Rating Model Act. Therefore, in testing compliance for these models, the actual wording of the Access Model Acts has generally been used. Model Act 118 was revised in 1995 and the revised version was termed “The Small Employer Health Insurance Availability Model Act.” Revisions were extensive and included requiring adjusted community rating and expanding the model to encompass small groups of one.

In 1996, two alternative models were developed that addressed individual health insurance. The desire was to provide a choice for the states in selecting a model concerning individual health insurance. One model, Model 35, was known as “The Small Employer and Individual Health Insurance Availability Model Act.” This model contained sections addressing small employer health insurance and individual health insurance. The sections pertaining to small employer health insurance were similar to comparable sections in the Small Employer Health Insurance Availability Model Act. Corresponding sections were added to address individual health insurance. The second model, Model 37, was known as “The Individual Health Insurance Portability Model Act.” This model addressed only the regulation of individual health insurance and did not address small employer health insurance. The provisions for individual health insurance in this model were completely different than the individual provisions in the Small Employer and Individual Health Insurance Availability Model Act. This model was initially patterned after an existing statute in one of the states.

In 2000, revisions to Model Acts 118, 35 and 37 were adopted so that the Model Acts meet HIPAA’s requirements. Model Acts 115 and 116 were not updated to reflect HIPAA and are no longer supported by the NAIC.
Appendix A contains copies of the Model Acts for the examiner’s reference. Appendix B contains copies of the associated Model Regulations. Appendix C is a chart summarizing the rating provisions of the various models.

While this guidance manual is limited to rating and is not intended to address reinsurance programs, the examiner should note that rating tests relative to the basic and standard plans, as defined by the state in question, will be of particular importance.

D. THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, H.R. 3103 ("HIPAA") provides a federal framework for reforms of the employer group and individual markets. Pursuant to the provisions of HIPAA relating to availability of coverage, 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 individuals first become eligible under the terms of the group health plan, in accordance with the terms of the plan and state law. The Act also contains provisions relating to individual market reforms. The individual market reforms may vary from state to state as the Act affords the states significant flexibility in implementing these reforms.

NAIC Model Acts, as well as this manual, have been revised so that they are consistent with the federal law. A description of the provisions of HIPAA and issues for the states to consider in implementing HIPAA may be found in the NAIC Draft Template for State Implementation of the Health Insurance Portability and Accountability Act of 1996.
III. EVALUATING THE ACTUARIAL CERTIFICATION

The actuarial certification is a most important resource in monitoring compliance with the NAIC Model Acts. The examiner should not underestimate the importance of analyzing the actuarial certification, and should not hesitate to raise questions to the actuary who signed the certification.

This section addresses the following topics:

- Designations and Qualifications
- Actuarial Standards of Practice
- Actuarial Board for Counseling and Discipline (ABCD)
- Actuary’s Documentation
- Opinion Language
- Material Changes
- Certification Time Period

Designations and Qualifications

The first thing is to verify that the signatory is a member of the American Academy of Actuaries. Membership in the American Academy of Actuaries (M.A.A.A.) is a minimum requirement (unless the individual has been otherwise approved by the commissioner), but it should be noted that not all M.A.A.A.’s are qualified to perform all actuarial tasks. The American Academy of Actuaries has qualification standards which a member must satisfy in order to issue a statement of public opinion, such as an actuarial certification under the NAIC Model Acts. For example, an Enrolled Actuary, qualified by federal government standards to sign Form 5500s for pension valuations, may be eligible to be a member of the American Academy of Actuaries. However, that same actuary would clearly not meet the Academy’s general qualification standards with regard to signing the certification required under the NAIC Model Acts, unless the actuary had experience in the group health area and had met other educational requirements. The American Academy of Actuaries also has standards of practice, which may apply to various aspects of the work required to sign the actuarial certification.

Actuarial Standards of Practice

Precept 4 of the American Academy of Actuaries states “An actuary shall ensure that professional services performed by or under the direction of the actuary shall meet applicable standards of practice.” Several standards of practice apply to individual and small employer health ratemaking. Actuarial Standard of Practice No. 26 “Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans” specifically addresses certifications. While state law provides the basis for required practices, the standard provides useful information particularly in the areas of communication, documentation, and disclosure.
Actuarial Board for Counseling and Discipline

Of course, the examiner is not expected to be familiar with the specific qualification requirements or standards of practice that may apply. The actuarial profession established the Actuarial Board for Counseling and Discipline. If, after discussion with the actuary, the examiner has reason to doubt the actuary’s qualifications, the examiner should contact the ABCD in Washington, D.C., at (202) 223-8196, and request an investigation of the actuary’s qualifications. The ABCD will undertake review of the examiner’s request in accordance with its Rules of Procedure.

Actuary’s Documentation

The examiner should not hesitate to call the actuary to determine the level of testing which was performed by the actuary and to inquire as to the documentation supporting the formation of the actuary’s opinion with regard to the particular insurance carrier’s practices. It is not appropriate for an actuary to sign such a certification just based on general knowledge of the carrier’s practices without documenting the basis for the opinion. While the specific documentation may not necessarily be readily understandable to a non-actuary, verification of its existence is important if it has not been specified to the examiner’s satisfaction.

Opinion Language

Another important step in evaluating the actuarial certification is to carefully read the words to determine whether it is a clean opinion or a qualified opinion. A qualified opinion would normally use wording such as the following: “except for the matter referred to in the preceding paragraph...”. This is an indication that the information described in the preceding paragraph modifies the actuary’s opinion and in some manner weakens the certification. The examiner should carefully read any qualifying language and discuss the specific meaning of the qualification with the actuary. If the qualification is deemed to be material, it may be that the carrier has not complied with the requirements of the law. In other words, the practices which cause the actuary to qualify the opinion may indicate non-compliance. In other cases, the actuary may not have had sufficient time and/or budget to perform the testing necessary to issue an unqualified opinion. Again, this would be evidence that the carrier has not complied with the requirement to provide a certification.

Material Changes

The examiner should also look carefully for references in the actuarial certification to material changes in rating practices which have been implemented since the prior certification. The actuarial certification should make explicit note of such changes, so that it is clear that the actuary has determined the compliance of the new methodology with regulatory requirements. The Model Regulation requires that a carrier obtain the Commissioner’s approval prior to modifying a rating method. The examiner should verify that the Commissioner’s approval of the change in methodology was obtained.
Certification Time Period

The examiner should also review the timing of the certification. Generally the certification should cover a full twelve-month period. As part of the certification, the actuary should consider not only compliance over the last twelve month period, but also any subsequent or planned events or actions of which the actuary is aware that would place the carrier out of compliance.
IV. ANALYZING THE REQUIRED DOCUMENTATION

There is no doubt that, at least initially, companies will vary considerably in the level of detail which is provided in the required documentation maintained in the carrier’s office. Regardless of the level of detail provided, the examiners should carefully review all information and raise questions where appropriate.

It should be emphasized that a lack of detail does not necessarily imply non-compliance. There is a great variation among the different rating approaches used in practice, from computer controlled rating systems to simple community rating approaches. The level of detail provided in the documentation should be consistent with the complexity of the rating approach.

At a minimum, a carrier’s documentation should include the following; where relevant:

- A complete and detailed description of its rating practices and renewal underwriting practices. This should include any exceptions or variations which may be used for the business or any subset of the business for which rates are determined. Specifically, this description would include:
  - A copy of the benefit plan contracts and certificates.
  - Copies of the sales brochures and other materials for each benefit plan.
  - A copy of the rating manual.
  - Formulae for calculating any rate from the rating manual, including both new business rates and renewal rates.
  - Examples of application of the rating formulae to verify rates actually being charged.
  - A description of any material changes to previously reviewed benefit plan contracts and certificates which were not mandated by statute or regulation.

- Complete information concerning any policy fee, administrative charges or application charges which may apply, regardless of whether or not such fees or charges end up being remitted to the carrier, if such charges are allowed.

- Information and documentation that demonstrate that the carrier’s rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. This might include copies of appropriate sections of actuarial standards of practice, references to actuarial literature such as study notes and
transcripts of recorded sessions from actuarial meetings (published as *Transactions* or *Record* by the Society of Actuaries) or references to other such published material or information.

- A demonstration or explanation supporting the actuarial certification that the rates are in compliance with the rating laws. Some aspects of this are discussed further in the Additional Required Documentation portion of Sections VIII - XI of this manual. The examiner should keep in mind the confidential nature of material provided by the carrier, to the extent confidentiality is permitted by state laws and regulations.
V. RATING PRACTICES

A. DISCLOSURE

The carrier is required to make reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

- The provisions of the health benefit plan concerning the carrier’s right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

- The provisions relating to renewability of policies and contracts; and

- The provisions relating to any pre-existing condition provision.

Small Employer Health Insurance

The following additional disclosures are required for Small Employer Health Insurance:

- 1993 version of the Small Employer Health Insurance Availability Model Act:
  - The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents

- 1995 version of the Small Employer Health Insurance Availability Model Act and the Small Employer and Individual Health Insurance Availability Model Act:
  - A listing of and descriptive information, including benefits and premiums, about all benefit plans for which the small employer is qualified

Individual Health Insurance

The following additional disclosures are required for Individual Health Insurance:

- The Small Employer and Individual Health Insurance Availability Model Act:
  - A listing of and descriptive information, including benefits and premiums, about all benefit plans for which the eligible person is qualified

- The Individual Health Insurance Portability Model Act:
  - The extent to which premium rates are established or adjusted based upon rating characteristics (e.g., age, family composition, and geographic area)
All individual health benefit plans offered by the carrier, the prices of the plans if available to the eligible person, and the availability of the plans to the individual

The examiner needs to ascertain that appropriate elements have been included and to ask relevant questions. The examiner should also verify that the descriptions in sales materials are consistent with the contract and certificate language and comply with the law.

B. RATING PRACTICES

Small Employer Health Insurance

Some of the above provisions may be applicable only at renewal or in some instances may be applicable when additions or deletions are made to a group. Carriers may apply the per employee rate to the new number of employees. This is not considered a rate change. However, rates must be recomputed on the basis of the actual group census no later than the next policy anniversary.

Alternately, rates may be changed at a time other than the anniversary because of additions or deletions. The adjustment to the rate is subject to specific limitations.

- Case characteristic changes (1993 version of Small Employer Health Insurance Model Act).
- Benefit changes are allowed to be fully reflected in the new rates prior to an anniversary.
- If the change is considered an ‘early anniversary’ event, the change should include pro-rata trend and a pro-rata change to the existing percentage adjustment to base rates is allowed. For example, under the 1993 version of the Small Employer Health Insurance Model Act, if after six months a small group was changing to a new plan and was currently at the base rate for their existing plan, the limit for change to the base rate would be 7.5% (pro-rata share of the 15% per annum maximum).
- If the change is not considered an early anniversary, no change for trend or in the existing percentage adjustment to base rates or adjusted community rates is allowed until the anniversary processing.

The carrier must use a consistent method. Rates must be recomputed on the basis of the rate manual no later than the policy anniversary.

Individual Health Insurance

Under both the Availability and Portability Acts, premium rates may not be adjusted more often than annually except for changes in the composition of the individual insured’s family, or changes to the health benefit plan requested by the insured person.
In addition, the examiner should verify that these rating practices are actually being followed. To perform these tests, a sample should be chosen. For this sample, which should include active as well as terminated cases, the examiner should verify that the rating action taken is consistent with the rating practices disclosed by the carrier. Exceptions should, of course, be followed up and discussed with the carrier.
VI. OTHER DATA REQUIRED TO VERIFY COMPLIANCE

In addition to the actuarial certification, required documentation, and disclosure of rating practices, the examiner will want to request other data from the carrier in order to verify compliance. This data request will be based on an analysis of the items discussed in the last three sections. Additional data to be requested will depend on the findings of the review of the other information. However, at a minimum, the following additional items would normally be requested (if not provided as part of the other supporting documentation):

- actual rate tables in effect for the state during the time period being reviewed,
- certificates or contract forms,
- rating manuals,
- sales brochures and other solicitation materials,
- For small employer insurance, a statement disclosing which, if any, health benefit plans are currently available for purchase in each class (if classes are allowed under the Model Act) and any significant limitations related to the purchase of such plans.
- For individual insurance, a statement disclosing which individual health benefit plans are available for purchase by eligible individuals, as well as rating and renewability information about these health plans. In the case of an eligible individual under the Availability Act, the carrier is only required to disclose information about plans available to eligible individuals. In the case of an eligible individual under the Portability Act, the carrier is required to disclose all individual health benefit plans offered by the carrier, and which plans are available for guaranteed issue. Premium rate information is required to be disclosed only for plans available for guarantee issue.

In general, carriers will be expected to maintain hard copy documentation at least until the period in question has been examined, and in accordance with the Model Regulation.
VII. GENERAL ISSUES

A. SAMPLING TECHNIQUES

At various stages in the compliance testing process, it will be necessary to use samples of in-force business to test compliance with various elements of the rating requirements. These samples may consist of groups or individuals depending upon whether testing is for small employer or individual insurance. In general, it is preferable for the examiner to specify the actual sample or the basis for choosing the sample, rather than letting the carrier do it. While there is no reason to suspect that carriers would attempt to bias the sample, if the sample is specified by the examiner this eliminates any possible question.

In choosing samples, there are basically two families of techniques that can be used, namely random and non-random. Each technique is valid in certain circumstances and invalid in others. The examiner’s judgment should be used in determining which approach is most applicable and reasonable in the circumstances.

There are many ways to choose a random sample. Many of the techniques would not meet a strict statistical definition of randomness, but will normally suffice. One approach is for the examiner to obtain a listing of all groups by group number or individuals by policy number. One entry may be chosen from each page, every other page, every tenth page, etc. The examiner could also choose every fifth entry on each page or any specified number. To be even more refined, a random number generator, available in many software and spreadsheet packages, can be used. The particular entry and page numbers can be chosen using the random numbers. Normally, this degree of sophistication is not warranted.

As a practical consideration, the size of such samples will normally be quite small. However, if the examiner detects any problems or potential problems, the sample size can be expanded.

Non-random techniques include stratified sampling, such as choosing the groups with the ten highest rates, highest rate increases, lowest rates, or lowest rate increases. Such techniques can be very valuable in looking for cases which are more apt than average to represent problems. However, because of the allowance of variations for case characteristics and plan design features, the lowest or highest premium rates for a group of a certain size may not indicate that the rates are at the highest or lowest percentage of the index rate. In spite of this, non-random techniques can be useful for most of the testing which will be done in conjunction with compliance verification.

The NAIC Financial Examiners Handbook also contains an extensive discussion of sampling techniques.
If a sampled group or individual does not comply with one or more elements of the rating requirements, the examiner should inquire as to the reason for the noncompliant sample (e.g., keypunch error, programming error, etc.), and ask the certifying actuary to verify that the problem does not exist in the rest of the population. The analysis may require additional target sampling.

B. RATING CONSIDERATIONS

In order for a health insurer to be financially sound it must establish a financing system that provides revenue in excess of expected costs. (See actuarial soundness definition in the Actuarial Standard of Practice No. 26.) The Model Acts generally place this responsibility with an actuary. A significant portion of the expected costs are the expected claims. Estimates of expected claims can be divided into an expected utilization times the expected cost for that utilization. Over time actuaries have found certain measures to be useful in predicting future claims. Among these are age, sex, health condition, type of coverage, duration of coverage, claims experience, industry, occupation, location, and others.

Not all of these predictive measures are used in the actual rating of health plans. Some possible measures such as income and race are not used in rating even though they may be predictive of future claims. The model acts establish prohibitions and limitations regarding what variables may be used for rating purposes.

Since prohibiting the use of rating variables may not change the actuarial estimate of the expected claims there may be financial and market pressures for rates to increase on groups that have a higher than average mix of persons with the high cost measures. The examiner needs to carefully check that the allowable rating factors have not been used inappropriately as a surrogate for these other factors.

For example, it has been common for forms with higher average durations to have higher than average claims. If those blocks also differ on an allowable rating characteristic, such as age, the carrier may attempt to adjust the age slope as a substitute for durational rating. There are innumerable variations of this same theme so the examiner must use experience and judgment. A good start might be to compare the rating variables for the lowest rated and highest rated plans and look for inconsistencies in methodology.
VIII. SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY
MODEL ACT (Model 118 - 1993 version)

The NAIC adopted changes to this model act in 1995. The 1995 version of the model act has been updated to comport with HIPAA. However, the 1993 version of the model act addressed in this section was not updated to comport with HIPAA, since it is no longer the version supported by the NAIC. However, since several states have adopted variations of the 1993 version of the model act, this guidance manual will continue to address the 1993 version and highlight those provisions that may be impacted by HIPAA.

A. KEY ELEMENTS OF THE RATING REQUIREMENTS

The key element of the rating requirements is that within a given class of business, the highest rate which may be offered cannot exceed the lowest rate which may be offered by more than 67%. This requirement applies to groups with similar case characteristics, however, which allows the carrier to vary rates by elements such as age, gender, geography, dependent categories, group size, and industry. In addition, of course, carriers are allowed to vary rates for different plan design features. Therefore, within a class of business, rates may still vary by more than 67%. However, for groups with similar case characteristics and plan designs, the variation is limited to plus or minus 25% of the rate range midpoint (with 125% divided by 75% = 1.67, or 67% total variation).

Carriers are allowed to establish different classes of business for substantial differences in expected claims experience or administrative expenses. Three reasons are explicitly allowed for establishment of a separate class. These are for (1) different marketing systems, (2) acquired books of business from another carrier, and (3) true association groups. The definition of a true association group is an association which exists for reasons other than obtaining insurance and which links its members through a common occupation or profession. For a full description of what constitutes a true association, see the NAIC Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act. Carriers are limited to a maximum of nine classes of business, unless special permission is obtained from the insurance commissioner.

Carriers are also allowed to vary rating requirements for different rating periods. A rating period would normally be a six or twelve month period beginning with a given renewal month. Rating periods of other than six or twelve months are allowed, but should be clearly defined.

The rating process can be described as a two step process. First, a premium rate is determined based on case characteristics and plan design, but without regard to other risk characteristics. Second, the rate may be adjusted, subject to the limits imposed by the Model Act, to reflect such other risk characteristics. This adjustment must apply uniformly to all members of the group, however.
In addition to the requirement that the rates within a class of business fall within a band of plus or minus 25%, the rate increase given to any particular group cannot exceed the rate increase for the new business rate or lowest rate available (base premium rate) by more than 15%. Thus, if a carrier were to hold its rates level for new business and there were no changes in the group’s case characteristics, no group could receive an annual rate increase of greater than 15% of the base premium rate. If new business rates were increased by 10%, then carriers could increase other group rates by as much as that 10% plus an additional 15% for a total increase of 25% of the base premium rates. The Model Regulation provides detail on how this calculation should be performed. It should be noted that changes in case and coverage characteristics are reflected through use of the carrier’s revised manual, and are therefore not additive.

Among given classes of business, the index rate cannot vary by more than 20%. As will be discussed in later sections of this report, comparing rates among different classes of business is one of the more difficult aspects of compliance testing.

Carriers have three years under the 1993 Access Model Act from the effective date of the Act in which to bring their books of business into compliance with these requirements. Premium rates for groups issued prior to the effective date may exceed the rate ranges. However, carriers are allowed only to increase these group rates by the rate increase for the new business rate if the group rate falls outside of the allowable band (plus any adjustment for changes in case characteristics or coverage).

Accordingly, carriers will still need to calculate the allowable rate ranges and certify to compliance with the law during the transition period.

B. ADDITIONAL REQUIRED DOCUMENTATION

As mentioned in Section IV, documentation may include a demonstration or explanation supporting the actuarial certification that the rates are in compliance with the rating law. This demonstration might include:

- A description of each class of business which has been established and the criteria used in assigning groups to each class.
- A written demonstration that each established class meet the requirements of the Model Act.
- A written demonstration showing the methodology for calculation and results of determining the base or index rates for each class.
- A written description of the basis for defining the rating period for each class of business and a written demonstration that the assigned rating period is consistent with current and planned practices with regard to the timing of rate increases.
- A written demonstration that the rates for groups within a class are between ±25% of the index rate (or alternatively not more than 67% higher than the base premium rate).
- A written demonstration that the index rate for the rating period for any class does not exceed the index rate for any other class of business by more than 20%.

- A written demonstration that any exceptions to the above are due to the transition period allowances of the Model Act.

- A written demonstration that rate increases have not exceeded the percentage increases allowed by the Model Act, applied in the manner specified in the Model Regulation.

C. CLASSES OF BUSINESS AND RATING PERIODS

Classes of business and rating periods represent two problematic areas in terms of testing compliance with the Model Act. Clearly, both of these concepts were included in the Model Act to provide flexibility for small employer health insurance carriers. However, the intent was neither to allow loopholes in the law nor to encourage carrier gaming, as mentioned earlier. Verification of the authenticity of different classes of business is an important responsibility of the examiner.

CLASSES OF BUSINESS

Companies must have justification for establishing classes of business. Significant differences in expected claim costs or administrative and/or marketing practices and costs must exist. The examiner should request the definition of all classes of business and be satisfied that the differences are in fact significant. Clearly, a new class of business should not be established just to introduce a new policy form or contract language. Classes of business should not exist just for differences in case characteristics. However, a class of business can indicate a different marketing or distribution system (TPA vs. own marketing staff, for example).

It is important that each class of business should have one and only one rating manual for new business and verifying compliance with rating constraints for new business and renewals. After the initial transition period, all renewals would also use the one manual. This is necessary to be able to make comparisons within and among classes of business and is specified in the Model Regulation. There are however, likely to be transition periods where two or more manuals will be “in-force.” Examples are the initial transition period allowed by statute where it may be appropriate to allow multiple manuals in a class in order to permit a rational transition to the new rating requirements for existing business. Another example would be where a carrier was using a different set of case characteristics within the class for all new business and renewals but needed to maintain the old manual for additions and deletions of in-force business until their next renewal date. In this case, compliance testing will be required to use both the new and the old manuals.
Another key concept related to classes of business is determination of whether or not the class is being actively marketed. Since different rate increase limit criteria apply when a class is no longer actively marketed, the examiner should seek objective proof, such as new enrollment statistics. In particular, if new business rates are increased by more than the increase in the lowest rate in the class, the examiner should carefully review other available information to determine whether the class is being actively marketed.

When it is determined that a class of business is no longer actively marketed, the maximum rate increase is defined in terms of the increase in new business rates for the most similar other class of business. The examiner should carefully review the carrier’s determination of the most similar class. New enrollment into the identified class should be evident.

**RATING PERIODS**

Similarly, the concept of rating periods was included in the Model Act to reflect the fact that not all groups are rated for a twelve-month period nor are increases implemented on all business at one point in time. Carriers follow various renewal rating approaches in terms of frequency of rate increases and implementation points. The most common rate increase intervals are every six months and every twelve months. Implementation points are usually either on a semi-anniversary, anniversary, or next premium due date after notice. The examiner should note, however, that only one rating period is allowed for any given renewal month within a class of business.

Further, the examiner should recognize that the rating period is not necessarily the same as the rate guarantee period. For the purposes of this manual, rate guarantees are considered a plan design feature, while the rating period represents the number of months to which the rates are calculated (but not necessarily guaranteed) to be applicable. This distinction is not specified in the Model Act, but is assumed in this manual. Even though there are theoretically an infinite number of rate guarantee periods within a rating period, rate guarantees will typically be extended in monthly increments. Even though there is no explicit limitation in the Model Act relative to the length of a rate guarantee period, it seems reasonable to limit the carrier to one rate guarantee period for each renewal month within a class of business, except if the carrier can demonstrate an imperative business reason for doing otherwise. At a minimum, the carrier should be required to demonstrate that multiple rate guarantee periods for a given renewal month will not unduly complicate the auditing of compliance with the rating standards.

The carrier is likely to have established rating group cohorts for each class which will receive rate increases over similar time periods. For example, groups with anniversaries in the second quarter of the year (i.e., April, May, or June) may be scheduled for rate increases on their semi-anniversaries. The groups in these class cohorts should be examined together as defining a common rating period. The examiner should be alert for the misuse of rating periods.
D. RATING FACTORS

The examiner should recognize that the Model Act implicitly allows a certain degree of latitude for underwriting judgment or carrier prerogative. Specifically, carriers are allowed to continue to use such practices as durational and tier rating provided the resulting rates comply with the rating requirements of the Model Act.

Much of the examiner’s work in reviewing case and coverage characteristics will of necessity be subjective. Factors such as the examiner’s knowledge of the carrier and the actuary who signed the opinion, as well as the wording of the opinion itself, will be important. These factors are discussed elsewhere in this manual. The purpose of this section is to provide guidance in interpreting case and coverage characteristics in the context of the review.

The values shown in this section of the manual are intended to represent safe harbors. That is, if an examiner finds that a carrier’s factors fall within the parameters defined, the carrier’s factors can generally be assumed to be reasonable. If a carrier’s factors fall outside the safe harbors defined, the examiner may request the carrier to furnish supporting documentation. Note that the safe harbor factors in this manual were developed in 1992 and have not been updated since development. Therefore, the examiner should carefully consider this in using the safe harbor factors to determine the appropriateness of a carrier’s factors.

One question which will undoubtedly occur during the course of any examination is: what action should be taken if the parameter in questions falls outside of the range shown in this manual? If the examiner feels that this is a material breech of the requirements, actuarial justification may be requested from the actuary. This justification should take the form of an experience study or other well thought-out and documented source. Where appropriate data are not available, the actuary should at least provide a demonstration of the reasonableness of the result. The actuary’s opinion, in and of itself, would normally not be sufficient.

The NAIC Model Act concerning small employer health insurance limits case characteristics to age, gender, family composition, group size, industry, and geographic location. For each of these characteristics, a discussion of the range of values which may be deemed reasonable is presented below. These ranges are based upon input from various small group carriers as well as other industry rate and claim cost data. To be allowable, case characteristics must be specific and uniformly applied.

The Model Act does not prohibit the use of case characteristics beyond those included in this guidance manual, if approved by the commissioner under criteria included in the Model Regulation. However, the fact that the specific case characteristics discussed in this manual were mentioned specifically in the Access Model Act implies that the drafters expected that these would be sufficient. Therefore, it is unlikely that the examiner will encounter a great deal of alternate case characteristics. However, actuarial justification should be required and reviewed by the examiner when any additional case characteristic is used.
Following the discussion of specific case characteristics is a discussion of coverage, or plan design, characteristics.

1. **Case Characteristics**

   a. **Age**

   Variation of claims costs by age is an understandable characteristic since it is well known that, on average, health status deteriorates as one grows older. However, the relative differences in premium rates by age will tend to vary by other characteristics as well, such as gender and plan design. The safe harbor values discussed in this section are based on a comprehensive major medical plan design without maternity coverage.

   First, the examiner should check the ratio of the highest premium rate charged to the lowest premium rate charged. Normally, this will be the age 64 premium related to an age 20 premium, but the maximum and minimums may vary. An overall ratio of 5:1 or less is allowable. This test, and all the tests in this section, should be performed using the single employee rates.

   Secondly, the examiner should test the relationship of the premium rate for age 22 to the rate for age 42. If the rates differ by gender, the test should be performed for males and for females. If the resulting ratio is at least .50, it can be presumed to be in compliance. If individuals age 65 or older are covered for full benefits, additional factors above the 5:1 can be expected.

   The values below may be used for testing specific ages. In each case, the ratio of the premium rate for the age shown to the premium rate for age 42 should be within the range of the factors shown. The factors should increase as the age grouping increases.

   ![Safe Harbor Age Slope Range](https://example.com/safe-harbor-age-slope-range.png)

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Safe Harbor Age Slope Range Relative to Age 42</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
</tr>
<tr>
<td>22</td>
<td>.50-1.00</td>
</tr>
<tr>
<td>27</td>
<td>.55-1.00</td>
</tr>
<tr>
<td>32</td>
<td>.67-1.00</td>
</tr>
<tr>
<td>37</td>
<td>.72-1.00</td>
</tr>
<tr>
<td>42</td>
<td>1.00</td>
</tr>
</tbody>
</table>

   * Excludes maternity coverage

   Finally, the examiner should determine the ratio of the age 62 rate to the age 42 rate. This ratio should be acceptable if it is no higher than 2.75 for unisex rates. If the rates differ by gender, the ratio should be acceptable if it does not exceed 3.2 for males and 2.2 for females. The values below may be used for testing specific ages. In each case, the ratio of the premium rate for the age shown to the premium rate for age 42 should be within the range of the factors shown. The factors should increase as the age grouping increases.
### Age Slope Range Relative to Age 42

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Males</th>
<th>Females*</th>
<th>Unisex*</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>1.00-3.20</td>
<td>1.00-2.20</td>
<td>1.00-2.75</td>
</tr>
<tr>
<td>57</td>
<td>1.00-2.45</td>
<td>1.00-1.62</td>
<td>1.00-2.05</td>
</tr>
<tr>
<td>52</td>
<td>1.00-1.80</td>
<td>1.00-1.46</td>
<td>1.00-1.61</td>
</tr>
<tr>
<td>47</td>
<td>1.00-1.40</td>
<td>1.00-1.26</td>
<td>1.00-1.28</td>
</tr>
<tr>
<td>42</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

* Excludes maternity coverage

Ratios and/or rates should progress in a consistent manner throughout the age span, as those shown in this manual. If they do not, separate tests may be performed at different ages. However, it is common to have flat age factors at the early adult ages (e.g., .70 for ages 22, 27, 32 and 37) and then increase them as age increases. This is also acceptable.

Rates that vary for each and every age are also acceptable, as are rates that vary by age bands other than the five years shown here, subject to the other comments in this section.

There are several points to note regarding the values shown in this section:

- The values in each column do not relate to the other columns.
- The values in the two tables do not relate to each other.
- The total slope shown is greater than most companies would use because we have shown a minimum value for age 22 and a maximum value for age 62.
- Rate slopes for females tend to be flatter than those for males. This is due primarily to greater utilization of health care services by women during childbearing years.
- The rate slopes do not include provision for normal maternity charges. Inclusion would have the impact of flattening the slope. Male rates which are designed to subsidize a portion of maternity costs will also result in a flatter slope. Generally, the examiner will not need to be concerned if the slope is flatter than those shown above.
- Claims costs curves (i.e., rates without expense, profit and contingency loadings) will tend to have steeper slopes than those shown above. Varying methodologies for loading rates introduce some of the variability shown above.
- Unisex rate relativities are dependent upon the assumed mix of males and females at each age. The factors shown above are based on a typical U.S. labor force population distribution.
b. **Gender**

Females incur greater medical costs than males at younger ages, particularly during childbearing years. The variances in costs diminish with age until male costs begin to exceed female costs in the late fifties or early sixties. The following table provides a safe harbor range by age for these gender differences. A decreasing relationship by age is expected (if not unisex).

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>1.00-1.45</td>
</tr>
<tr>
<td>27</td>
<td>1.00-1.45</td>
</tr>
<tr>
<td>32</td>
<td>1.00-1.45</td>
</tr>
<tr>
<td>37</td>
<td>1.00-1.45</td>
</tr>
<tr>
<td>42</td>
<td>1.00-1.35</td>
</tr>
<tr>
<td>47</td>
<td>1.00-1.20</td>
</tr>
<tr>
<td>52</td>
<td>1.00-1.05</td>
</tr>
<tr>
<td>57</td>
<td>.95-1.00</td>
</tr>
<tr>
<td>62</td>
<td>.85-1.00</td>
</tr>
</tbody>
</table>

The inclusion of normal maternity costs for females would result in significantly higher relativity factors at younger ages, to as high as perhaps 2.70. The factors shown above are lower than factors based on actual claim costs. They are consistent with premium rate factors being used in practice, however.

c. **Family Composition**

Companies use a number of rating structures to include dependent coverage. Among the more common structures, and relative rate factors, are the following. The relative rate factors are based on a comparison to an average composite member rate using an age/gender/employee/spouse distribution representative of the U.S. labor force. Expected distributions which are different may have different relationships. Carriers may be requested to provide the calculations for the rates they are using. The following table is illustrative only to provide the examiner with examples of different rate structures which he is likely to encounter.
### Rating Structure

<table>
<thead>
<tr>
<th>Rate Basis</th>
<th>Description</th>
<th>Relative Rate Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite</td>
<td>All Covered Employees</td>
<td>1.00</td>
</tr>
<tr>
<td>Two Tiered</td>
<td>Single Employee</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>2.60</td>
</tr>
<tr>
<td>Three Tiered</td>
<td>Single Employee</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Two Party (e.g., Employee &amp; Spouse, Employee &amp; Child)</td>
<td>2.30</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>2.90</td>
</tr>
<tr>
<td>Four Tiered</td>
<td>Single Employee</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Employee and Spouse</td>
<td>2.70</td>
</tr>
<tr>
<td></td>
<td>Employee and Child(ren)</td>
<td>1.70</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>3.00</td>
</tr>
<tr>
<td>Individual</td>
<td>Each covered person rated separately. Child structure could vary:</td>
<td>Sum of each individual rate (subject to child structure)</td>
</tr>
<tr>
<td></td>
<td>• each child</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 4 or more children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 3 or more children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 2 or more children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• all children</td>
<td></td>
</tr>
</tbody>
</table>

The single employee rate will often be a gender distinct rate for small groups.

Companies can set spouse rates in different ways. Some discount the spouse rate from the employee rate, most likely due to the ability to spread expenses over an additional covered person. On the other hand, others set spouse rates higher than employee rates, presumably in anticipation of higher utilization patterns on the part of the spouse. The majority of carrier rates appear to have spouse rates set equal to employee rates. Dependent rating structures should be supported by an appropriate demonstration.

Maternity claim costs for female spouses significantly exceed those for female employees. These differences may or may not be reflected in the rates depending upon carrier rate structure, target case size market, and applicable legal restraints. If maternity rates do vary between female spouse and female employee, a ratio up to 2.0 is acceptable without additional justification.

Child rates can show significant variation from one carrier to another. The rating structure can be on an each child, four or more children, three or more children, two or more, or all children basis. Sample rate relationships for these structures can be illustrated as follows:
Carriers may vary these relationships depending upon their actual distribution by family size. The carrier should be able to provide a demonstration as to the determination of its child rate.

Some carriers may also provide discounts for each additional child rather than just flat multiples of the single child rate as shown above. Often carriers will simply have a family rate or a single and dependent rate structure in lieu of a distinct child rate.

d. **Group Size**

Companies will often distinguish rates by group size. As an alternative to or in addition to rate differences, underwriting procedures and methods may vary by group size. Group size discounts (or surcharges) are appropriate for two key reasons:

- As group size increases, the per insured expenses required to issue and service the business decrease. This allows for a lower rate.

- Individuals and small groups tend to select against an insurer when purchasing medical coverage. The purchaser generally knows the needs for insurance for each employee in very small groups and can select coverage in line with these individuals’ needs. As group size increases, this selection becomes more difficult, and, to the extent it occurs, is spread over a larger base.

The magnitude of the group size discount is therefore dependent on the anticipated expense differences and morbidity variances between groups of different sizes for a given level of underwriting. A carrier’s rates might also vary because of differences in the level of underwriting used for one size of group versus another.

The following table of factors may be used as a guideline for group size surcharges for a given underwriting method. Selection is expected to have more effect for guaranteed issue products as groups get smaller, but the differential would diminish as the underwriting intensity increases. Expense savings due to group size would be an additional factor.

### Child Rate Structure

<table>
<thead>
<tr>
<th>Child Rate Structure</th>
<th>Relative Rate to Each Child Rate Number of Children in Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Each Child</td>
<td>1.000</td>
</tr>
<tr>
<td>4 or More</td>
<td>1.032</td>
</tr>
<tr>
<td>3 or More</td>
<td>1.065</td>
</tr>
<tr>
<td>2 or More</td>
<td>1.202</td>
</tr>
<tr>
<td>All Children</td>
<td>1.893</td>
</tr>
</tbody>
</table>

* Would continue to increase
<table>
<thead>
<tr>
<th>Group Size</th>
<th>Guaranteed Issue</th>
<th>Short Form</th>
<th>Full Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>1.00-1.20</td>
<td>1.00-1.15</td>
<td>1.00-1.10</td>
</tr>
<tr>
<td>5-9</td>
<td>1.00-1.10</td>
<td>1.00-1.10</td>
<td>1.00-1.05</td>
</tr>
<tr>
<td>10-24</td>
<td>1.00-1.00</td>
<td>1.00-1.00</td>
<td>1.00-1.00</td>
</tr>
</tbody>
</table>

Note that the values are valid within each column, but are not valid between columns. In the table, “Guaranteed Issue” means that there is no denial of coverage based upon underwriting criteria, although there may be participation requirements that a certain percentage of the group is to be covered and the coverage may include a limitation on pre-existing conditions; “Short Form” refers to an application with a limited number of medical questions to answer; “Full Medical” represents a thorough approach to underwriting each individual including a detailed medical history and attending physician statements where necessary.

Under HIPAA no denial of coverage is allowed based on health status. A carrier may underwrite each individual for purposes of developing premium rates, but may not deny coverage to an individual based on health status. HIPAA also restricts the waiting period for preexisting conditions to a maximum of 12 months and requires that carriers reduce the preexisting condition waiting period by the amount of time the individual was covered under creditable coverage. If the individual enrolled for coverage in the plan more than 63 days after the date the individual’s prior creditable coverage was terminated, the carrier is not required to reduce the preexisting condition waiting period.

Group size surcharges in excess of the guidelines shown above should be justified through actuarial demonstration (though surcharges above 20% are not allowed under the Model Regulation). The demonstration should include anticipated and experience claim differences, a description of differences in underwriting practices (including adjudication of the pre-existing condition limitation clause) and how much of the claim differences are due to underwriting. It should also show variances in commission rates and other expenses. Expense difference due to variance in underwriting approach is not an acceptable item for inclusion.

The guaranteed issue provisions of the law apply only to groups of 3 or more employees. As such, size surcharges for 1 or 2 employee groups different than those for 3-4 employee groups are not expected, even though some groups may get reduced to one or two over time. Similarly, for underwritten business, it is desirable that carriers not use a size surcharge for 1-2 life cases different than the size factor for 3-4 life cases. HIPAA small group requirements including guarantee issue apply to groups of 2 to 50 employees.

Carriers are allowed, however, to apply a revised group size case characteristic to other groups whose size changes into a new size category.
Larger small groups (e.g., 15 or more employees) may be subject to a greater number of mandates. These would tend to increase larger small group rates. However, these are to be considered coverage characteristics and not part of the group size case characteristic. This includes differences in pre-existing condition clause limitations. Attention should be given that they do not mask a larger group size surcharge than is reasonable.

The examiner should note that any policy fees, administrative fees or application charges should be taken into account in comparing the premium rates for groups of one size to those of another. Such fees can effectively represent additional surcharges, and should not be used to allow the carrier to exceed the allowable 20% maximum. The amount of such fees should be prorated over the premium for the group, and should be prorated over the full rating period if the charge only applies one time.

e. **Industry**

People working in some industries exhibit higher medical claim costs than in other industries. This is due in part to the working conditions, the type and lifestyles of people attracted to the industry and to the prevalence of accidents in the industry. Higher turnover in some industries may result in higher administrative costs for the insurer. The Access Model Act has limited rate differentials for this case characteristic to a maximum range of 15%. However, the Rating Model Act does not contain this limit.

The examiner should look for evidence of “redlining,” or avoiding certain risks through the use of industry ratings. There is no standard set of industry rating factors, and opinions on the predictive value of industry vary widely. Therefore, experience studies which justify the industry factors used should be requested and reviewed by the examiner. This is especially true under the Rating Model Act if the factors vary by more than 15%.

f. **Geographic Location**

The cost of medical care can vary dramatically from one area to another. This is due to the general cost level of the area, the differences in medical practices by region, the specialization and intensity of services, and the amount of competition in the area. Most small group plans vary rates by either county or ZIP code (usually 3-digit but sometimes 5-digit). The employer’s business address is normally used.

Because of the many factors involved in setting area rates, including competitive posturing and regulatory concerns, area rating factors used by companies can vary significantly.

The following table indicates the safe harbor ratio of highest factor to lowest factor for each state. Some states have laws or regulations that require lower factors than those shown in the table. The laws or regulations would, of course, prevail. An example would be a state which does not allow geographic variation in rates, where the factor would effectively be 1.00.
## State Area Relativities

### Ratio of the Highest Area Factor to the Lowest Area Factor in Each State

<table>
<thead>
<tr>
<th>State</th>
<th>Maximum Area Ratio</th>
<th>State</th>
<th>Maximum Area Ratio</th>
<th>State</th>
<th>Maximum Area Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1.40</td>
<td>Kentucky</td>
<td>1.50</td>
<td>North Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Alaska</td>
<td>1.20</td>
<td>Louisiana</td>
<td>1.50</td>
<td>Ohio</td>
<td>1.60</td>
</tr>
<tr>
<td>Arizona</td>
<td>1.40</td>
<td>Maine</td>
<td>1.20</td>
<td>Oklahoma</td>
<td>1.40</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1.40</td>
<td>Maryland</td>
<td>1.50</td>
<td>Oregon</td>
<td>1.30</td>
</tr>
<tr>
<td>California</td>
<td>1.70</td>
<td>Massachusetts</td>
<td>1.40</td>
<td>Pennsylvania</td>
<td>1.80</td>
</tr>
<tr>
<td>Colorado</td>
<td>1.30</td>
<td>Michigan</td>
<td>1.50</td>
<td>Rhode Island</td>
<td>1.20</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1.40</td>
<td>Minnesota</td>
<td>1.50</td>
<td>South Carolina</td>
<td>1.40</td>
</tr>
<tr>
<td>Delaware</td>
<td>1.20</td>
<td>Mississippi</td>
<td>1.40</td>
<td>South Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Dist. of Columbia</td>
<td>1.00</td>
<td>Missouri</td>
<td>1.40</td>
<td>Tennessee</td>
<td>1.30</td>
</tr>
<tr>
<td>Florida</td>
<td>1.90</td>
<td>Montana</td>
<td>1.20</td>
<td>Texas</td>
<td>1.70</td>
</tr>
<tr>
<td>Georgia</td>
<td>1.40</td>
<td>Nebraska</td>
<td>1.40</td>
<td>Utah</td>
<td>1.20</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1.20</td>
<td>Nevada</td>
<td>1.40</td>
<td>Vermont</td>
<td>1.20</td>
</tr>
<tr>
<td>Idaho</td>
<td>1.20</td>
<td>New Hampshire</td>
<td>1.30</td>
<td>Virginia</td>
<td>1.60</td>
</tr>
<tr>
<td>Illinois</td>
<td>1.70</td>
<td>New Jersey</td>
<td>1.50</td>
<td>Washington</td>
<td>1.30</td>
</tr>
<tr>
<td>Indiana</td>
<td>1.70</td>
<td>New Mexico</td>
<td>1.30</td>
<td>West Virginia</td>
<td>1.40</td>
</tr>
<tr>
<td>Iowa</td>
<td>1.40</td>
<td>New York</td>
<td>1.80</td>
<td>Wisconsin</td>
<td>1.50</td>
</tr>
<tr>
<td>Kansas</td>
<td>1.40</td>
<td>North Carolina</td>
<td>1.30</td>
<td>Wyoming</td>
<td>1.20</td>
</tr>
</tbody>
</table>

It is possible that the rates for some carriers may exceed these ranges. These are to be considered guideline ratios. The examiner may wish to have the carrier provide demonstration of the need for a ratio beyond those illustrated above.

### 2. Coverage Characteristics

The Model Act concerning small employer health insurance sets certain criteria and limitations for premium rates. The Model Act states that the limitations are to be measured for rates “with similar case characteristics for the same or similar coverage.” This section provides guidelines on rate relationships for various benefit provisions and types of coverage. The values shown represent typical comprehensive plans (excluding normal maternity coverage). Other types of benefits packages may have different relationships than those discussed in this section and, therefore, the value guidelines provided below may not be appropriate for these types of benefit designs. As mentioned in section II of this manual, the examiner should look especially closely at the relationship of heavily marketed plans to the basic and standard plans, where the Access Models are applicable.
a. Deductible

The value of a deductible feature depends upon the size of the deductible, the age and gender of the insured, the area in which the insured lives, and the impact of trend leveraging over time. For example, a $100 deductible impacts the cost of a plan far less today than it did in 1972. Similarly, a $100 deductible has greater impact to rates in a low cost area such as rural Iowa than in a high cost area such as Los Angeles. In other words, the relative cost of one deductible level to another depends upon the cost levels to which the deductibles are applied. As an example, consider the following two situations for a $250 deductible and a $1,000.

<table>
<thead>
<tr>
<th>Eligible Charges</th>
<th>Cost Level A</th>
<th>Cost Level B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible 1</td>
<td>$12,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Remaining Charges</td>
<td>$11,750</td>
<td>$6,750</td>
</tr>
<tr>
<td>Deductible 2</td>
<td>$12,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Remaining Charges</td>
<td>$11,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

Relative Impact of $1,000 Deductible to $250 Deductible: .936 to .889

The lower the charge level, the greater the impact the deductible has on premium.

One difficulty in reviewing deductible relationships is that many carriers have traditionally allowed selection to affect the relationship in their rates. That is, the relative rates reflect the characteristics of the groups that would tend to select the particular deductible. Such selection is not an appropriate coverage characteristic. Utilization differences would also occur for a given group just based on the effect of the deductible itself. This effect is difficult to quantify. The safe harbors shown below reflect some element of this effect.

The safe harbors shown in the table below are values typical of an 80%/20% coinsurance plan with a $5,000 stop-loss level (i.e., $1,000 insured out-of-pocket maximum after the deductible).
### Deductible Range Relative to a $500 Deductible Level

<table>
<thead>
<tr>
<th>Deductible Level</th>
<th>Safe Harbor if Ratio to $500 Deductible Level is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>less than 1.50</td>
</tr>
<tr>
<td>250</td>
<td>less than 1.25</td>
</tr>
<tr>
<td>500</td>
<td>1.00</td>
</tr>
<tr>
<td>750</td>
<td>more than .85</td>
</tr>
<tr>
<td>1,000</td>
<td>more than .75</td>
</tr>
<tr>
<td>1,500</td>
<td>more than .70</td>
</tr>
<tr>
<td>2,000</td>
<td>more than .65</td>
</tr>
<tr>
<td>2,500</td>
<td>more than .60</td>
</tr>
</tbody>
</table>

Besides the rate ratio, the absolute dollar difference in rates should also be reviewed to be certain the annual premium difference does not exceed the dollar difference in the deductible.

There are several points to note regarding the deductible relativities:

- These ranges are for plans with 80% coinsurance and $5,000 stop-loss levels. Some companies will vary their deductibles relativities for different coinsurance or out-of-pocket levels. However, it is anticipated that ratios for plans with other stop-loss levels will generally fall within these safe harbor ranges.

- These ranges may not be appropriate for plans which waive the deductible for certain qualifying medical care or types of services.

- The ranges are based upon plans excluding supplemental accident coverage, though such coverage is frequently offered as a policy option.

- For deductibles of $1,000 or more, companies may sometimes include deductible adjustments to recognize the impact of an employer self-insuring his employees for a corridor within the deductible amount. This is more common for groups of 10 or more employees.

b. **Stop-Loss Coinsurance Limits**

Most small group insurance plans provide a stop-loss coinsurance limit feature. This provides assurance to the insured that in a catastrophic situation out-of-pocket responsibilities will be capped at a specified level for covered expenses.

These limits are usually presented from one of two perspectives:

- Maximum out-of-pocket expense (including or excluding the deductible).
Maximum levels of covered expenses (after the deductible) to which the coinsurance percentage will be applied. Amounts above this threshold would be paid at 100%.

The following table presents guidelines for evaluating rating relativities between four stop-loss levels for an 80%/20% coinsurance plan.

<table>
<thead>
<tr>
<th>Stop-Loss Limit</th>
<th>Coinsurance Out-of-Pocket</th>
<th>Safe Harbor if Ratio to $5,000 Stop-Loss Limit is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000</td>
<td>$400</td>
<td>less than 1.15</td>
</tr>
<tr>
<td>2,500</td>
<td>500</td>
<td>less than 1.10</td>
</tr>
<tr>
<td>5,000</td>
<td>1,000</td>
<td>1.00</td>
</tr>
<tr>
<td>10,000</td>
<td>2,000</td>
<td>greater than .85</td>
</tr>
</tbody>
</table>

Besides the rate ratio, the absolute dollar difference in rates should also be reviewed to be certain the annual premium difference does not exceed the dollar difference in coinsurance.

Some companies offer higher stop-loss limits such as $12,500 ($2,500 OOP), and $25,000 ($5,000 OOP), in order to reduce premiums more. The rate differential for these higher limits would not be expected to be more than 25% lower than the rates for a $5,000 stop-loss limit (i.e., a low factor of .75 for no out-of-pocket limit).

c. Maternity

As discussed in the section on case characteristics, maternity coverage may vary by group size. Because it is anticipated that maternity coverage will be included in most states’ definitions of basic and standard plans under the Access Model Act, however, the examiner may have to compare rate relativities for plans with maternity to plans without maternity. It is possible that the relationship could be very complex depending on the age and gender distribution of the group. Safe harbor ratios of values less than or equal to 1.70 for gender distinct and 1.40 for unisex individual attained age rates during the childbearing years and 1.20 for rates which do not vary by age or gender can be used as benchmarks for the ratio of a plan with maternity to a plan without maternity coverage.

d. Managed Care

Managed care products introduce a set of variables which go beyond the scope of this manual at this point. Cost containment techniques, such as pre-admission certification, concurrent utilization review, discharge planning, second surgical opinion and large case management may be reflected in discounts relative to otherwise appropriate rates of up to about 10%. Any discount greater than 10% is likely to be indicative of tighter utilization controls than most carriers have in place. The examiner may wish to investigate such large discounts.
Because of discounts from providers, it is very complicated to compare a preferred provider plan or an HMO plan to a traditional indemnity program, such as discussed in this manual. However, comparisons can be made among similar preferred provider plans and among HMO plans. Further, in general, the rates for a preferred provider plan or IPA/HMO plan would not be expected to be more than 20% lower than the comparable indemnity plan as described in this manual. It is important to note that a plan using a restricted network of providers is not considered to be similar coverage to a plan with no such restrictions, even though the actual plan benefits may be similar.

There is no clear definition of what constitutes a “managed care” contract. In general, the covered persons have some limitations on access to care (e.g. networks, gate-keeper, pre-authorization etc.) and other controls or reviews of health care expenditures may be involved (e.g. provider discounts, concurrent review, case management etc.).

In some situations involving managed care, these controls are used almost exclusively to reduce costs and rate schedules are very similar to non-managed care rate schedules. Other managed care products may have very different benefit packages (e.g. federally qualified HMOs must have certain benefits) and frequently do not use all of the rate distinctions allowed by the models.

In the situation where a carrier has both managed care and non-managed care plans, the review should include the assumed sources of rate differences. Those which come from added controls should be fully credited to the managed care plans. Some, however, might be used to “game” the guaranteed issue rules. Such things as limiting network availability to selected areas, limiting network providers to selected specialties and inconsistent use of the right to exclude “out-of-area” employees are potential areas which should be reviewed under managed care plans.

Because most managed care plans include some provider discounts, a range of premium rate differences must be separated into two parts:

1) Cost-containment techniques, such as pre-admission testing, concurrent utilization review, discharge planning, second surgical opinion and large case management may be reflected in rate differences of up to 10%.

2) Any discount greater than 10% should be related to network variables such as discounts, gate-keeper controls etc.

The examiner should note that the rates of HMOs are also subject to the rating restrictions of the Model Act and Model Regulation. However, an important distinction must be made for certain HMOs which are stand-alone affiliates and those that are simply another line of business within a carrier’s product portfolio. Section 4D(2) of the Access Model Act allows an HMO which is an affiliated carrier having a certificate of authority from the state in which it is operating to be considered a separate carrier for the purposes of the Act. (Please note that this exception is not included in the Rating Model Act.)
However, it should be noted that an HMO plan which is another product line within a carrier is not given this same exception treatment. It must be included with the other business of the carrier subject to the Act. It may or may not qualify as a separate class depending on its ability to meet the criteria of Section 5 of the Model Act.

In the situation where an affiliated HMO carrier also writes other types of small employer plans subject to the Act (e.g. POS, EPO, or PPO plans), the Act appears to still allow for separate treatment of the business of this affiliate. However, the HMO business would need to be considered together with the other business of this carrier.

3. Interrelationship of Variables

Case and coverage characteristics are treated separately in this manual for simplification. However, as noted in the section under deductibles, many of the variables are, in fact, interrelated.

E. TESTING CRITERIA

1. Within a Class

To test compliance within a class of business, the examiner must first determine the base premium rate. Since variations are allowable for case and coverage characteristics, virtually every insured group can have a different base premium rate and index rate. However, since the carrier is required to maintain one and only one rating manual (note the only exceptions to this rule on page 17 relating to transition) for each class of business, the base premium rates and index rates should be determinable relative to the manual. Each group must have a rate which can be expressed as a percentage of either its base premium rate or its index rate.

The Model Act defines the base premium rate as the lowest premium rate available. While the definition of the base premium rate and the index rate are based on rates theoretically available within a class of business (that is, no specific group need have exactly the base premium rate or the index premium rate), in order for a rate to be considered the base premium rate, some actual groups must have the rate or, by the carrier’s underwriting and rating rules, be able to be eligible for the rate.

In general, the base premium rate will also be the new business premium rate. However, this is not necessarily true. The carrier should demonstrate what the base premium rate is, whether or not it equals the new business premium rate, and what change in the base premium rate has occurred from the prior period.

Perhaps the most complicated concept in the NAIC Model Act is that of the index rate. The index rate is clearly defined as a simple arithmetic average of the lowest rate and the highest rate within a class for a given set of case and coverage characteristics. Because it is intended that the index rate be determinable without reference to any particulars of the carrier’s in-force business, it has been defined for the purposes of compliance as the arithmetic average of the highest rate and the lowest rate which could be charged under the carrier’s rating system.
It should be noted that this guidance manual interprets the Act and the Regulation to imply that for the determination of the index rate, the base rate and the corresponding highest rate should not be outside of the range of rates that can be determined from the single rating manual. Therefore, the rates for any transition groups which are less than the lowest rate determinable from the rating manual or greater than the manual’s maximum rate are not to be used in the calculation of the index rate. However, the rates for transition business are subject to the rate increase limitations required by the Act.

Carriers are expected to have one and only one defined rating manual for each class of business. Therefore, determination of the lowest rate which can be charged may be relatively straightforward. That is, the manual should actually specify the new business rates, which in most instances would be the lowest rates available. Of course, the examiner needs to review the material sufficiently to determine that the new business rates are the lowest possible. If this is not the case, the lowest possible renewal rates (which are defined as the base rates) should be used. It may be that the lowest possible rate will be expressed as a percentage of some manual rate.

A similar situation may occur for the maximum rate chargeable within the system. It may be expressed as a rate table itself or as a percentage of the manual rate.

The following example indicates a situation where both the lowest rate and the highest rate chargeable within the class are known.

**Example 1**
- Monthly manual premium rate for a particular plan design for a defined census $1,000.00
- Defined Census
  - Male 27 with spouse
  - Female 24 without dependents
  - Male 52 without dependents
  - Female 37 with three children
- Carrier Plan A, rating area 1, standard industry
- Carrier defines minimum rate as 90% of manual. This rate is used for new business.
- Carrier defines maximum rate of 120% of manual.
- Index rate for these case characteristics and plan design = 

$$\frac{0.90 \times 1,000 + 1.20 \times 1,000}{2} = $1,050.00$$
• Lowest = 90% of manual = $900 = 86% of index

• Highest = 120% of manual = $1,200 = 114% of index

Note that the calculated index rate of $1,050.00 is not equal to the manual premium rate, nor is it necessarily a rate which could be charged under the carrier’s rating system. Notice also that the lowest rate is 86% of the index while the highest rate is 114% of the index. Therefore, the carrier in this example would meet the test, presuming that the sample of actual cases confirms that no groups are being charged less than the lowest rate within the rating system and no groups higher than the highest rate within the rating system.

For comparison between rating classes, a similar calculation would be performed under the ‘other’ rating class. The index rates for any rating class must not exceed another by more than 20%. For this example, that means that the similarly determined index rate for the ‘other’ rating class must be no more than $1,260.00, if there were only two rating classes in effect for this particular carrier.

Next, consider an example where the only rate known is the new business rate, which in this case is the lowest rate (base premium rate) which is offered by the carrier.

**Example 2**
- Monthly new business premium rate for same plan design and case characteristics as Example 1 $850.00
- No maximum rate is defined by carrier rating system
- Maximum rate = 125/75 x minimum = 1.67 x minimum
  
  \[
  = 1.67 \times 850 = 1,419.50
  \]
- Index rate = \( \frac{850.00 + 1,419.50}{2} \) = \$1,134.75

In this case, the examiner must test to determine that no groups are being charged more than the maximum rate of $1,419.50 or less than the minimum of $850.00. The index rate of $1,134.75 would be used for comparison among different rating classes.

Of course, the difficulty of this in practice is that there can be a different index rate for each particular set of case characteristics and plan design.

It should be noted that the testing is performed on the overall premium rate for the group, not on the individual or family components of the rate. Note also that attempting to convert the rate for comparison purposes across groups to either a per subscriber or per member basis does not work, without recognizing the relative exposure weights of the various family coverage units.
2. **Class to Class**

Verifying compliance with the requirement that the index rate for a given class of business not exceed the index rate of any other class of business by more than 20% is undoubtedly the most complicated aspect of the Model Act. In order to perform the required tests in a theoretically correct manner, each and every group within a rating class would have to be rated according to the criteria of each and every one of the carriers’ other rating classes. This results from the fact that index rate is defined in terms of groups with similar case and coverage characteristics.

Since the theoretically correct way to test for compliance from class to class is often not practical, various alternatives were considered in development of this manual. One approach which was considered was to specify a particular group census and plan of benefits for the test. While that approach would have the advantage of simplicity, no artificial sample of case characteristics and plan designs could sufficiently test a carrier’s rating practices. Therefore, it was believed that this approach could result in less than acceptable verification of compliance of the intent of the class to class comparison.

For these reasons, the approach which is recommended is to follow the theoretically correct approach, but on a sample of the carrier’s business as opposed to all of its business.

While the carrier must complete the steps as part of its own compliance testing, the examiner should understand the steps involved in order to review the work done by the carrier. This means that the carrier must keep detailed records of the samples chosen, the basis for choosing the sample, and the actual results of the test.

For each rating class, the carrier should pick a minimum of 100 actual groups (unless, of course, there are fewer than 100 groups in the class) through a random method (see Section X of this manual). For some large classes, 100 groups may not be sufficient. Therefore, the carrier is allowed to increase the size of the sample if it is necessary to demonstrate compliance. However, the expanded sample must include the groups originally chosen in the sample of 100. Note that it is not appropriate for the carrier to choose alternate samples of 100 until it finds one that passes.

Once the sample is chosen, the aggregate index rate for the class should be determined by adding together the index rate of all of the groups in the sample.

Next, each of the groups in the sample must be rated according to the manual of each of the other rating classes. The appropriately determined aggregate index rate for the sample under each of the other classes must not exceed the aggregate index rate of the original class by more than 20%.

Note that a sample of at least 100 groups must be chosen from each class, and that this testing procedure needs to be performed against each other class. The tests should be performed for at least three non-consecutive renewal months in a given calendar year, unless the carrier renews all cases on one or two dates.
A simplified example will illustrate how this would work

<table>
<thead>
<tr>
<th></th>
<th>CLASS A</th>
<th></th>
<th>CLASS B</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Area Factor</td>
<td>Number of Groups</td>
<td>Index Rate</td>
<td>Area Factor</td>
</tr>
<tr>
<td>Area 1</td>
<td>1.1</td>
<td>80</td>
<td>1,100</td>
<td>1.2</td>
</tr>
<tr>
<td>Area 2</td>
<td>1.0</td>
<td>15</td>
<td>1,000</td>
<td>.9</td>
</tr>
<tr>
<td>Area 3</td>
<td>.9</td>
<td>5</td>
<td>900</td>
<td>.7</td>
</tr>
</tbody>
</table>

The aggregate index rate for Class A is \((80 \times 1,100 + 15 \times 1,000 + 5 \times 900) = 107,500\). The aggregate index rate for Class B is \((20 \times 1,200 + 40 \times 900 + 40 \times 700) = 88,000\). On the surface it would appear that the class to class test is not met \((107,500/88,000 = 1.22 > 1.2)\). However, this is a result of the varying distribution of groups by area within the two classes. This is why it is necessary to rate the groups within each class according to the rate manual of the other class.

The aggregate index rate for the groups in Class A rated by the manual for Class B is \((80 \times 1,200 + 15 \times 900 + 5 \times 700) = 113,000\). This passes the test for Class A \((113,000/107,500 = 1.05 < 1.20)\).

Similarly, the aggregate index rate for Class B rated in Class A is \((20 \times 1,100 + 40 \times 1,000 + 40 \times 900) = 98,000\). This passes the test for Class B \((98,000/88,000 = 1.11 < 1.20)\).

Policy fees, administrative fees or application charges, if such fees are allowed, should be reflected in determining the applicable aggregate index rate used in class to class comparisons, as well as within class tests. Where such fees are one-time charges, they should be prorated over the rating period.

If a carrier uses identical factors for case and coverage characteristics between two classes, and if all of the same case characteristics are recognized in each class, this level of detail testing can be avoided.

In certain classes of a carrier’s business, items might not be retained that represent case characteristics in another class. For example, a class that does not use industry as a case characteristic might not capture SIC code. If this occurs, the carrier should begin capturing SIC code for future business in the class, in order to be able to prove compliance.
3. **Rate Increases**

In addition to the test that a particular group’s rate must fall within 25% of the index rate and that the index rates of different classes must be within 20% of each other, an additional limitation is imposed by the Model Act and the Model Regulation concerning rate increases. That is, the rate increase for any particular group cannot exceed the rate increase for its new base premium rate based on its current case and coverage characteristics plus 15% of such new base premium rate.

To illustrate how this is defined in the Model Regulation, consider a carrier that maintains a manual premium rating system and charges every group, including new business, the manual premium rate. If the manual rate change for a particular year is 10%, but the carrier decides to discount rates for new business by 5% from the manual, the maximum allowable rate increase for any particular group becomes the change in base premium rate for that group plus 15%. However, the base premium rate is the lowest rate charged. Therefore, it increased by only 4.5% \((1.10 \times .95 - 1)\), not by the 10% that the manual rate changed.

The carrier could increase the group’s rates by the additional 15% of the new base rate, for a total increase of slightly over 20% \((1.045 \times 1.15)\).

Thus, rather than having a permissible rate increase for a given group of 25% (the 10% manual increase plus the allowable 15%), the maximum permissible rate increase is 20%, reflecting the reduction in the new business rates relative to the manual.

For rating periods of less than one year, the 15% allowance must be prorated. The appropriate factor is 1.25% for each month in the rating period. For a six-month rating period, the appropriate pro-rata factor is 7.5%. Therefore, in the example above, the maximum rate increase for a one-month rating period would be 5.8% \((1.045 \times 1.0125 - 1)\). For a six-month rating period, the maximum increase would be 12.3% \((1.045 \times 1.075 - 1)\).

Next, consider the case where a particular group had been rated at 125% of the manual rate (which, prior to the carrier’s change in approach with regard to new business, was the base premium rate). The new base premium rate on the group’s current case and coverage characteristics would be 95% of the manual and 104.5% of the prior base premium rate \((i.e., .95 \times 1.10)\).

According to the Model Regulation, the maximum allowable new rate that the group could be charged is 140% of the new base premium rate \((i.e., \text{the previous risk load of } 25\% \text{ plus } 15\%\). Since the new base premium rate is 104.5% of the prior base premium rate and since the group’s prior rate was 125% of the prior base rate, the maximum allowable rate increase over the group’s prior rate would be 17% \((i.e., 1.045 \times 1.40/1.25 - 1)\).
F. TRANSITION

The requirements of the Model Act apply to all business issued after the effective date of the law in a particular state. However, for business issued prior to the effective date of the law, a transition period is allowed. During this transition period, previously issued business does not have to comply in all cases with the plus or minus 25% requirement within a class of business or the 20% variation allowed among classes of business.

During the transition period (three years under the Rating Model and five years under the Access Model), rates for particular groups are not allowed to move further out of compliance. That is, rate increases can equal the rate increase of the base premium rate, but cannot include any additional increase. This applies only to groups whose rates are too high relative to the index rate. Groups whose rates are too low may be increased more than the increase in base premium rates in order to bring them closer to compliance, but still subject to the 15% additional increase allowance.

In situations where the additional 15% is not sufficient to bring a group’s rates into compliance, the additional increase necessary should be spread over the entire transition period. It is not anticipated that this situation will occur very often in practice.

The requirement that each rating class be based on only one rating manual may require a transition for some carriers.

The examiner should, for examinations during the transition period, include in any samples a number of groups with effective dates prior to the effective date of the Act to test the compliance with the transition rules.
A. KEY ELEMENTS OF THE RATING REQUIREMENTS

The key element of the rating requirements is that rates must be based on an adjusted community rate and may only vary from the adjusted community rate for the following case characteristics:

- Geographic area;
- Family composition; and
- Age

Permissible adjustments for the case characteristics are discussed in Subsection E below.

Carriers may develop separate rates for individuals age 65 or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates are subject to the rating requirements described in this section.

Rates may not be changed more frequently than annually except to reflect the following:

- Changes to the enrollment of the small employer;
- Changes to the family composition of the employee;
- Changes to the health benefit plan requested by the small employer;

Rating factors must produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

B. ADDITIONAL REQUIRED DOCUMENTATION

As mentioned in Section IV, documentation may include a demonstration or explanation supporting the actuarial certification that the rates are in compliance with the rating law. This demonstration might include:

- A written description of the basis for defining the rating period and a written demonstration that the assigned rating period is consistent with current and planned practices with regard to the timing of rate increases.
A written demonstration that the relative ratios of the rates for the rating period do not exceed
the appropriate permitted ratios (4:1, 3:1, or 2:1 depending upon the time period since
enactment of the Act)

A written demonstration that any exceptions to the above are due to the transition period
allowances of the Model Act.

C. CLASSES OR BLOCKS OF BUSINESS

This model does not permit separating business into classes or blocks. All classes and blocks
must be rated together using the same adjusted community rate and rating factors.

D. RATING PERIODS

For purposes of this manual, rating period represents the number of months to which the rates are
calculated to be applicable. The adjusted community rating required by the Model Act should not
be construed to prohibit different trend adjustments depending upon the anniversary date. The
carrier is likely to have established adjusted community rates that vary time periods (e.g.,
monthly or quarterly). For example, the adjusted community rate for groups with January 1
anniversaries may include a trend adjustment of 1.00 whereas the adjusted community rate for
groups having April 1 anniversaries may include a trend adjustment of 1.03. The groups in these
rating cohorts should be examined together as defining a common rating period. The examiner
should be alert for the misuse of rating periods.

The guidance manual presumes that rates based on a complying rate manual are not out of
compliance if the rate manual changes and the rates are adjusted at the next anniversary date.

Historically, carriers followed various renewal rating approaches in terms of implementation
points. The most common implementation points were semi-anniversary, anniversary, or next
premium due date after notice. The examiner should note, however, that the Act prohibits rates
from being adjusted more frequently than annually except to reflect changes to the enrollment of
the small employer, changes to the family composition of the employee, and changes to the
health benefit plan requested by the small employer. It should also be noted that increases for
experience adjustments and aging (if an employee’s age transfers him into a new age bracket)
must be implemented at the same time. The Act does not permit multiple rate adjustments within
one year for increases due to experience and for aging. The carrier should be required to
demonstrate that rate adjustments comply with the requirements of the act.

E. RATING FACTORS

The examiner should recognize that the Model Act implicitly does not allow any latitude for
underwriting judgment or carrier prerogative. Specifically, carriers are not allowed to continue to
use such practices as durational and tier rating.

Much of the examiner’s work in reviewing rating will of necessity be subjective. Factors such as
the examiner’s knowledge of the carrier and the actuary who signed the opinion, as well as the
wording of the opinion itself, will be important. These factors are discussed elsewhere in this manual. The purpose of this section is to provide guidance in interpreting rating factors in the context of the review.

The values shown in this section of the manual are intended to represent safe harbors. That is, if an examiner finds that a carrier’s factors fall within the parameters defined, the carrier’s factors can generally be assumed to be reasonable. If a carrier’s factors fall outside the safe harbors defined, the examiner may request the carrier to furnish supporting documentation. Note that the safe harbor factors in this manual were developed in 1992 and have not been updated since development. Therefore, the examiner should carefully consider this in using the safe harbor factors to determine the appropriateness of a carrier’s factors.

One question which will undoubtedly occur during the course of any examination is: what action should be taken if the parameter in questions falls outside of the range shown in this manual? If the examiner feels that this is a material breach of the requirements, actuarial justification may be requested from the actuary. This justification should take the form of an experience study or other well thought-out and documented source. Where appropriate data are not available, the actuary should at least provide a demonstration of the reasonableness of the result. The actuary’s opinion, in and of itself, would normally not be sufficient.

This Model Act limits case characteristics to geographic area, family composition, and age. For each of these characteristics, a discussion of the required ranges and/or a range of values which may be deemed reasonable is presented below. These ranges are based upon the requirements contained within the Act and input from various small group carriers as well as other industry rate and claim cost data. To be allowable, case characteristics must be specific and uniformly applied.

Following the discussion of specific case characteristics is a discussion of coverage, or plan design, characteristics.

1. **Case Characteristics**

a. **Age**

Variation of claims costs by age is an understandable characteristic since it is well known that, on average, health status deteriorates as one grows older. However, the relative differences in premium rates by age will tend to vary by other characteristics as well, such as plan design. According to the Act, adjustments for age may not use age brackets with smaller than five-year increments. In addition, the adjustments must begin with age 30 and end with age 65. A further limitation on the maximum adjustment for age is phased in as follows:

- During the first two years after the enactment of this Act, the permitted rates for any age group shall be no more than 400% of the lowest rate for all age groups;

- Two years after the enactment of this Act, the permitted rates for any age group shall be no more than 300% of the lowest rate for all age groups.
Five years after the enactment of this Act, the adjustment for age may not result in a rate per enrollee for a particular health benefit plan that is more than 200% of the lowest rate for all age groups.

First, the examiner should confirm that age brackets with smaller than 5-year increments have not been used and that the age brackets begin at age 30 and end at age 65. Separate rates are permitted for individuals age 65 and older for coverage for which Medicare is the primary payer and for which Medicare is not the primary payer.

Second, the examiner should check the ratio of the highest possible premium rate to the lowest possible premium rate. Normally, this will be the highest age bracket premium related to the lowest age bracket premium. The allowable ratio varies depending on the length of time which has passed since the enactment of the Act.

<table>
<thead>
<tr>
<th>Period of Time Since Enactment of Act:</th>
<th>Less than 2 years</th>
<th>Less than 5 years</th>
<th>5 or more years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permitted ratio:</td>
<td>4 to 1</td>
<td>3 to 1</td>
<td>2 to 1</td>
</tr>
</tbody>
</table>

The age rate limitations apply separately for enrollees and spouses before calculating the rate for each family composition. Spouse premium rates are not compared to enrollee premium rates. It could be possible to have the most expensive spouse rate be more than the permitted multiple (i.e., 4, 3 or 2 depending upon the time period since enactment) of the cheapest employee rate and still be in compliance. Compliance would be met as long as the highest spouse rate was not more than the permitted multiple of the lowest spouse rate, and the highest employee rate was not more than the permitted multiple of the lowest employee rate.

Ratios and/or rates should progress in a consistent manner throughout the age span. If they do not, separate tests may be performed at different ages. However, it is common to have flat age factors at the early adult ages (e.g., .70 for ages 22, 27, 32 and 37) and then increase them as age increases. This is also acceptable. The Act requires flat age factors for ages 30 and below and for ages 65 and above. In addition, rates for ages within age brackets must be flat.

b. Family Composition

Historically, companies have used a number of rating structures to include dependent coverage. The Act defines family composition to mean: enrollee; enrollee, spouse and children; enrollee and spouse; or enrollee and children. The relative rate factors shown below are based on a comparison to an average composite member rate using an age/gender/employee/spouse distribution representative of the U.S. labor force. Expected distributions which are different may have different relationships. Carriers may be requested to provide the calculations for the rates they are using. The following table is illustrative only to provide the examiner with examples of family composition rating factors.
<table>
<thead>
<tr>
<th>Description</th>
<th>Relative Rate Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Enrollee</td>
<td>1.00</td>
</tr>
<tr>
<td>Enrollee and Spouse</td>
<td>2.70</td>
</tr>
<tr>
<td>Enrollee and Child(ren)</td>
<td>1.70</td>
</tr>
<tr>
<td>Family</td>
<td>3.00</td>
</tr>
</tbody>
</table>

Rates may not be gender distinct for small groups.

Companies can set spouse rates in different ways. Some discount the spouse rate from the employee rate, most likely due to the ability to spread expenses over an additional covered person. On the other hand, others set spouse rates higher than employee rates, presumably in anticipation of higher utilization patterns on the part of the spouse. The majority of carrier rates appear to have spouse rates set equal to employee rates. Dependent rating structures should be supported by an appropriate demonstration.

Historically, child rates showed significant variation from one carrier to another. The rating structure was on an each child, four or more children, three or more children, two or more, or all children basis. The Model permits only the all children basis.

The portion of the rates attributable only to children may vary by the age of the employee. The children rates should not vary based on the age of the children. Any variation in the children portion of the rates should be attributable to the expected number of children for that age of employee. If a carrier elects such variation, the children portion of the rates should decrease at the older employee ages because children will have grown. Often, however, carriers do not vary children rates by the age of the employee. This is also acceptable.

c. **Geographic Location**

The cost of medical care can vary dramatically from one area to another. This is due to the general cost level of the area, the differences in medical practices by region, the specialization and intensity of services, and the amount of competition in the area. Most small group plans vary rates by either county or ZIP code (usually 3-digit but sometimes 5-digit). The employer’s business address is normally used.

Because of the many factors involved in setting area rates, including competitive posturing and regulatory concerns, area rating factors used by companies can vary significantly.

The following table indicates the safe harbor ratio of highest factor to lowest factor for each state. Some states have laws or regulations that require lower factors than those shown in the table. The laws or regulations would, of course, prevail. An example would be a state which does not allow geographic variation in rates, where the factor would effectively be 1.00.
### State Area Relativities

**Ratio of the Highest Area Factor to the Lowest Area Factor in Each State**

<table>
<thead>
<tr>
<th>State</th>
<th>Maximum Area Ratio</th>
<th>State</th>
<th>Maximum Area Ratio</th>
<th>State</th>
<th>Maximum Area Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1.40</td>
<td>Kentucky</td>
<td>1.50</td>
<td>North Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Alaska</td>
<td>1.20</td>
<td>Louisiana</td>
<td>1.50</td>
<td>Ohio</td>
<td>1.60</td>
</tr>
<tr>
<td>Arizona</td>
<td>1.40</td>
<td>Maine</td>
<td>1.20</td>
<td>Oklahoma</td>
<td>1.40</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1.40</td>
<td>Maryland</td>
<td>1.50</td>
<td>Oregon</td>
<td>1.30</td>
</tr>
<tr>
<td>California</td>
<td>1.70</td>
<td>Massachusetts</td>
<td>1.40</td>
<td>Pennsylvania</td>
<td>1.80</td>
</tr>
<tr>
<td>Colorado</td>
<td>1.30</td>
<td>Michigan</td>
<td>1.50</td>
<td>Rhode Island</td>
<td>1.20</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1.40</td>
<td>Minnesota</td>
<td>1.50</td>
<td>South Carolina</td>
<td>1.40</td>
</tr>
<tr>
<td>Delaware</td>
<td>1.20</td>
<td>Mississippi</td>
<td>1.40</td>
<td>South Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Dist. of Columbia</td>
<td>1.00</td>
<td>Missouri</td>
<td>1.40</td>
<td>Tennessee</td>
<td>1.30</td>
</tr>
<tr>
<td>Florida</td>
<td>1.90</td>
<td>Montana</td>
<td>1.20</td>
<td>Texas</td>
<td>1.70</td>
</tr>
<tr>
<td>Georgia</td>
<td>1.40</td>
<td>Nebraska</td>
<td>1.40</td>
<td>Utah</td>
<td>1.20</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1.20</td>
<td>Nevada</td>
<td>1.40</td>
<td>Vermont</td>
<td>1.20</td>
</tr>
<tr>
<td>Idaho</td>
<td>1.20</td>
<td>New Hampshire</td>
<td>1.30</td>
<td>Virginia</td>
<td>1.60</td>
</tr>
<tr>
<td>Illinois</td>
<td>1.70</td>
<td>New Jersey</td>
<td>1.50</td>
<td>Washington</td>
<td>1.30</td>
</tr>
<tr>
<td>Indiana</td>
<td>1.70</td>
<td>New Mexico</td>
<td>1.30</td>
<td>West Virginia</td>
<td>1.40</td>
</tr>
<tr>
<td>Iowa</td>
<td>1.40</td>
<td>New York</td>
<td>1.80</td>
<td>Wisconsin</td>
<td>1.50</td>
</tr>
<tr>
<td>Kansas</td>
<td>1.40</td>
<td>North Carolina</td>
<td>1.30</td>
<td>Wyoming</td>
<td>1.20</td>
</tr>
</tbody>
</table>

It is possible that the rates for some carriers may exceed these ranges. These are to be considered guideline ratios. The examiner may wish to have the carrier provide demonstration of the need for a ratio beyond those illustrated above.

### 2. Coverage Characteristics

The Model Act sets certain criteria and limitations for premium rates. The Model Act states that the rating factors must produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. This section provides guidelines on rate relationships for various benefit provisions and types of coverage. The values shown represent typical comprehensive plans (excluding normal maternity coverage). Other types of benefits packages may have different relationships than those discussed in this section and, therefore, the value guidelines provided below may not be appropriate for these types of benefit designs. As mentioned in Section II of this manual, the examiner should look especially closely at the relationship of heavily marketed plans to the basic and standard plans, where the Access Models are applicable.
a. **Deductible**

The rating of a deductible feature depends upon the size of the deductible, allowable case characteristics, and the impact of trend leveraging over time. For example, a $100 deductible impacts the cost of a plan far less today than it did in 1972. Similarly, a $100 deductible has greater impact to rates in a low cost area such as rural Iowa than in a high cost area such as Los Angeles. In other words, the relative cost of one deductible level to another depends upon the cost levels to which the deductibles are applied. As an example, consider the following two situations for a $250 deductible and a $1,000.

<table>
<thead>
<tr>
<th></th>
<th>Cost Level A</th>
<th>Cost Level B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Charges</td>
<td>$12,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Deductible 1</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Remaining Charges</td>
<td>$11,750</td>
<td>$6,750</td>
</tr>
<tr>
<td>Eligible Charges</td>
<td>$12,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Deductible 2</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Remaining Charges</td>
<td>$11,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Relative Impact of $1,000 Deductible to $250 Deductible</td>
<td>.936</td>
<td>.889</td>
</tr>
</tbody>
</table>

The lower the charge level, the greater the impact the deductible has on premium.

One difficulty in reviewing deductible relationships is that many carriers have traditionally allowed selection to affect the relationship in their rates. That is, the relative rates reflect the characteristics of the groups that would tend to select the particular deductible. Such selection is not an appropriate coverage characteristic. Utilization differences would also occur for a given group just based on the effect of the deductible itself. This effect is difficult to quantify. The safe harbors shown below reflect some element of this effect.

The safe harbors shown in the table below are values typical of an 80%/20% coinsurance plan with a $5,000 stop-loss level (i.e., $1,000 insured out-of-pocket maximum after the deductible).
### Deductible Range Relative to a $500 Deductible Level

<table>
<thead>
<tr>
<th>Deductible Level</th>
<th>Safe Harbor if Ratio to $500 Deductible Level is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>less than 1.50</td>
</tr>
<tr>
<td>250</td>
<td>less than 1.25</td>
</tr>
<tr>
<td>500</td>
<td>1.00</td>
</tr>
<tr>
<td>750</td>
<td>more than .85</td>
</tr>
<tr>
<td>1,000</td>
<td>more than .75</td>
</tr>
<tr>
<td>1,500</td>
<td>more than .70</td>
</tr>
<tr>
<td>2,000</td>
<td>more than .65</td>
</tr>
<tr>
<td>2,500</td>
<td>more than .60</td>
</tr>
</tbody>
</table>

Besides the rate ratio, the absolute dollar difference in rates should also be reviewed to be certain the annual premium difference does not exceed the dollar difference in the deductible.

There are several points to note regarding the deductible relativities:

- These ranges are for plans with 80% coinsurance and $5,000 stop-loss levels. Some companies will vary their deductibles relativities for different coinsurance or out-of-pocket levels. However, it is anticipated that ratios for plans with other stop-loss levels will generally fall within these safe harbor ranges.

- These ranges may not be appropriate for plans which waive the deductible for certain qualifying medical care or types of services.

- The ranges are based upon plans excluding supplemental accident coverage, though such coverage is frequently offered as a policy option.

- For deductibles of $1,000 or more, companies may sometimes include deductible adjustments to recognize the impact of an employer self-insuring his employees for a corridor within the deductible amount. This is more common for groups of 10 or more employees.

b. **Stop-Loss Coinsurance Limits**

Most small group insurance plans provide a stop-loss coinsurance limit feature. This provides assurance to the insured that in a catastrophic situation out-of-pocket responsibilities will be capped at a specified level for covered expenses.

These limits are usually presented from one of two perspectives:

- Maximum out-of-pocket expense (including or excluding the deductible).
- Maximum levels of covered expenses (after the deductible) to which the coinsurance percentage will be applied. Amounts above this threshold would be paid at 100%.

The following table presents guidelines for evaluating rating relativities between four stop-loss levels for an 80%/20% coinsurance plan.

<table>
<thead>
<tr>
<th>Stop-Loss Limit</th>
<th>Coinsurance Out-of-Pocket</th>
<th>Safe Harbor if Ratio to $5,000 Stop-Loss Limit is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000</td>
<td>$400</td>
<td>less than 1.15</td>
</tr>
<tr>
<td>2,500</td>
<td>500</td>
<td>less than 1.10</td>
</tr>
<tr>
<td>5,000</td>
<td>1,000</td>
<td>1.00</td>
</tr>
<tr>
<td>10,000</td>
<td>2,000</td>
<td>greater than .85</td>
</tr>
</tbody>
</table>

Besides the rate ratio, the absolute dollar difference in rates should also be reviewed to be certain the annual premium difference does not exceed the dollar difference in coinsurance.

Some companies offer higher stop-loss limits such as $12,500 ($2,500 OOP), and $25,000 ($5,000 OOP), in order to reduce premiums more. The rate differential for these higher limits would not be expected to be more than 25% lower than the rates for a $5,000 stop-loss limit (i.e., a low factor of .75 for no out-of-pocket limit).

c. **Maternity**

The examiner may have to compare rate relativities for plans with maternity to plans without maternity. The relationship may vary based upon the population. No safe harbor values are given because the appropriate value in the maternity is dependent upon other benefit provisions.

d. **Managed Care**

Managed care products introduce a set of variables, which go beyond the scope of this manual at this point. Cost containment techniques, such as pre-admission certification, concurrent utilization review, discharge planning, second surgical opinion and large case management may be reflected in discounts relative to otherwise appropriate rates of up to about 10%. Any discount greater than 10% is likely to be indicative of tighter utilization controls than most carriers have in place. The examiner may wish to investigate such large discounts.

Because of discounts from providers, it is very complicated to compare a preferred provider plan or an HMO plan to a traditional indemnity program, such as discussed in this manual. However, comparisons can be made among similar preferred provider plans and among HMO plans. Further, in general, the rates for a preferred provider plan or IPA/HMO plan would not be expected to be more than 20% lower than the comparable indemnity plan as described in this manual. It is important to note that a plan using a restricted network of providers is not
considered to be similar coverage to a plan with no such restrictions, even though the actual plan benefits may be similar.

There is no clear definition of what constitutes a “managed care” contract. In general, the covered persons have some limitations on access to care (e.g. networks, gate-keeper, pre-authorization etc.) and other controls or reviews of health care expenditures may be involved (e.g. provider discounts, concurrent review, case management etc.).

In some situations involving managed care, these controls are used almost exclusively to reduce costs and rate schedules are very similar to non-managed care rate schedules. Other managed care products may have very different benefit packages (e.g. federally qualified HMOs must have certain benefits) and frequently do not use all of the rate distinctions allowed by the models.

In the situation where a carrier has both managed care and non-managed care plans, the review should include the assumed sources of rate differences. Those which come from added controls should be fully credited to the managed care plans. Some, however, might be used to “game” the guaranteed issue rules. Such things as limiting network availability to selected areas, limiting network providers to selected specialties and inconsistent use of the right to exclude “out-of-area” employees are potential areas which should be reviewed under managed care plans.

Because most managed care plans include some provider discounts, a range of premium rate differences must be separated into two parts:

1) Cost-containment techniques, such as pre-admission testing, concurrent utilization review, discharge planning, second surgical opinion and large case management may be reflected in rate differences of up to 10%.

2) Any discount greater than 10% should be related to network variables such as discounts, gate-keeper controls etc.

The examiner should note that the rates of HMOs are also subject to the rating restrictions of the Model Act. However, an important distinction must be made for certain HMOs which are stand-alone affiliates and those that are simply another line of business within a carrier’s product portfolio. Section 4E(2) of the Model Acts allows an HMO which is an affiliated carrier having a certificate of authority from the state in which it is operating to be considered a separate carrier for the purposes of the Act.

However, it should be noted that an HMO plan, which is another product line within a carrier is not given this same exception treatment. It must be included with the other business of the carrier subject to the Act.

In the situation where an affiliated HMO carrier also writes other types of small employer plans subject to the Acts (e.g., POS, EPO, or PPO plans), the Act appears to still allow for separate treatment of the business of this affiliate. However, the HMO business would need to be considered together with the other business of this carrier.
3. **Interrelationship of Variables**

Case and coverage characteristics are treated separately in this manual for simplification. However, as noted in the section under deductibles, many of the variables are, in fact, interrelated.

**F. TESTING CRITERIA**

Testing consists of examining the development of the adjusted community rates and rating factors. Factors for rating characteristics should be consistent with the key elements of the rating provisions listed in Section IX.A of the Guidance Manual. Once the examiner is satisfied that the rating factors comply with the rating requirements, the examiner should test samples using the sampling techniques described in Section VII.A.

**G. TRANSITION**

The requirements of the Model Act apply to all business issued after the effective date of the law in a particular state. However, for business issued prior to the effective date of the law, the rating provisions are effective on the renewal date following the effective date of the Act.

The examiner should include in any samples a number of groups with effective dates prior to the effective date of the Act.
X.  SMALL EMPLOYER AND INDIVIDUAL HEALTH INSURANCE
AVAILABILITY MODEL ACT
(Model 035, includes 2000 amendments for HIPAA)

A.  KEY ELEMENTS OF THE RATING REQUIREMENTS

The Act contains premium rate restrictions for small employer carriers and individual carriers. An individual risk assuming carrier shall establish uniform rates for all the small employer and individual health benefit plans, subject only to the consistent application of permitted factors for varying rates. A risk-assuming carrier complies with Section 11 of the Act and does not reinsure the risk. A non-risk-assuming or reinsuring carrier complies with Section 12 and does reinsure the risk. A reinsuring carrier is not required to establish uniform rates for small employers and individual health benefit plans.

The key element of the rating requirements is that rates must be based on an adjusted community rate and may only vary from the adjusted community rate for the following case characteristics:

- Geographic area;
- Family composition; and
- Age

Permissible adjustments for the case characteristics are discussed in Subsection E below.

Small employer carriers may develop separate rates for individuals age 65 or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates are subject to the rating requirements described in this section. Note that HIPAA requires carriers to guarantee renew individual policies and does not allow carriers to non-renew individual policies based on Medicare eligibility due to age.)

Rates may not be changed more frequently than annually except to reflect the following:

- Changes to the enrollment of the small employer;
- Changes to the family composition of the employee or eligible person;
- Changes to the health benefit plan requested by the small employer or eligible person;

Rating factors must produce premiums for identical groups, and for identical eligible persons in the case of individual health benefit plans, which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.
**Professional Association Plans**

A health benefit plan that is offered through a professional association is subject to somewhat different rating and availability requirements than other health benefit plans. If an association meets the criteria listed in Section 3. Definitions of the Model Act (see “professional associations”), then the health benefit plan offered through that association are subject to the same rating provisions as all other health benefit plans with the following exceptions:

1) If the health benefit plan covers at least 2,000 members then that association’s experience can be used as the basis for setting rates.

2) If the health benefit plan covers fewer than 2,000 members the carrier must community rate the experience of that professional association with the experience of the other professional associations offered by the carrier.

The minimum qualifying number of members is an average of at least 2,000 members covered by that carrier nationwide during the preceding calendar year. In the event that the carrier did not provide coverage for the association health plan in the preceding calendar year the member count shall be based on the average number of members that are reasonably expected to be covered in the current calendar year.

The provisions of the Portability Act relating to renewability, availability, and pre-existing conditions apply to professional association plans, except that professional associations are not required to offer individual basic and standard health benefit plans.

**B. ADDITIONAL REQUIRED DOCUMENTATION**

As mentioned in Section IV, documentation may include a demonstration or explanation supporting the actuarial certification that the rates are in compliance with the rating law. This demonstration might include:

- A written description of the basis for defining the rating period and a written demonstration that the assigned rating period is consistent with current and planned practices with regard to the timing of rate increases.

- A written demonstration that the relative ratios of the rates for the rating period do not exceed the appropriate permitted ratios (4:1, 3:1, or 2:1 depending upon the time period since enactment of the Act)

- A written demonstration that any exceptions to the above are due to the transition period allowances of the Model Act.

- For risk-assuming individual carriers, a written demonstration that rates for all small employer and individual health benefit plans are uniform, subject only to the consistent application of permitted factors for varying rates.
C. CLASSES OR BLOCKS OF BUSINESS

This model does not permit separating business into classes or blocks. All classes and blocks must be rated together using the same adjusted community rate and rating factors.

D. RATING PERIODS

For purposes of this manual, rating period represents the number of months to which the rates are calculated to be applicable. The adjusted community rating required by the Model Act should not be construed to prohibit different trend adjustments depending upon the anniversary date. The carrier is likely to have established adjusted community rates that vary time periods (e.g., monthly or quarterly). For example, the adjusted community rate for January 1 anniversaries may include a trend adjustment of 1.00 whereas the adjusted community rate for April 1 anniversaries may include a trend adjustment of 1.03. These rating cohorts should be examined together as defining a common rating period. The examiner should be alert for the misuse of rating periods.

The guidance manual presumes that rates based on a complying rate manual are not out of compliance if the rate manual changes and the rate are adjusted at the next anniversary date.

Historically, carriers followed various renewal rating approaches in terms of implementation points. The most common implementation points were semi-anniversary, anniversary, or next premium due date after notice. The examiner should note, however, that the Act prohibits rates from being adjusted more frequently than annually except to reflect changes to the enrollment of the small employer, changes to the family composition of the employee or eligible person, and changes to the health benefit plan requested by the small employer or eligible person. It should also be noted that increases for experience adjustments and aging (if a participant transfers into a new age bracket) must be implemented at the same time. The Act does not permit multiple rate adjustments within one year for increases due to experience and for aging. The carrier should be required to demonstrate that rate adjustments comply with the requirements of the act.

E. RATING FACTORS

The examiner should recognize that the Model Act implicitly does not allow any latitude for underwriting judgment or carrier prerogative. Specifically, carriers are not allowed to continue to use such practices as durational and tier rating.

Much of the examiner’s work in reviewing rating will of necessity be subjective. Factors such as the examiner’s knowledge of the carrier and the actuary who signed the opinion, as well as the wording of the opinion itself, will be important. These factors are discussed elsewhere in this manual. The purpose of this section is to provide guidance in interpreting rating factors in the context of the review.

The values shown in this section of the manual are intended to represent safe harbors. That is, if an examiner finds that a carrier’s factors fall within the parameters defined, the carrier’s factors can generally be assumed to be reasonable. If a carrier’s factors fall outside the safe harbors
defined, the examiner may request the carrier to furnish supporting documentation. Note that the
safe harbor factors in this manual were developed in 1992 and have not been updated since
development. Therefore, the examiner should carefully consider this in using the safe harbor
factors to determine the appropriateness of a carrier’s factors.

One question which will undoubtedly occur during the course of any examination is: what action
should be taken if the parameter in question falls outside of the range shown in this manual? If
the examiner feels that this is a material breech of the requirements, actuarial justification may be
requested from the actuary. This justification should take the form of an experience study or
other well thought-out and documented source. Where appropriate data are not available, the
actuary should at least provide a demonstration of the reasonableness of the result. The actuary’s
opinion, in and of itself, would normally not be sufficient.

This Model Act limits case characteristics to geographic area, family composition, and age. For
each of these characteristics, a discussion of the required ranges and/or a range of values which
may be deemed reasonable is presented below. These ranges are based upon the requirements
contained within the Act and input from various small group carriers as well as other industry
rate and claim cost data. To be allowable, case characteristics must be specific and uniformly
applied.

Following the discussion of specific case characteristics is a discussion of coverage, or plan
design, characteristics.

1. Case Characteristics

a. Age

Variation of claims costs by age is an understandable characteristic since it is well known that,
on average, health status deteriorates as one grows older. However, the relative differences in
premium rates by age will tend to vary by other characteristics as well, such as plan design.
According to the Act, small employer carriers may not use age brackets with smaller than five-
year increments. In addition, the adjustments must begin with age 30 and end with age 65.
Individual carriers may use one-year increment age brackets beginning at age nineteen. A further
limitation on the maximum adjustment for age is phased in as follows:

- During the first two years after the enactment of this Act, the permitted rates for any age
group shall be no more than 400% of the lowest rate for all adult age groups;

- Two years after the enactment of this Act, the permitted rates for any age group shall be no
more than 300% of the lowest rate for all adult age groups.

- Five years after the enactment of this Act, the adjustment for age may not result in a rate per
enrollee for a particular health benefit plan that is more than 200% of the lowest rate for all
adult age groups.
First, the examiner should confirm that age brackets comply with requirements in the Act. For small employers, separate rates are permitted for individuals age 65 and older for coverage for which Medicare is the primary payer and for which Medicare is not the primary payer. Both rates are subject to the rating requirements described in this section. Note that HIPAA requires carriers to guarantee renew individual policies and does not allow carriers to non-renew individual policies based on Medicare eligibility due to age.

Second, the examiner should check the ratio of the highest possible premium rate to the lowest possible premium rate. Normally, this will be the highest age bracket premium related to the lowest age bracket premium. The allowable ratio varies depending on the length of time which has passed since the enactment of the Act.

<table>
<thead>
<tr>
<th>Period of Time Since Enactment of Act</th>
<th>Less than 2 years</th>
<th>Less than 5 years</th>
<th>5 or more years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permitted ratio:</td>
<td>4 to 1</td>
<td>3 to 1</td>
<td>2 to 1</td>
</tr>
</tbody>
</table>

The age rate limitations apply separately for enrollees and spouses before calculating the rate for each family composition. Spouse premium rates are not compared to enrollee premium rates. It could be possible to have the most expensive spouse rate be more than the permitted multiple (i.e., 4, 3 or 2 depending upon the time period since enactment) of the cheapest employee rate and still be in compliance. Compliance would be met as long as the highest spouse rate was not more than the permitted multiple of the lowest spouse rate, and the highest employee rate was not more than the permitted multiple of the lowest employee rate.

Ratios and/or rates should progress in a consistent manner throughout the age span. If they do not, separate tests may be performed at different ages. However, it is common to have flat age factors at the early adult ages (e.g., .70 for ages 22, 27, 32 and 37) and then increase them as age increases. This is also acceptable. The Act requires flat age factors for ages 30 and below and for ages 65 and above if the coverage is issued to small employers, and for ages below age nineteen if the coverage is issued to individuals. In addition, rates for ages within age brackets must be flat.

b. Family Composition

Historically, companies have used a number of rating structures to include dependent coverage. The Act defines family composition to mean: enrollee; enrollee, spouse and children; enrollee and spouse; or enrollee and children. The relative rate factors shown below are based on a comparison to an average composite member rate using an age/gender/employee/spouse distribution representative of the U.S. labor force. Expected distributions which are different may have different relationships. Carriers may be requested to provide the calculations for the rates they are using. The following table is illustrative only to provide the examiner with examples of family composition rating factors.
<table>
<thead>
<tr>
<th>Description</th>
<th>Relative Rate Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Enrollee</td>
<td>1.00</td>
</tr>
<tr>
<td>Enrollee and Spouse</td>
<td>2.70</td>
</tr>
<tr>
<td>Enrollee and Child(ren)</td>
<td>1.70</td>
</tr>
<tr>
<td>Family</td>
<td>3.00</td>
</tr>
</tbody>
</table>

Rates may not be gender distinct for small groups or individuals.

Companies can set spouse rates in different ways. Some discount the spouse rate from the enrollee rate, most likely due to the ability to spread expenses over an additional covered person. On the other hand, others set spouse rates higher than enrollee rates, presumably in anticipation of higher utilization patterns on the part of the spouse. For small employers, the majority of carrier rates appear to have spouse rates set equal to employee rates. Dependent rating structures should be supported by an appropriate demonstration.

Historically, child rates showed significant variation from one carrier to another. The rating structure was on an each child, four or more children, three or more children, two or more, or all children basis. The Model permits only the all children basis.

The portion of the rates attributable only to children may vary by the age of the enrollee. The children rates should not vary based on the age of the children. Any variation in the children portion of the rates should be attributable to the expected number of children for that age of enrollee. If a carrier elects such variation, the children portion of the rates should decrease at the older enrollee ages because children will have grown. Often, however, carriers do not vary children rates by the age of the enrollee. This is also acceptable.

c. **Geographic Location**

The cost of medical care can vary dramatically from one area to another. This is due to the general cost level of the area, the differences in medical practices by region, the specialization and intensity of services, and the amount of competition in the area. Most small group plans vary rates by either county or ZIP code (usually 3-digit but sometimes 5-digit). The employer’s business address is normally used.

Because of the many factors involved in setting area rates, including competitive posturing and regulatory concerns, area rating factors used by companies can vary significantly.

The following table indicates the safe harbor ratio of highest factor to lowest factor for each state. Some states have laws or regulations that require lower factors than those shown in the table. The laws or regulations would, of course, prevail. An example would be a state which does not allow geographic variation in rates, where the factor would effectively be 1.00.
State Area Relativities
Ratio of the Highest Area Factor to the Lowest Area Factor in Each State

<table>
<thead>
<tr>
<th>State</th>
<th>Maximum Area Ratio</th>
<th>State</th>
<th>Maximum Area Ratio</th>
<th>State</th>
<th>Maximum Area Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1.40</td>
<td>Kentucky</td>
<td>1.50</td>
<td>North Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Alaska</td>
<td>1.20</td>
<td>Louisiana</td>
<td>1.40</td>
<td>North Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Arizona</td>
<td>1.40</td>
<td>Maine</td>
<td>1.20</td>
<td>Oklahoma</td>
<td>1.40</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1.40</td>
<td>Maryland</td>
<td>1.50</td>
<td>Oregon</td>
<td>1.30</td>
</tr>
<tr>
<td>California</td>
<td>1.70</td>
<td>Massachussetts</td>
<td>1.40</td>
<td>Pennsylvania</td>
<td>1.80</td>
</tr>
<tr>
<td>Colorado</td>
<td>1.30</td>
<td>Michigan</td>
<td>1.50</td>
<td>Rhode Island</td>
<td>1.20</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1.40</td>
<td>Minnesota</td>
<td>1.50</td>
<td>South Carolina</td>
<td>1.40</td>
</tr>
<tr>
<td>Delaware</td>
<td>1.20</td>
<td>Mississippi</td>
<td>1.40</td>
<td>South Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Dist. of Columbia</td>
<td>1.00</td>
<td>Missouri</td>
<td>1.40</td>
<td>Tennessee</td>
<td>1.30</td>
</tr>
<tr>
<td>Florida</td>
<td>1.90</td>
<td>Montana</td>
<td>1.20</td>
<td>Texas</td>
<td>1.70</td>
</tr>
<tr>
<td>Georgia</td>
<td>1.40</td>
<td>Nebraska</td>
<td>1.40</td>
<td>Utah</td>
<td>1.20</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1.20</td>
<td>Nevada</td>
<td>1.40</td>
<td>Vermont</td>
<td>1.20</td>
</tr>
<tr>
<td>Idaho</td>
<td>1.20</td>
<td>New Hampshire</td>
<td>1.30</td>
<td>Virginia</td>
<td>1.60</td>
</tr>
<tr>
<td>Illinois</td>
<td>1.70</td>
<td>New Jersey</td>
<td>1.50</td>
<td>Washington</td>
<td>1.30</td>
</tr>
<tr>
<td>Indiana</td>
<td>1.70</td>
<td>New Mexico</td>
<td>1.30</td>
<td>West Virginia</td>
<td>1.40</td>
</tr>
<tr>
<td>Iowa</td>
<td>1.40</td>
<td>New York</td>
<td>1.80</td>
<td>Wisconsin</td>
<td>1.50</td>
</tr>
<tr>
<td>Kansas</td>
<td>1.40</td>
<td>North Carolina</td>
<td>1.30</td>
<td>Wyoming</td>
<td>1.20</td>
</tr>
</tbody>
</table>

It is possible that the rates for some carriers may exceed these ranges. These are to be considered guideline ratios. The examiner may wish to have the carrier provide demonstration of the need for a ratio beyond those illustrated above.

2. **Coverage Characteristics**

The Model Act sets certain criteria and limitations for premium rates. The Model Act states that the rating factors must produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans. This section provides guidelines on rate relationships for various benefit provisions and types of coverage. The values shown represent typical comprehensive plans (excluding normal maternity coverage). Other types of benefits packages may have different relationships than those discussed in this section and, therefore, the value guidelines provided below may not be appropriate for these types of benefit designs. As mentioned in Section II of this manual, the examiner should look especially closely at the relationship of heavily marketed plans to the basic and standard plans, where the Access Models are applicable.
The rating of a deductible feature depends upon the size of the deductible, allowable case characteristics, and the impact of trend leveraging over time. For example, a $100 deductible impacts the cost of a plan far less today than it did in 1972. Similarly, a $100 deductible has greater impact to rates in a low cost area such as rural Iowa than in a high cost area such as Los Angeles. In other words, the relative cost of one deductible level to another depends upon the cost levels to which the deductibles are applied. As an example, consider the following two situations for a $250 deductible and a $1,000.

<table>
<thead>
<tr>
<th>Eligible Charges</th>
<th>Cost Level A</th>
<th>Cost Level B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible 1</td>
<td>$12,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Remaining Charges</td>
<td>$11,750</td>
<td>$6,750</td>
</tr>
<tr>
<td></td>
<td>$11,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

The lower the charge level, the greater the impact the deductible has on premium.

One difficulty in reviewing deductible relationships is that many carriers have traditionally allowed selection to affect the relationship in their rates. That is, the relative rates reflect the characteristics of the groups that would tend to select the particular deductible. Such selection is not an appropriate coverage characteristic. Utilization differences would also occur for a given group just based on the effect of the deductible itself. This effect is difficult to quantify. The safe harbors shown below reflect some element of this effect.

The safe harbors shown in the table below are values typical of an 80%/20% coinsurance plan with a $5,000 stop-loss level (i.e., $1,000 insured out-of-pocket maximum after the deductible).
<table>
<thead>
<tr>
<th>Deductible Level</th>
<th>Safe Harbor if Ratio to $500 Deductible Level is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>less than 1.50</td>
</tr>
<tr>
<td>250</td>
<td>less than 1.25</td>
</tr>
<tr>
<td>500</td>
<td>1.00</td>
</tr>
<tr>
<td>750</td>
<td>more than .85</td>
</tr>
<tr>
<td>1,000</td>
<td>more than .75</td>
</tr>
<tr>
<td>1,500</td>
<td>more than .70</td>
</tr>
<tr>
<td>2,000</td>
<td>more than .65</td>
</tr>
<tr>
<td>2,500</td>
<td>more than .60</td>
</tr>
</tbody>
</table>

Besides the rate ratio, the absolute dollar difference in rates should also be reviewed to be certain the annual premium difference does not exceed the dollar difference in the deductible.

There are several points to note regarding the deductible relativities:

- These ranges are for plans with 80% coinsurance and $5,000 stop-loss levels. Some companies will vary their deductibles relativities for different coinsurance or out-of-pocket levels. However, it is anticipated that ratios for plans with other stop-loss levels will generally fall within these safe harbor ranges.

- These ranges may not be appropriate for plans which waive the deductible for certain qualifying medical care or types of services.

- The ranges are based upon plans excluding supplemental accident coverage, though such coverage is frequently offered as a policy option.

- For deductibles of $1,000 or more, companies may sometimes include deductible adjustments to recognize the impact of an employer self-insuring his employees for a corridor within the deductible amount. This is more common for groups of 10 or more employees.

b. **Stop-Loss Coinsurance Limits**

Most small group insurance plans provide a stop-loss coinsurance limit feature. This provides assurance to the insured that in a catastrophic situation out-of-pocket responsibilities will be capped at a specified level for covered expenses.

These limits are usually presented from one of two perspectives:

- Maximum out-of-pocket expense (including or excluding the deductible).
Maximum levels of covered expenses (after the deductible) to which the coinsurance percentage will be applied. Amounts above this threshold would be paid at 100%.

The following table presents guidelines for evaluating rating relativities between four stop-loss levels for an 80%/20% coinsurance plan.

<table>
<thead>
<tr>
<th>Stop-Loss Limit</th>
<th>Coinsurance Out-of-Pocket</th>
<th>Safe Harbor if Ratio to $5,000 Stop-Loss Limit is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000</td>
<td>$400</td>
<td>less than 1.15</td>
</tr>
<tr>
<td>2,500</td>
<td>500</td>
<td>less than 1.10</td>
</tr>
<tr>
<td>5,000</td>
<td>1,000</td>
<td>1.00</td>
</tr>
<tr>
<td>10,000</td>
<td>2,000</td>
<td>greater than .85</td>
</tr>
</tbody>
</table>

Besides the rate ratio, the absolute dollar difference in rates should also be reviewed to be certain the annual premium difference does not exceed the dollar difference in coinsurance.

Some companies offer higher stop-loss limits such as $12,500 ($2,500 OOP), and $25,000 ($5,000 OOP), in order to reduce premiums more. The rate differential for these higher limits would not be expected to be more than 25% lower than the rates for a $5,000 stop-loss limit (i.e., a low factor of .75 for no out-of-pocket limit).

c. **Maternity**

The examiner may have to compare rate relativities for plans with maternity to plans without maternity. The relationship may vary based upon the population. No safe harbor values are given because the appropriate value in the maternity is dependent upon other benefit provisions.

d. **Managed Care**

Managed care products introduce a set of variables which go beyond the scope of this manual at this point. Cost containment techniques, such as pre-admission certification, concurrent utilization review, discharge planning, second surgical opinion and large case management may be reflected in discounts relative to otherwise appropriate rates of up to about 10%. Any discount greater than 10% is likely to be indicative of tighter utilization controls than most carriers have in place. The examiner may wish to investigate such large discounts.

Because of discounts from providers, it is very complicated to compare a preferred provider plan or an HMO plan to a traditional indemnity program, such as discussed in this manual. However, comparisons can be made among similar preferred provider plans and among HMO plans. Further, in general, the rates for a preferred provider plan or IPA/HMO plan would not be expected to be more than 20% lower than the comparable indemnity plan as described in this
manual. It is important to note that a plan using a restricted network of providers is not considered to be similar coverage to a plan with no such restrictions, even though the actual plan benefits may be similar.

There is no clear definition of what constitutes a “managed care” contract. In general, the covered persons have some limitations on access to care (e.g. networks, gate-keeper, pre-authorization etc.) and other controls or reviews of health care expenditures may be involved (e.g. provider discounts, concurrent review, case management etc.).

In some situations involving managed care, these controls are used almost exclusively to reduce costs and rate schedules are very similar to non-managed care rate schedules. Other managed care products may have very different benefit packages (e.g. federally qualified HMOs must have certain benefits) and frequently do not use all of the rate distinctions allowed by the models.

In the situation where a carrier has both managed care and non-managed care plans, the review should include the assumed sources of rate differences. Those which come from added controls should be fully credited to the managed care plans. Some, however, might be used to “game” the guaranteed issue rules. Such things as limiting network availability to selected areas, limiting network providers to selected specialties and inconsistent use of the right to exclude “out-of-area” employees are potential areas which should be reviewed under managed care plans.

Because most managed care plans include some provider discounts, a range of premium rate differences must be separated into two parts:

1) Cost-containment techniques, such as pre-admission testing, concurrent utilization review, discharge planning, second surgical opinion and large case management may be reflected in rate differences of up to 10%.

2) Any discount greater than 10% should be related to network variables such as discounts, gate-keeper controls etc.

The examiner should note that the rates of HMOs are also subject to the rating restrictions of the Model Act. However, an important distinction must be made for certain HMOs which are stand-alone affiliates and those that are simply another line of business within a carrier’s product portfolio. Section 4C(2) of the Model Acts allows an HMO which is an affiliated carrier having a certificate of authority from the state in which it is operating to be considered a separate carrier for the purposes of the Act.

However, it should be noted that an HMO plan which is another product line within a carrier is not given this same exception treatment. It must be included with the other business of the carrier subject to the Act.

In the situation where an affiliated HMO carrier also writes other types of small employer plans subject to the Acts (e.g. POS, EPO, or PPO plans), the Act appears to still allow for separate treatment of the business of this affiliate. However, the HMO business would need to be considered together with the other business of this carrier.
3. **Interrelationship of Variables**

Case and coverage characteristics are treated separately in this manual for simplification. However, as noted in the section under deductibles, many of the variables are, in fact, interrelated.

**F. TESTING CRITERIA**

Once the examiner is satisfied that the rating factors comply with the rating requirements, the examiner should test samples using the sampling techniques described in Section VII.A.

**G. TRANSITION**

The requirements of the Model Act apply to all small employer health benefit plans issued or renewed after the effective date of the law in a particular state, and to individual health benefit plans issued after the effective date of this Act.

The examiner should include in any samples a number of groups with effective dates prior to the effective date of the Act.
XI. INDIVIDUAL HEALTH INSURANCE PORTABILITY MODEL ACT (Model 037, includes 2000 amendments for HIPAA)

A. KEY ELEMENTS OF THE RATING REQUIREMENTS

The key element of the rating provisions is the requirement for a single uniform rate for each “block” of individual health benefit plan business which is adjusted for rating characteristics.

Blocks of business may be defined using some or all of the following factors: distribution systems, policy forms, and whether business was directly written or acquired from another carrier. Other factors may be used with the approval of the State Insurance Commissioner. An individual carrier can create up to nine blocks of business. A carrier may exceed this number only if it assumes blocks of business from another carrier.

For each block of business, the carrier can set only one single uniform rate. Rates for individuals are determined by applying rating factors to this single uniform rate, or by using rate tables which implicitly reflect the single uniform rate and the accompanying rating factors. Rating factors may be based on the following rating characteristics:

1) Geographic area;
2) Age bracket; and
3) Family composition;
4) Other characteristics allowed by regulation, including plan design.

The Act’s key restriction is the requirement that no rate charged to an enrollee in a given block of business can exceed any rate charged to an enrollee with similar rating characteristics in any other block of business by more than 100%.

The single uniform rate, which applies to a block cannot be changed more frequently than annually. The rate charged to an enrollee also may not be changed more frequently than once in twelve (12) months except to reflect:

1) Changes to the family composition of the enrollee; or
2) Changes to the health benefit plan requested by the enrollee.

Also, the annualized amount of rate change applied to a single block of business cannot exceed the annualized amount of rate change for any other block of business by more than 15% due to the claim experience or health status of that block of business (after adjusted for rating characteristics and benefit design).

Finally, the Act contains two types of eligibility determinations. A “recently insured individual” is a person who is a resident of the state and who had qualifying previous coverage within the
past 31 days, or who has had a qualifying event occur within the past 31 days. (See Section 3LL and Section 3OO) Individual carriers are required to guarantee issue basic and standard health plans (as defined in the Act) to such individuals. The Act sets the rates for these coverages as the average of the carrier’s lowest available rate for issuance and the maximum rate allowable by law (both rates being adjusted for allowable rate characteristics and benefit design. A “Federally Defined Eligible Individual” meets the HIPAA portability criteria. (See Section 3L and Section 3S of the Act). The two types of eligibility are substantially similar. The main differences are that HIPAA establishes a longer period for which an individual may have a break in coverage and still qualify for coverage without a preexisting condition waiting period, and is only applicable to individuals losing group coverage, while a “recently insured individual” also qualifies for guarantee issue if they had previous individual coverage.

**Professional Association Plans**

A health benefit plan that is offered through a professional association is subject to somewhat different rating and availability requirements than other health benefit plans. If an association meets the criteria listed in Section 3 - Definitions of the Model Act (see “professional associations”), then the health benefit plans offered through that association are subject to the same rating provisions as all other health benefit plans with the following exceptions:

1) If the health benefit plan covers at least 2,000 members then that association’s experience can be used as the basis for setting rates.

2) If the health benefit plan covers fewer than 2,000 members the carrier must community rate the experience of that professional association with the experience of the other professional associations offered by the carrier.

The minimum qualifying number of members is an average of at least 2,000 members covered by that carrier nationwide during the preceding calendar year. In the event that the carrier did not provide coverage for the association health plan in the preceding calendar year the member count shall be based on the average number of members that are reasonably expected to be covered in the current calendar year. HIPAA contains a definition for a “bona fide association”. A professional association as defined by the Act is more narrowly defined than the HIPAA definition of a bona fide association. However, HIPAA permits states to set additional requirements in defining associations and therefore the definition of professional association in the Act complies with HIPAA.

The provisions of the Portability Act relating to renewability, availability, and pre-existing conditions apply to professional association plans, except that professional associations are not required to offer individual basic and standard health benefit plans.
B. ADDITIONAL REQUIRED DOCUMENTATION

As mentioned in Section IV, documentation may include a demonstration or explanation supporting the actuarial certification that the rates are in compliance with the rating law. This demonstration might include:

- A rationale of how the carrier has defined its blocks of business. If a carrier has more than one block of business, then the regulation lists what is required.

- A listing of rate characteristics used in setting individual rates, and the corresponding rating factors applied to each block of business.

- A demonstration of compliance with the 100% limitation on the ratio of highest to lowest individual rates.

- A list of health benefit plans available for guarantee issue to eligible individuals

- A demonstration that the rates for basic and standard health benefit plans comply with the requirements of the Act.

C. BLOCKS OF BUSINESS

The “block of business” is the key to all of the rating restrictions in the Portability Act. Therefore, the issues related to defining and maintaining blocks of business are very important.

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

1) Distribution system;
2) Policy form;
3) Business directly written or assumed from another carrier;
4) Other characteristics approved by the Commissioner.

Individual basic and standard health benefit plans must constitute a separate block in order for the carrier to receive a distribution for assessable losses (See Section 10 of the Portability Act).

As mentioned above, an individual carrier may have a maximum of nine blocks of business. This maximum may be exceed if a carrier assumes blocks of business from another carrier. However, the Commissioner must approve a suspension of the maximum limit before the blocks can be assumed. The assumption must be completed according to the requirements of Section 5 of the Portability Act. (See Section 5 of the Portability Act for the assumption requirements. They are beyond the scope of this manual.) In cases where the carrier has more than nine blocks, the responsibility of the examiner is to determine whether the carrier has obtained a suspension from the Commissioner.
A block of business can have only one rate manual. (The same rate manual may be used for more than one block, but within a block of business only one rate manual can be used.) Once a block is formed by pooling policy forms, the configuration of the block (i.e., adding or removing policy forms) cannot be changed without permission of the Commissioner.

For compliance purposes, the carrier must document and have available to the examiner the rationale underlying each block of business. This includes the following information for each block of business: a description of the criteria used for determining membership in the block, and a justification for establishing the block as a separate block of business.

D. RATING PERIODS

The Act effectively established the relevant rating period at 12 months. First, it prohibits changing the single uniform rate for a block of business more frequently than annually. Second, it prohibits changing the rate charged to an enrollee more frequently than annually (except for changes in family composition or requested benefit changes). It should be noted that increases due to overall experience and aging (if an employee’s age transfers him into a new age bracket) must be implemented at the same time. The Act does not permit multiple rate adjustments for increases due to overall experience and for aging within a one-year (12 month) period.

The guidance manual presumes that rates based on a complying rate manual are not out of compliance if the rate manual changes and the rate are adjusted at the next anniversary date.

E. RATING FACTORS

The examiner should recognize that the Model Act implicitly does not allow any latitude for underwriting judgment or carrier prerogative. Specifically, carriers are not allowed to use such practices as durational and tier rating, and claim experience or changes in health status after issue are not allowed to be used in setting rates.

Much of the examiner’s work in reviewing rating will of necessity be subjective. Factors such as the examiner’s knowledge of the carrier and the actuary who signed the opinion, as well as the wording of the opinion itself, will be important. These factors are discussed elsewhere in this manual. The purpose of this section is to provide guidance in interpreting rating factors in the context of the review.

The Model Act specifically lists allowable rating characteristics as family composition, geographic area, and age bracket. It also allows other characteristics approved by the Commissioner to be used as well. For each of the listed characteristics a discussion of the required ranges and/or a range of factors which may be deemed reasonable is presented below. These ranges are based upon the requirements contained within the Act and input from various small group carriers as well as other industry rate and claim cost data. Note that the factors in this manual were developed in 1992 and have not been updated since development. Therefore, the examiner should carefully consider this in using the safe harbor factors to determine the appropriateness of a carrier’s factors.
1. **Age**

Variation of claims costs by age is an understandable characteristic since it is well known that, on average, health status deteriorates as one grows older. However, the relative differences in premium rates by age will tend to vary by other characteristics as well, such as gender and plan design. The safe harbor values discussed in this section are based on a comprehensive major medical plan design without maternity coverage.

First, the examiner should check the ratio of the highest premium rate charged to the lowest premium rate charged. Normally, this will be the age 64 premium related to an age 20 premium, but the maximum and minimums may vary. An overall ratio of 5:1 or less is allowable. This test, and all the tests in this section, should be performed using the single employee rates.

Secondly, the examiner should test the relationship of the premium rate for age 22 to the rate for age 42. If the rates differ by gender, the test should be performed for males and for females. If the resulting ratio is at least .50, it can be presumed to be in compliance. If individuals age 65 or older are covered for full benefits, additional factors above the 5:1 can be expected.

The values below may be used for testing specific ages. In each case, the ratio of the premium rate for the age shown to the premium rate for age 42 should be within the range of the factors shown. The factors should increase as the age grouping increases.

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Males</th>
<th>Females*</th>
<th>Unisex*</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>.50-1.00</td>
<td>.50-1.00</td>
<td>.50-1.00</td>
</tr>
<tr>
<td>27</td>
<td>.55-1.00</td>
<td>.56-1.00</td>
<td>.57-1.00</td>
</tr>
<tr>
<td>32</td>
<td>.67-1.00</td>
<td>.71-1.00</td>
<td>.66-1.00</td>
</tr>
<tr>
<td>37</td>
<td>.72-1.00</td>
<td>.74-1.00</td>
<td>.73-1.00</td>
</tr>
<tr>
<td>42</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

* Excludes maternity coverage

Finally, the examiner should determine the ratio of the age 62 rate to the age 42 rate. This ratio should be acceptable if it is no higher than 2.75 for unisex rates. If the rates differ by gender, the ratio should be acceptable if it does not exceed 3.2 for males and 2.2 for females. The values below may be used for testing specific ages. In each case, the ratio of the premium rate for the age shown to the premium rate for age 42 should be within the range of the factors shown. The factors should increase as the age grouping increases.
### Age Slope Range Relative to Age 42

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Males</th>
<th>Females*</th>
<th>Unisex*</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>1.00-3.20</td>
<td>1.00-2.20</td>
<td>1.00-2.75</td>
</tr>
<tr>
<td>57</td>
<td>1.00-2.45</td>
<td>1.00-1.62</td>
<td>1.00-2.05</td>
</tr>
<tr>
<td>52</td>
<td>1.00-1.80</td>
<td>1.00-1.46</td>
<td>1.00-1.61</td>
</tr>
<tr>
<td>47</td>
<td>1.00-1.40</td>
<td>1.00-1.26</td>
<td>1.00-1.28</td>
</tr>
<tr>
<td>42</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
</tbody>
</table>

* Excludes maternity coverage

Ratios and/or rates should progress in a consistent manner throughout the age span, as those shown in this manual. If they do not, separate tests may be performed at different ages. However, it is common to have flat age factors at the early adult ages (e.g., .70 for ages 22, 27, 32 and 37) and then increase them as age increases. This is also acceptable.

Rates that vary for each and every age are also acceptable, as are rates that vary by age bands other than the five years shown here, subject to the other comments in this section.

While HIPAA does not contain any rating provisions, the final interim federal regulations do contain the following interpretation which individual carriers should consider: HIPAA does not contain an exception to guaranteed renewability in the case of an enrollee’s attaining eligibility for Medicare. In other words, if a policyholder wants to keep his/her present coverage after turning 65, the company must keep the policy in force. However, the interim regulation does state that: “If permitted by state law, however, policies that are sold to individuals before they attained Medicare eligibility may contain coordination of benefit clauses that exclude payment under the policy to the extent that Medicare pays.”

Regulators will need to develop standards for determining reasonable relationships for premium rates for over-65 age groups relative to under-65 age groups, while also taking into account whether or not benefits are coordinated with Medicare.

### Family Composition

Historically, companies have used a number of rating structures to include dependent coverage. The Act defines family composition to mean: enrollee; enrollee, spouse and children; enrollee and spouse; enrollee and children, or child only. The relative rate factors shown below are based on a comparison to an average composite member rate using an age/gender/employee/souse distribution representative of the U.S. labor force. Expected distributions which are different may have different relationships. Carriers may be requested to provide the calculations for the rates they are using. The following table is illustrative only to provide the examiner with examples of family composition rating factors.
<table>
<thead>
<tr>
<th>Description</th>
<th>Relative Rate Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Enrollee</td>
<td>1.00</td>
</tr>
<tr>
<td>Enrollee and Spouse</td>
<td>2.70</td>
</tr>
<tr>
<td>Enrollee and Child(ren)</td>
<td>1.70</td>
</tr>
<tr>
<td>Family</td>
<td>3.00</td>
</tr>
</tbody>
</table>

Companies can set spouse rates in different ways. Some discount the spouse rate from the employee rate, most likely due to the ability to spread expenses over an additional covered person. On the other hand, others set spouse rates higher than employee rates, presumably in anticipation of higher utilization patterns on the part of the spouse. The majority of carrier rates appear to have spouse rates set equal to employee rates. Dependent rating structures should be supported by an appropriate demonstration.

Historically, child rates showed significant variation from one carrier to another. The rating structure was on an each child, four or more children, three or more children, two or more, or all children basis. The Model permits only the all children basis.

The portion of the rates attributable only to children may vary by the age of the enrollee. The children rates should not vary based on the age of the children. Any variation in the children portion of the rates should be attributable to the expected number of children for that age of enrollee. If a carrier elects such variation, the children portion of the rates should decrease at the older enrollee ages because children will have grown. Often, however, carriers do not vary children rates by the age of the enrollee. This is also acceptable.

The Act allows carriers to charge the lowest allowable adult rate for child only coverage.

3. **Geographic Location**

The cost of medical care can vary dramatically from one area to another. This is due to the general cost level of the area, the differences in medical practices by region, the specialization and intensity of services, and the amount of competition in the area. Most small group plans vary rates by either county or ZIP code (usually 3-digit but sometimes 5-digit). The employer’s business address is normally used.

Because of the many factors involved in setting area rates, including competitive posturing and regulatory concerns, area rating factors used by companies can vary significantly.

The following table indicates the safe harbor ratio of highest factor to lowest factor for each state. Some states have laws or regulations that require lower factors than those shown in the table. The laws or regulations would, of course, prevail. An example would be a state which does not allow geographic variation in rates, where the factor would effectively be 1.00.
### State Area Relativities

**Ratio of the Highest Area Factor to the Lowest Area Factor in Each State**

<table>
<thead>
<tr>
<th>State</th>
<th>Maximum Area Ratio</th>
<th>State</th>
<th>Maximum Area Ratio</th>
<th>State</th>
<th>Maximum Area Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1.40</td>
<td>Kentucky</td>
<td>1.50</td>
<td>North Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Alaska</td>
<td>1.20</td>
<td>Louisiana</td>
<td>1.50</td>
<td>Ohio</td>
<td>1.60</td>
</tr>
<tr>
<td>Arizona</td>
<td>1.40</td>
<td>Maine</td>
<td>1.20</td>
<td>Oklahoma</td>
<td>1.40</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1.40</td>
<td>Maryland</td>
<td>1.50</td>
<td>Oregon</td>
<td>1.30</td>
</tr>
<tr>
<td>California</td>
<td>1.70</td>
<td>Massachusetts</td>
<td>1.40</td>
<td>Pennsylvania</td>
<td>1.80</td>
</tr>
<tr>
<td>Colorado</td>
<td>1.30</td>
<td>Michigan</td>
<td>1.50</td>
<td>Rhode Island</td>
<td>1.20</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1.40</td>
<td>Minnesota</td>
<td>1.50</td>
<td>South Carolina</td>
<td>1.40</td>
</tr>
<tr>
<td>Delaware</td>
<td>1.20</td>
<td>Mississippi</td>
<td>1.40</td>
<td>South Dakota</td>
<td>1.20</td>
</tr>
<tr>
<td>Dist. of Columbia</td>
<td>1.00</td>
<td>Missouri</td>
<td>1.40</td>
<td>Tennessee</td>
<td>1.30</td>
</tr>
<tr>
<td>Florida</td>
<td>1.90</td>
<td>Montana</td>
<td>1.20</td>
<td>Texas</td>
<td>1.70</td>
</tr>
<tr>
<td>Georgia</td>
<td>1.40</td>
<td>Nebraska</td>
<td>1.40</td>
<td>Utah</td>
<td>1.20</td>
</tr>
<tr>
<td>Hawaii</td>
<td>1.20</td>
<td>Nevada</td>
<td>1.40</td>
<td>Vermont</td>
<td>1.20</td>
</tr>
<tr>
<td>Idaho</td>
<td>1.20</td>
<td>New Hampshire</td>
<td>1.30</td>
<td>Virginia</td>
<td>1.60</td>
</tr>
<tr>
<td>Illinois</td>
<td>1.70</td>
<td>New Jersey</td>
<td>1.50</td>
<td>Washington</td>
<td>1.30</td>
</tr>
<tr>
<td>Indiana</td>
<td>1.70</td>
<td>New Mexico</td>
<td>1.30</td>
<td>West Virginia</td>
<td>1.40</td>
</tr>
<tr>
<td>Iowa</td>
<td>1.40</td>
<td>New York</td>
<td>1.80</td>
<td>Wisconsin</td>
<td>1.50</td>
</tr>
<tr>
<td>Kansas</td>
<td>1.40</td>
<td>North Carolina</td>
<td>1.30</td>
<td>Wyoming</td>
<td>1.20</td>
</tr>
</tbody>
</table>

It is possible that the rates for some carriers may exceed these ranges. These are to be considered guideline ratios. The examiner may wish to have the carrier provide demonstration of the need for a ratio beyond those illustrated above.

### Coverage Characteristics

This section provides guidelines on rate relationships for various benefit provisions and types of coverage. The values shown represent typical comprehensive plans (excluding normal maternity coverage). Other types of benefits packages may have different relationships than those discussed in this section and, therefore, the value guidelines provided below may not be appropriate for these types of benefit designs.

#### a. Deductible

The value of a deductible feature depends upon the size of the deductible, the age and gender of the insured, the area in which the insured lives, and the impact of trend leveraging over time. For example, a $100 deductible impacts the cost of a plan far less today than it did in 1972. Similarly, a $100 deductible has greater impact to rates in a low cost area such as rural Iowa than in a high cost area such as Los Angeles. In other words, the relative cost of one deductible level to another depends upon the cost levels to which the deductibles are applied. As an example, consider the following two situations for a $250 deductible and a $1,000.
<table>
<thead>
<tr>
<th>Eligible Charges</th>
<th>Cost Level A</th>
<th>Cost Level B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible 1</td>
<td>$12,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Remaining Charges</td>
<td>$11,750</td>
<td>$6,750</td>
</tr>
<tr>
<td>Deductible 2</td>
<td>$12,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Remaining Charges</td>
<td>$11,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

Relative Impact of $1,000 Deductible to $250 Deductible:

<table>
<thead>
<tr>
<th></th>
<th>Cost Level A</th>
<th>Cost Level B</th>
</tr>
</thead>
<tbody>
<tr>
<td>.936</td>
<td>.889</td>
<td></td>
</tr>
</tbody>
</table>

The lower the charge level, the greater the impact the deductible has on premium.

One difficulty in reviewing deductible relationships is that many carriers have traditionally allowed selection to affect the relationship in their rates. That is, the relative rates reflect the characteristics of the groups that would tend to select the particular deductible. Such selection is not an appropriate coverage characteristic. Utilization differences would also occur for a given group just based on the effect of the deductible itself. This effect is difficult to quantify. The safe harbors shown below reflect some element of this effect.

The safe harbors shown in the table below are values typical of an 80%/20% coinsurance plan with a $5,000 stop-loss level (i.e., $1,000 insured out-of-pocket maximum after the deductible).

<table>
<thead>
<tr>
<th>Deductible Range Relative to a $500 Deductible Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Level</td>
</tr>
<tr>
<td>$ 100</td>
</tr>
<tr>
<td>250</td>
</tr>
<tr>
<td>500</td>
</tr>
<tr>
<td>750</td>
</tr>
<tr>
<td>1,000</td>
</tr>
<tr>
<td>1,500</td>
</tr>
<tr>
<td>2,000</td>
</tr>
<tr>
<td>2,500</td>
</tr>
</tbody>
</table>

Besides the rate ratio, the absolute dollar difference in rates should also be reviewed to be certain the annual premium difference does not exceed the dollar difference in the deductible.
There are several points to note regarding the deductible relativities:

- These ranges are for plans with 80% coinsurance and $5,000 stop-loss levels. Some companies will vary their deductibles relativities for different coinsurance or out-of-pocket levels. However, it is anticipated that ratios for plans with other stop-loss levels will generally fall within these safe harbor ranges.

- These ranges may not be appropriate for plans which waive the deductible for certain qualifying medical care or types of services.

b. Maternity

Depending on the benefit design of the plans available for guaranteed issue to recently insured individuals (including the Basic and Standard plans), the examiner may have to compare rate relativities for plans with maternity to plans without maternity. It is possible that the relationship could be very complex depending on the age and gender distribution of the group. Safe harbor ratios of values less than or equal to 1.70 for gender distinct and 1.40 for unisex individual attained age rates during the childbearing years and 1.20 for rates which do not vary by age or gender can be used as benchmarks for the ratio of a plan with maternity to a plan without maternity coverage.

c. Managed Care

Managed care products introduce a set of variables which go beyond the scope of this manual at this point. Cost containment techniques, such as pre-admission certification, concurrent utilization review, discharge planning, second surgical opinion and large case management may be reflected in discounts relative to otherwise appropriate rates of up to about 10%. Any discount greater than 10% is likely to be indicative of tighter utilization controls than most carriers have in place. The examiner may wish to investigate such large discounts.

Because of discounts from providers, it is very complicated to compare a preferred provider plan or an HMO plan to a traditional indemnity program, such as discussed in this manual. However, comparisons can be made among similar preferred provider plans and among HMO plans. Further, in general, the rates for a preferred provider plan or IPA/HMO plan would not be expected to be more than 20% lower than the comparable indemnity plan as described in this manual. It is important to note that a plan using a restricted network of providers is not considered to be similar coverage to a plan with no such restrictions, even though the actual plan benefits may be similar.

There is no clear definition of what constitutes a “managed care” contract. In general, the covered persons have some limitations on access to care (e.g. networks, gate-keeper, pre-authorization etc.) and other controls or reviews of health care expenditures may be involved (e.g., provider discounts, concurrent review, case management etc.).

In some situations involving managed care, these controls are used almost exclusively to reduce costs and rate schedules are very similar to non-managed care rate schedules. Other managed
care products may have very different benefit packages (e.g. federally qualified HMOs must have certain benefits) and frequently do not use all of the rate distinctions allowed by the models.

In the situation where a carrier has both managed care and non-managed care plans, the review should include the assumed sources of rate differences. Those which come from added controls should be fully credited to the managed care plans. Some, however, might be used to “game” the guaranteed issue rules. Such things as limiting network availability to selected areas, limiting network providers to selected specialties and inconsistent use of the right to exclude “out-of-area” employees are potential areas which should be reviewed under managed care plans.

Because most managed care plans include some provider discounts, a range of premium rate differences must be separated into two parts:

1) Cost-containment techniques, such as pre-admission testing, concurrent utilization review, discharge planning, second surgical opinion and large case management may be reflected in rate differences of up to 10%.

2) Any discount greater than 10% should be related to network variables such as discounts, gate-keeper controls etc.

The examiner should note that the rates of HMOs are also subject to the rating restrictions of the Model Acts and Model Regulation. However, an important distinction must be made for certain HMOs which are stand-alone affiliates and those that are simply another line of business within a carrier’s product portfolio. Section 4C of the Acts allows an HMO which is an affiliated carrier having a certificate of authority from the state in which it is operating to be considered a separate carrier for the purposes of the Act.

However, it should be noted that an HMO plan which is another product line within a carrier is not given this same exception treatment. It must be included with the other business of the carrier subject to the Act. It may or may not qualify as a separate block depending on its ability to meet the definition in Section 3F of the Act and Section 4A of the Regulation.

5. Optional Rating Characteristics

Although not specifically mentioned in the Act, gender and industry are commonly used rating characteristics. Under the Act, they can be used if approved by the Commissioner.

a. Industry

People working in some industries exhibit higher medical claim costs than in other industries. This is due in part to the working conditions, the type and lifestyles of people attracted to the industry and to the prevalence of accidents in the industry.
The examiner should look for evidence of “redlining,” or avoiding certain risks through the use of industry ratings. There is no standard set of industry rating factors, and opinions on the predictive value of industry vary widely. Therefore, experience studies which justify the industry factors used should be requested and reviewed by the examiner.

b. Gender

Females incur greater medical costs than males at younger ages, particularly during childbearing years. The variances in costs diminish with age until male costs begin to exceed female costs in the late fifties or early sixties. The following table provides a safe harbor range by age for these gender differences. A decreasing relationship by age is expected (if not unisex).

<table>
<thead>
<tr>
<th>Attained Age</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>1.00-1.45</td>
</tr>
<tr>
<td>27</td>
<td>1.00-1.45</td>
</tr>
<tr>
<td>32</td>
<td>1.00-1.45</td>
</tr>
<tr>
<td>37</td>
<td>1.00-1.45</td>
</tr>
<tr>
<td>42</td>
<td>1.00-1.35</td>
</tr>
<tr>
<td>47</td>
<td>1.00-1.20</td>
</tr>
<tr>
<td>52</td>
<td>1.00-1.05</td>
</tr>
<tr>
<td>57</td>
<td>.95-1.00</td>
</tr>
<tr>
<td>62</td>
<td>.85-1.00</td>
</tr>
</tbody>
</table>

The inclusion of normal maternity costs for females would result in significantly higher relativity factors at younger ages, to as high as perhaps 2.70. The factors shown above are lower than factors based on actual claim costs. They are consistent with premium rate factors being used in practice, however.

6. **Interrelationship of Variables**

Case and coverage characteristics are treated separately in this manual for simplification. However, as noted in the section under deductibles, many of the variables are, in fact, interrelated.
F. INDIVIDUAL BASIC AND STANDARD HEALTH PLANS

The Portability Act requires an individual carrier to guarantee issue to an eligible individual the individual’s choice of either an individual basic or individual standard health plan. The design of the basic and standard health plans is left to the Commissioner, with the general provision that these plans provide coverages comparable to small employer coverages required by the Small Employer Availability Model. The Portability Act provides for a Health Benefit Plan Committee to advise the Commissioner on coverage design.

The Portability Act requires that the rates for the basic and standard plans offered by a carrier be set as the average of the lowest rate available for issuance by the carrier (adjusted for rating characteristics) and the maximum allowable rate (after adjustments for rating characteristics) for the carrier. Adjustments are not allowed for health status, claim experience, or benefits.

G. REQUIREMENTS FOR PLANS OFFERED TO FEDERALLY DEFINED ELIGIBLE INDIVIDUALS

An individual carrier must offer coverage to Federally Defined Eligible (FDE) Individuals if they apply for an individual health plan within 90 days of termination of prior creditable coverage. The individual carrier may elect to limit the coverages it offers to FDE individuals to two plans; either its two largest individual plans currently being sold (as measured by premium volume), or a high benefit level or low benefit level plan, both of which must have substantially similar benefits to other health benefit plans offered by the carrier in the state. In the case of the latter, the two plans must be covered under some sort of risk adjustment, risk spreading, or financial subsidization mechanism (See Section 8C(4)).

The definition of high level and low level benefit plans is based on the concept of a weighted average actuarial value of benefits. The Act presents two alternate definitions. In the first definition this is calculated as the average actuarial value of benefits of all individual health benefit plans issued by the carrier in the individual market during the previous year, weight by enrollment. In the second definition, the weighted average is based on the value of actuarial benefits provided by all carriers in the state in the individual market during the previous year, weighted by enrollment for the different coverages. A policy form is defined as low level if the actuarial value of its benefits is at least 85%, but not more than 100%, of the weighted average (however it is calculated). A high level policy form provides benefits which have an actuarial value of 100% to 120% of the weighted average, and at least 15% greater than the actuarial value of the coverage of the low level policy form.

H. TESTING CRITERIA

Establishing compliance with the Act’s restrictions on premium rates is a two step process.
1. **Within a Block of Business**

For different health benefit plans within the same block of business, premiums for identical individuals may differ only because of differences in the design and benefits of the health benefit plans. Furthermore, the differences in design and benefits must be reasonable and objective. Identical individuals are persons who possess identical rating characteristics (e.g., the same age, the same family composition, and the same geographic area).

Furthermore, the specific categories of rating characteristics applied to a single uniform rate must be the same across all health benefit plans, and the rating factors must be the same for all health benefit plans within a block and applied in the same manner.

Compliance within a block of business can be demonstrated by an actuarial demonstration and certification by a qualified actuary that: 1) rating factors for age, family composition, and geographic area are uniformly applied to health benefit plans within the block, and 2) rating factors for plan and benefit design accurately reflect the actuarial difference in plan and benefit design.

For example, if two health benefit plans are identical except that one uses a PPO network while the other does not, then the difference in rates between these two plans can only reflect the differences in expected claim costs, all other rating characteristics being held constant. Differences in rates which reflect other factors (e.g., lower PPO rates due to an expectation that younger, healthier individuals will select such plans) are not allowed by the Act.

2. **Between Blocks of Business**

While this manual is intended to be reasonably comprehensive, it is impossible to anticipate every possible set of circumstances. Therefore, it must be emphasized that this manual is only one of a number of tools and source references which should be used in testing compliance with the Model Acts. This section presents three possible procedures for establishing compliance between blocks of business: Exhaustive Testing; Defined Census; and Sampling. These are discussed in the following sections.

a. **Exhaustive Testing**

In Exhaustive Testing, for each block of business premiums for all possible rate cells (i.e. combinations of rating characteristics) are computed. Across all blocks of business and for any given rate cell the maximum ratio of the highest to the lowest premium can be no more than 2:1.

For example, assume that the rating characteristics used are age, geographic area, and family composition. Further assume that there are nine quinquennial age brackets (between ages 20 and 64), four different family compositions, and two geographical areas. This results in 72 possible rate cells, each corresponding to a particular combination of age bracket, geographic area, and family composition. For each block of business, rates are determined for the age cells. Then each set of rate cells is compared to rate cells for the other blocks pair by pair.
Exhaustive testing is easily performed by developing a computer application.

b. **Sampling Based Testing**

Compliance can also be demonstrated if the following procedure is followed for each block of business:

1. Verifying compliance shall be based on a randomly selected sample of 500 or more actual individuals in the block of business being tested. If there are fewer than 500 actual individuals in the block, then the entire block shall be tested.

2. The carrier may not choose alternate samples of 500 until it finds a sample that shows compliance.

3. The carrier must keep detailed records of the sample chosen, the basis for choosing the sample, and the actual results of the test.

4. Once the sample is chosen, the aggregate rate for the block being tested shall be determined by summing the rates of all of the individuals in the sample.

5. Each of the individuals in the sample from the block being tested must be rated according to the manual of each of the other rating blocks. The aggregate rate under each of the other blocks is determined by adding together the rates of the individuals drawn from the block being tested.

6. The aggregate rate under each of the other blocks’ manuals must not be greater than 200% nor be less than 50% of the aggregate rate of the block being tested.

7. Tests are to be performed for at least three non-consecutive renewal months in a given calendar year.

If a carrier uses identical factors for rating characteristics and benefit designs between two blocks, and if all of the same rating characteristics are recognized in each block, sampling is not necessary in demonstrating compliance between the blocks. Rather, a demonstration that each theoretically possible premium falls within the 2:1 limitation will constitute compliance.

c. **Defined Census**

The distribution of individuals within a sample across rating characteristics will vary from sample to sample, reflecting both sampling error and the differences among policyholders in each block of business.

A defined census specifies or defines a hypothetical distribution of policyholders across rating characteristics. The Commissioner shall specify either: i) a specific hypothetical distribution to be used for testing purposes; or ii) the methodology to be used by carriers to develop such a
distribution. Once this distribution has been established then the procedure proceeds as above, following steps four through seven for each block of business.

As above, if a carrier uses identical factors for rating characteristics and benefit designs between two blocks of business, and if all of the same rating characteristics are recognized in each block, then steps four through seven need not be performed. A demonstration that each theoretically possible premium falls within the 2:1 limitation demonstrates compliance.

I. CONVERSIONS

The Portability Act allows carriers providing group insurance to meet requirements for conversion policies by offering a choice of the individual or basic health plans, as defined above. Once a carrier decides to do this, these plans are subject to the Portability Act provisions in all respects. The carrier cannot offer any other conversion plans.

Carriers that issue both individual and group coverages are required to set premiums for the individual basic and standard benefit plans in the same way as described in the section on Individual Basic and Standard Health Benefit plans.

In the case of a carrier that issues only group coverages, the Portability Act requires the premiums for the individual basic and standard converted policies to be set at the average premium charged by the five largest individual carriers (as measure by premium volume) for respectively, their individual basic and standard health plans for each type (e.g., indemnity, PPO, or HMO) of the basic or standard health benefit plan. These averages are to be calculated each quarter by the Commissioner and published no later than the first day of the month prior to their effective date, and are applicable to converted policies issued in the following calendar quarter.

The same rates (either new business or renewal rates) must be charged for persons with the same converted policies who have the same rating characteristics.

The Portability Act requires that converted plans other than the individual basic and standard conversion plans be rated as if they were individual basic or standard plans.

J. TRANSITION

The Portability Act applies only to new policies issued after the effective date of the Act in a state. Because the Act applies prospectively there are no direct transition issues relating to rates. However, there are issues related to the implementation of the Act.

One area where issues arise concerns policy forms approved prior to the effective date of the Act. Policies issued on these forms after the effective date will be subject to much different rating requirements than policies issued prior to the effective date. This presents potential compliance issues for both carriers and examiners.
For example, policies issued after the effective date would be subject to an overall maximum 2:1 ratio on the highest to lowest rates (after rating characteristics are taken into account). Similarly, these policies would be subject to restrictions on annual rate increases and to restrictions on allowable rating characteristics, as well as other limitations. Policies issued prior to the effective date have none of these restrictions. Obviously, in these cases, it will be necessary for the carrier to distinguish which requirements apply to which policies. For the examiner, it will be necessary to make sure the carrier has done this before any testing or assessment of compliance can be performed.

If a carrier adjusts premiums for a block of business to a higher level than permitted by loss ratio requirements in order to comply with provisions in Section 5 of the Model Act, then those loss ratio requirements must be met on the carrier’s entire individual health benefit business.
APPENDIX A
Model Acts

115—PREMIUM RATES AND RENEWABILITY OF COVERAGE FOR HEALTH INSURANCE SOLD TO SMALL GROUPS

116—SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT
(ALLOCATION WITH OR WITHOUT AN OPT-OUT)

118—SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT (PROSPECTIVE REINSURANCE WITH OR WITHOUT AN OPT-OUT) – 1993 VERSION

118—SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT (PROSPECTIVE REINSURANCE WITH OR WITHOUT AN OPT-OUT) – 1995 VERSION, INCLUDES 2000 AMENDMENTS FOR HIPAA

035—SMALL EMPLOYER AND INDIVIDUAL HEALTH INSURANCE AVAILABILITY MODEL ACT – INCLUDES 2000 AMENDMENTS FOR HIPAA

037—INDIVIDUAL HEALTH INSURANCE PORTABILITY MODEL ACT – INCLUDES 2000 AMENDMENTS FOR HIPAA
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Section 9. Effective Date

Section 1. Purpose

The intent of this Act is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

Section 2. Definitions

A. “Actuarial certification” means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 4 of this Act, based upon the person’s examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

B. “Base premium rate” means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

C. “Carrier” means a person that provides health insurance in this state. For the purposes of this Act, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation.

D. “Case characteristics” mean demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Act.

E. “Class of business” means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(a) Are marketed and sold through individuals and organizations that are not participating in the marketing or sale of other distinct groupings of small employers for the small employer carrier;
(b) Have been acquired from another small employer carrier as a distinct grouping of plans;

(c) Are provided through an association with membership of not less than [insert number] small employers that has been formed for purposes other than obtaining insurance; or

(d) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in Section 4A(1)(a).

(2) A small employer carrier may establish no more than two (2) additional groupings under each of the subparagraphs in Paragraph (1) on the basis of underwriting criteria that are expected to produce substantial variation in the health care costs.

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

F. “Commissioner” means the Commissioner of Insurance.

G. “Department” means the Department of Insurance.

H. “Health benefit plan” or “plan” means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental or disability income insurance; coverage issued as a supplement to liability insurance; worker’s compensation or similar insurance; or automobile medical-payment insurance.

I. “Index rate” means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

J. “New business premium rate” means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

K. “Rating period” means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

L. “Small employer” means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than twenty-five (25) eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which 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 a “small employer,” depending on the underwriting and marketing practices of carriers in the state and any other factors that the state finds relevant.

M. “Small employer carrier” means a carrier that offers health benefit plans covering the employees of a small employer.

Section 3. Health Insurance Plans Subject to this Act

A. Except as provided in Subsection B of this section, the provisions of this Act apply to any health benefit plan that provides coverage to one or more employees of a small employer.
B. The provisions of this Act shall not apply to individual health insurance policies that are subject to policy form and premium rate approval as provided in [insert reference to insurance code provisions for approval of individual forms and rates].

Section 4. Restrictions Relating to Premium Rates

A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:

1. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%). Paragraph (1) shall not apply to a class of business if all of the following apply:

   a. The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status;

   b. The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

   c. The class of business is currently available for purchase.

2. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate.

3. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

   a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

   b. An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier’s rate manual for the class of business; and

   c. Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier’s rate manual for the class of business.

4. In the case of health benefit plans issued prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges described in Subsection A(1) or (2) of this section for a period of five (5) years following the effective date of this Act. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

   a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the
case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier’s rate manual for the class of business.

B. Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

C. A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

Section 5. Provisions on Renewability of Coverage

A. Except as provided in Subsection B of this section, a health benefit plan subject to this Act shall be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons:

(1) Nonpayment of required premiums;

(2) Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or such individual’s representative;

(3) Noncompliance with plan provisions;

(4) The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; or

(5) The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

B. A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least ninety (90) days prior to termination of coverage. A carrier which exercises its right to cease to renew all plans in a class of business shall not:

(1) Establish a new class of business for a period of five (5) years after the nonrenewal of the plans without prior approval of the commissioner; or

(2) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.


Each small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following:
A. The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer;

B. The provisions concerning the carrier’s right to change premium rates and the factors, including case characteristics, that affect changes in premium rates;

C. A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and

D. The provisions relating to renewability of coverage.

Section 7. Maintenance of Records

A. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

B. Each small employer carrier shall file each March 1 with the commissioner an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of the certification shall be retained by the carrier at its principal place of business.

C. A small employer carrier shall make the information and documentation described in Subsection A of this section available to the commissioner upon request. The information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

Section 8. Discretion of the Commissioner

The commissioner may suspend all or any part of Section 4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Section 9. Effective Date

The provisions of this Act shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed or continued in this state after the effective date of this Act. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this Act.

Legislative History (all references are to the Proceedings of the NAIC).

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Section 1. Short Title

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

Section 2. Purpose

The purpose and intent of this Act are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of “basic” and “standard” health benefit plans to be offered to all small employers, to provide for establishment of an allocation program, and to improve the overall fairness and efficiency of the small group health insurance market.

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

Section 3. Definitions

As used in this Act:

A. “Actuarial certification” means a written statement by a member of the American Academy of Actuaries, or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 6 of this Act, based upon the person’s examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

B. “Affiliate” or “affiliated” means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
C. “Allocating carrier” means a small employer carrier participating in the allocation program pursuant to Section 11.

D. “Base premium rate” means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

E. “Basic health benefit plan” means a lower cost health benefit plan developed pursuant to Section 12.

F. “Board” means the board of directors of the program established pursuant to Section 11.

G. “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.

Drafting Note: The term “multiple employer welfare arrangement” should be added to the list of carriers in those states that have separate certificates of authority for such arrangements. In states that do not have separate licenses for self-funded multiple employer welfare arrangements, such arrangements should be treated as unauthorized insurers. States should enforce their laws against transaction of unauthorized insurance against such unauthorized self-funded multiple employer welfare arrangements.

H. “Case characteristics” means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this Act.

I. “Class of business” means all or a separate grouping of small employers established pursuant to Section 5.

J. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Where the word “commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

K. “Committee” means the Health Benefit Plan Committee created pursuant to Section 12.

L. “Control” shall be defined in the same manner as [insert reference to state law corresponding to NAIC Model Holding Company Act].

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

Drafting Note: States without a statutory definition of dependent may wish to use the following definition: “Dependent” means a spouse; an unmarried child under the age of [nineteen (19)] years; an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the parent; and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Drafting Note: If using suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law.
N. “Eligible employee” means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis.

O. “Established geographic service area” means a geographic area, as approved by the commissioner and based on the carrier’s certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

P. (1) “Health benefit plan” means any hospital or medical policy or certificate, major medical expense insurance; [insert reference to subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan], or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, or automobile medical payment insurance.

(2) “Health benefit plan” shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

(a) The carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in Subparagraph (b).

(b) The certification required in Subparagraph (a) shall contain the following:

(i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

(ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this state.

(c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the Commissioner the information and statement required in Subparagraph (b) at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.

Q. “Index rate” means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

R. “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 such individual is entitled to enroll under the terms of the health benefit plan, provided that such 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 that 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.

S. “New business premium rate” means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

T. “Plan of operation” means the plan of operation of the program established pursuant to Section 11.

U. “Premium” means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

V. “Producer” means [incorporate reference to definition in state’s law for licensing producers].

Drafting Note: States that have not adopted the NAIC Single License Procedure Model Act should substitute the terms “agent” and/or “broker” for the term “producer” as appropriate.

W. “Program” means the [State] Small Employer Allocation Program created pursuant to Section 11.

X. “Qualifying previous coverage” and “qualifying existing coverage” mean 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.

Y. “Rating period” means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

Z. “Restricted network provision” means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws...
regulating health maintenance organizations and preferred provider organizations or arrangements to provide health care services to covered individuals.

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

**AA.** “Risk-assuming carrier” means a small employer carrier whose application is approved by the commissioner pursuant to Section 10.

**Drafting Note:** The definitions in Subsections C and AA can be deleted if participation in the allocation program is mandatory.

**BB.** “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 a “small employer,” depending on the underwriting and marketing practices of carriers in the state and other relevant factors.

**CC.** “Small employer carrier” means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

**DD.** “Standard health benefit plan” means a health benefit plan developed pursuant to Section 12.

### Section 4. Applicability and Scope

This Act shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

**A.** Any portion of the premium or benefits is paid by or on behalf of the small employer;

**B.** An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

**C.** The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code.

**Drafting Note:** In some cases, individual health benefit plans sold to small employers could be subject both to the provisions of this Act and to the provisions of the state’s laws for individual health insurance. A state should consider whether inconsistencies in regulatory standards would result, especially in the provisions relating to premium rates. A state may wish to consider exempting individual health benefit plans from the rating provisions of this Act.

**D.** (1) Except as provided in Paragraph (2), for the purposes of this Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this Act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.
(2) An affiliated carrier that is a health maintenance organization having a certificate of authority under Section [insert reference to state health maintenance organization licensing act] may be considered to be a separate carrier for the purposes of this Act.

(3) Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. [The provisions of {insert applicable reference to state law on assumption reinsurance} shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.]

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

E. (1) A Taft-Hartley trust, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Section 6A with respect to a health benefit plan provided to the trust.

(2) The commissioner may grant such a waiver if the commissioner finds that application of Section 6A with respect to the trust would:

(a) Have a substantial adverse effect on the participants and beneficiaries of such trust, and

(b) Require significant modifications to one or more collective bargaining arrangement under which the trust is established or maintained.

(3) A waiver granted under this section shall not apply to an individual if the person participates in such a trust as an associate member of an employee organization.

Section 5. Establishment of Classes of Business

A. A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) The small employer carrier has acquired a class of business from another small employer carrier; or

(3) The small employer carrier provides coverage to one or more association groups that meet the requirements of [insert appropriate statutory reference to Section 1E of the NAIC Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act].

B. A small employer carrier may establish up to nine (9) separate classes of business under Subsection A.

C. The commissioner may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with Subsection B in the instance of acquisition of an additional class of business from another small employer carrier.
D. The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

**Section 6. Restrictions Relating to Premium Rates**

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

A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:

1. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

2. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate.

3. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

   a. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

   b. Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier’s rate manual for the class of business; and

   c. Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier’s rate manual for the class of business.

4. Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

5. A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent (15%).
(6) In the case of health benefit plans delivered or issued for delivery prior to the effective
date of this Act, a premium rate for a rating period may exceed the ranges set forth in
Subsections A(1) and (2) for a period of three (3) years following the effective date of
this Act. In such case, the percentage increase in the premium rate charged to a small
employer for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the
first day of the prior rating period to the first day of the new rating period. In the
case of a health benefit plan into which the small employer carrier is no longer
enrolling new small employers, the small employer carrier shall use the
percentage change in the base premium rate, provided that such change does not
exceed, on a percentage basis, the change in the new business premium rate for
the most similar health benefit plan into which the small employer carrier is
actively enrolling new small employers.

(b) Any adjustment due to change in coverage or change in the case characteristics
of the small employer, as determined from the carrier’s rate manual for the class
of business.

(7) (a) Small employer carriers shall apply rating factors, including case characteristics,
consistently with respect to all small employers in a class of business. Rating
factors shall produce premiums for identical groups which differ only by
amounts attributable to plan design and do not reflect differences due to the
nature of the groups assumed to select particular health benefit plans.

(b) A small employer carrier shall treat all health benefit plans issued or renewed in
the same calendar month as having the same rating period.

(8) For the purposes of this subsection, a health benefit plan that contains a restricted
network provision shall not be considered similar coverage to a health benefit plan that
does not contain such a provision, provided that the restriction of benefits to network
providers results in substantial differences in claim costs.

(9) A small employer carrier shall not use case characteristics, other than age, gender,
industry, geographic area, family composition, and group size without prior approval of
the commissioner.

(10) The commissioner may establish regulations to implement the provisions of this section
and to assure that rating practices used by small employer carriers are consistent with the
purposes of this act, including regulations that:

(a) Assure that differences in rates charged for health benefit plans by small
employer carriers are reasonable and reflect objective differences in plan design,
(not including differences due to the nature of the groups assumed to select
particular health benefit plans); and

(b) Prescribe the manner in which case characteristics may be used by small
employer carriers.

B. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of
business. A small employer carrier shall not offer to transfer a small employer into or out of a
class of business unless such offer is made to transfer all small employers in the class of business
without regard to case characteristics, claim experience, health status or duration of coverage.

C. The commissioner may suspend for a specified period the application of Subsection A(1) as to the
premium rates applicable to one or more small employers included within a class of business of a
small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

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

(1) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(2) The provisions of the health benefit plan concerning the small employer carrier’s right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

(3) The provisions relating to renewability of policies and contracts; and

(4) The provisions relating to any preexisting condition provision.

E. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file with the commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in Subsection E(1) available to the commissioner upon request. Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Section 7. Renewability of Coverage

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

A. A health benefit plan subject to this Act shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

(1) Nonpayment of the required premiums;

(2) Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;
(3) Noncompliance with the carrier’s minimum participation requirements;

(4) Noncompliance with the carrier’s employer contribution requirements;

(5) Repeated misuse of a provider network provision;

(6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:

(a) Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

(b) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected covered individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected small employers; or

(7) The commissioner finds that the continuation of the coverage would:

(a) Not be in the best interests of the policyholders or certificate holders; or

(b) Impair the carrier’s ability to meet its contractual obligations.

In such instance the commissioner shall assist affected small employers in finding replacement coverage.

B. A small employer carrier that elects not to renew a health benefit plan under Subsection A(6) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the commissioner.

C. In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier’s operations in that service area.

Section 8. General Small Employer Carrier Requirements

A health benefit plan covering small employers shall comply with the following provisions:

A. 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:

(1) 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;

(2) 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

(3) A pregnancy existing on the effective date of coverage.
B. A small employer carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

C. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen (18) months or for an eighteen-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months from the date the individual enrolls for coverage under the health benefit plan.

D. (1) Except as provided in Paragraph (4), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3) (a) Except as provided in Paragraph (2), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(b) With respect to a small employer [with ten (10) or fewer eligible employees], a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

Drafting Note: In determining whether to include the bracketed language, states should consider the impact of dual choice on small employer carriers in relationship to both the number of health maintenance organizations in the state and the effect on small employers and their employees.

(4) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

E. (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in Subsection C.

(2) Except as permitted under Subsections A and C, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.
Section 9. Notice of Intent to Operate as a Risk-Assuming Carrier or an Allocation Carrier

A. Within thirty (30) days after the plan of operation is approved by the commissioner under Section 11, each small employer carrier shall notify the commissioner of the carrier’s intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 10.

B. The decision shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The commissioner may permit a carrier to modify its decision at any time for good cause shown.

C. The commissioner shall establish as application process for small employer carrier seeking to change their status under this subsection. In the case of a small employer carrier that has been acquired by another such carrier, the commissioner may waive or modify the time periods established in Subsection B.

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

Section 10. Application to Become a Risk-Assuming Carrier

A. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

B. The commissioner shall consider the following factors in evaluating an application filed under Subsection A:

(1) The carrier’s financial condition;

(2) The carrier’s history of rating and underwriting small employer groups;

(3) The carrier’s commitment to market fairly to all small employers in the state or its established geographic service area, as applicable; and

(4) The carrier’s experience with managing the risk of small employer groups.

C. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the commissioner, the carrier may request a hearing.

D. The commissioner may rescind the approval granted to a risk-assuming carrier under this section if the commissioner finds that:

(1) The carrier’s financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with Subsection E;

(2) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or

(3) The carrier has failed to provide coverage to eligible small employers as required in Subsection E.

E. (1) A risk-assuming carrier shall make available to all eligible small employers in this state, as described in Paragraph (2), at least a basic health benefit plan and a standard benefit plan. Such health benefit plans shall be offered to eligible small employers on a year-round basis and without regard to the health status or
industry of the eligible employees and dependents of the small employers. Such health benefit plans shall comply with the requirements of Sections 6, 7 and 8.

(b) In the case of a risk-assuming carrier that establishes more than one class of business pursuant to Section 5, the risk-assuming carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A risk-assuming carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(i) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(ii) The criteria are not related to the health status or claim experience of the small employer;

(iii) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(iv) The risk-assuming carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of this subparagraph shall not apply to a class of business into which the risk-assuming carrier is no longer enrolling new small businesses.

(2) A small employer is eligible under Paragraph (1) if it employed at least three (3) or more eligible employees within this state on at least fifty percent (50%) of its working days during the preceding calendar quarter.

Drafting Note: The minimum group size of three (3) is included to protect the small employer carriers from excessive adverse selection.

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

(3) A risk-assuming carrier shall not be required to offer coverage or accept applications pursuant to this subsection in the case of the following:

(a) To a small employer, where the small employer is not physically located in the carrier’s established geographic service area;

(b) To an employee, when the employee does not work or reside within the carrier’s established geographic service area; or

(c) Within an area where the risk-assuming carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(4) A risk-assuming carrier that cannot offer coverage pursuant to Paragraph (3)(c) may not offer coverage in the applicable area to new cases of employer groups with more than twenty-five (25) eligible employees or to any small employer groups until the later of 180
days following each such refusal or the date on which the carrier notifies the
commissioner that it has regained capacity to deliver services to small employer groups.

(5) A risk-assuming carrier shall not be required to provide coverage to small employers
pursuant to this subsection for any period of time for which the commissioner determines
that requiring the acceptance of small employers in accordance with the provisions of
Subsection A would place the risk-assuming carrier in a financially impaired condition.

Section 11. Small Employer Allocation Program

A. All small employer carriers, other than risk-assuming carriers, issuing health benefit plans in this
state on and after the operative date of this Act shall be required to meet the requirements of this
section as a condition of authority to transact business in this state.

Drafting Note: References to risk-assuming carriers and allocation carriers can be deleted if allocation is
mandatory.

B. There is hereby created a nonprofit entity to be known as the [State] Small Employer Allocation
Program. All small employer carriers, other than risk-assuming carriers, issuing health benefit
plans in this state on and after the effective date of this Act shall be allocating carriers in the
program.

C. (1) The program shall operate subject to the supervision and control of the board. The board
shall consist of [eight (8)] members appointed by the commissioner plus the
commissioner or his or her designated representative, who shall serve as an ex officio
member of the board.

(2) In selecting the members of the board, the commissioner shall include representatives of
small employers and small employer carriers and such other individuals determined to be
qualified by the commissioner. At least five (5) of the members of the board shall be
representatives of carriers and shall be selected from individuals nominated by small
employer carriers in this state pursuant to procedures and guidelines developed by the
commissioner.

Drafting Note: The commissioner should consider the appropriateness of appointing allocating carriers to the board
of the reinsurance program. The potential for conflict of interest as well as the type and scope of powers given to the
board should be considered.

(3) The initial board members shall be appointed as follows: two (2) of the members to serve
a term of two (2) years; three (3) of the members to serve a term of four (4) years; and
three (3) of the members to serve a term of six (6) years. Subsequent board members
shall serve for a term of three (3) years. A board member’s term shall continue until his
or her successor is appointed.

(4) A vacancy in the board shall be filled by the commissioner. A board member may be
removed by the commissioner for cause.

D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a
filing with the commissioner containing the carrier’s net health insurance premium derived from
health benefit plans delivered or issued for delivery to small employers in this state in the previous
calendar year.

E. Within 180 days after the appointment of the initial board, the board shall submit to the
commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to
assure the fair, reasonable and equitable administration of the program. The commissioner may,
after notice and hearing, approve the plan of operation if the commissioner determines it to be
suitable to assure the fair, reasonable and equitable administration of the program and to provide
for the sharing of program gains or losses on an equitable and proportionate basis in accordance
with the provisions of this section. The plan of operation shall become effective upon approval in
writing by the commissioner.

F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the
commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation.
The commissioner shall amend or rescind any plan adopted under this section at the time a plan of
operation is submitted by the board and approved by the commissioner.

G. The plan of operation shall:

(1) Establish procedures for handling and accounting of program assets and moneys and for
an annual fiscal reporting to the commissioner;

(2) Establish procedures for selecting an administering carrier and setting forth the powers
and duties of the administering carrier;

(3) Establish procedures for allocating small employers among small employer carriers in
accordance with the provisions of this Act;

(4) Establish procedures for collecting assessments from all members subject to assessment
to provide for administrative expenses incurred or estimated to be incurred for the period
for which the assessment is made;

(5) Establish a methodology for applying the dollar thresholds contained in this section in the
case of carriers that pay or reimburse health care providers though capitation or salary;
and

(6) Provide for any additional matters necessary for the implementation and administration
of the program.

H. The program shall have the general powers and authority granted under the laws of this state to
insurance companies and health maintenance organizations licensed to transact business, except
the power to issue health benefit plans directly to either groups or individuals. In addition thereto,
the program shall have the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of
this Act, including the authority, with the approval of the commissioner, to enter into
contracts with similar programs of other states for the joint performance of common
functions or with persons or other organizations for the performance of administrative
functions;

(2) Sue or be sued, including taking any legal actions necessary or proper for recovering any
assessments and penalties for, on behalf of, or against the program or any allocating
 carriers;

(3) Establish rules, conditions and procedures pertaining to its functions under this Act;

(4) Assess allocating carriers in accordance with the provisions of Subsection M, and to
make interim assessments as may be reasonable and necessary for organizational and
interim operating expenses. Any interim assessments shall be credited as offsets against
any regular assessments due following the close of the fiscal year;
(5) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;

(6) Borrow money to effect the purposes of the program. Any notes or other indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets;

(7) Perform other functions necessary and proper to carry out its responsibilities under this Act.

I. (1) A small employer shall be eligible for coverage in the allocation program if it meets the requirements of Subparagraphs (a) and (b).

(a) The small employer employed at least three (3) or more eligible employees within this state on at least fifty percent (50%) of its working days during the preceding calendar quarter.

(b) The small employer has been refused coverage by at least two (2) small employer carriers in the preceding six (6) months.

Drafting Note: The minimum group size of three (3) is included to protect the small employer carriers from excessive adverse selection.

(2) A small employer that is insured through the allocation program shall be eligible to reapply to the program for the purpose of changing small employer carriers after a period of two (2) years. Such small employer must meet the requirements of Paragraph (1).

(3) A small employer that meets the eligibility requirements of this subsection may apply to the program for a basic health benefit plan or a standard health benefit plan.

J. The board shall establish procedures, as part of the plan of operation, for receiving applications pursuant to Subsection I and for allocating small employers among all allocating carriers. Such procedures shall be designed to assure a fair allocation of risks among allocating small employer carriers. The procedures shall include the following:

(1) A method by which the board shall estimate each year the total number of uninsurable individuals in small employer groups that will be allocated under this subsection during the year. The board shall develop a definition of an uninsurable individual for the purposes of this section.

(2) A method by which the program shall assign to each small employer carrier a target number of uninsurable individuals. The target number for a small employer carrier shall bear the same proportional relationship to the total number of uninsurable individuals estimated under Paragraph (1) as the small employer carrier’s annual net premiums for coverage of small employers bears to the annual net premiums of all small employer carriers for coverage of small employers. In the case of a small employer carrier with an established geographic service area, the board may adjust the target number of uninsurable individuals to account for the carrier’s increased or decreased exposure resulting from allocation.

(3) A procedure by which the program shall determine the number of uninsurable eligible employees and dependents of each small employer that is eligible for allocation.

(4) A procedure by which small employers that are eligible for allocation may select an allocating carrier from a list of the allocating carriers in the program. The procedure shall
provide for the small employer to be allocated to the selected allocating carrier unless, as a result of the addition of the small employer, the carrier’s target number determined under Paragraph (2) would be exceeded. A small employer that is not allocated to the carrier that it initially selects shall continue to make selections of allocating carriers until it is allocated.

(5) A procedure by which the board shall determine, as for each calendar year, the extent to which the average claims cost incurred by a small employer carrier for providing coverage to uninsurable individuals (whether allocated in that calendar year or any preceding year) is greater or less than the average claims cost incurred by small employer carriers for providing coverage to all uninsurable individuals (whether allocated in that calendar year or any preceding year) that have been allocated under the program.

(a) The procedure shall provide for the board to adjust the target number for a small employer carrier for the subsequent year if the average claims cost incurred by such small employer carrier from providing coverage to uninsurable individuals is either more or less, by at least the applicable percentage determined in Subparagraph (b), than the average claims cost for all uninsurable individuals allocated under the program.

(b) The procedure shall provide for the board to determine a percentage amount for the purpose of Subparagraph (a). In determining such percentage, the board shall balance the following objectives:

(i) Achieving an equitable distribution among small employer carriers of the claims costs of uninsurable individuals;

(ii) Efficient administration of the program; and

(iii) Providing incentive for small employer carriers to manage the care of uninsurable individuals allocated under the program.

(c) The procedure may provide for the board to further adjust the target number for a small employer carrier for the subsequent year on the basis of the carrier’s total claim experience from allocated groups in relation to the total premiums earned with respect to such groups.

K. The board shall periodically evaluate the program to assure equity in the distribution of allocated small employers. The board, subject to the approval of the commissioner, shall have the authority to make adjustments to the procedures established pursuant to Subsection J to further the goal of equitable distribution of allocated small employers.

L. A small employer carrier shall not be required to accept allocated small employers that are not located within their established geographic service area.

**Drafting Note**: This subsection is included to avoid allocation of small employers to geographically inaccessible small employer carriers.

M. (1) Following the close of each calendar year, the administering carrier shall determine the program expenses of administration, taking into account investment income and other appropriate gains and losses. The net expense for the year shall be recouped by assessments of allocating carriers. The administering carrier also shall determine the claims expense for allocated small employers for each small employer carrier for both the basic and the standard health benefit plans, on an annual basis, using information collected from carriers under Subsection P.
(2) Assessments to cover the administrative expenses of the program shall be apportioned by the board among allocating carriers in proportion to their respective shares of the total premiums earned from health benefit plans delivered or issued for delivery to small employers in this state by all allocating carriers during the previous calendar year.

(3) Each allocating carrier’s assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed with it by the allocating carrier.

(4) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(5) An allocating carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of an allocating carrier if the commissioner determines that the payment of the assessment would place the allocating carrier in a financially impaired condition. If all or part of an assessment against an allocating carrier is deferred, the amount deferred shall be assessed against the other allocating carriers in a manner consistent with the basis for the assessment set forth in this subsection. The allocating carrier receiving such deferment shall remain liable to the program for the amount deferred.

(6) Risk-assuming carriers shall not be subject to assessments imposed pursuant to this subsection. Premiums earned by risk-assuming carriers shall not be considered in the calculation of assessments under Paragraph (2).

N. Except as provided in Subsection L, allocating carriers shall accept applications from all small employers allocated to it by the program and shall offer such small employers a basic health benefit plan and a standard health benefit plan. An allocation carrier may also offer to a small employer allocated to it coverage that is more comprehensive than that required by this Act.

O. An allocation carrier shall not be required to provide coverage to small employers under this section for any period of time for which the commissioner determines that the participation in the program could place the small employer carrier in a financially impaired condition.

P. Each allocation carrier shall file with the commissioner, in a form and manner to be prescribed by the commissioner, an annual report. The report shall state the small employer carrier’s net premium for new small employer coverage written in the previous twelve-month period. The report also shall state the number of small employers allocated to it, the claims expenses for uninsurable individuals allocated to it by the program, the claims expenses for small employers allocated to it by the program, the names and number of the small employers that canceled or terminated coverage with it during the preceding calendar year, and the reasons for such cancellations or terminations, if known. The report shall be filed on or before March 1 for the preceding calendar year. A copy of the report shall be provided to the board.

Q. Neither the participation in the program, the establishment of procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any allocating carriers either jointly or separately.

R. The program shall be exempt from any and all taxes.

S. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration: the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of
compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

**Drafting Note:** States should consider the ability of the small employer marketplace to absorb the costs associated with allocating uninsurable individuals and small employers through the allocation program. States may wish to consider whether access to the program should be limited if the program exceeds a specified premium volume or whether additional sources of revenues may be needed to assist in meeting the costs from allocating these risks.

**Section 12. Health Benefit Plan Committee**

A. The [commissioner/governor] shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, small employers, employees, health care providers and producers.

**Drafting Note:** A state may wish to add a representative of third-party administrators to the committee membership.

B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Sections 10 and 11.

C. The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefits of health maintenance organizations, including any restrictions imposed by federal law.

(1) The plans recommended by the committee may include cost containment features such as:

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(b) Case management;

(c) Selective contracting with hospitals, physicians and other health care providers;

(d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(e) Other managed care provisions.

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

(3) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.

(b) The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this subsection.

**Section 13. Periodic Market Evaluation**

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

B. The board shall commission an actuarial study, by an independent actuary approved by the commissioner, within the first three (3) years of the operation of the program to evaluate and measure the relative risks being assumed by differing types of small employer carriers as a result of this Act.

Section 14. Waiver of Certain State Laws

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

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

Section 15. Administrative Procedures

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

Section 16. Standards to Assure Fair Marketing

A. A small employer carrier that denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents shall provide notice to the small employer, in a form and manner prescribed by the commissioner, of the potential availability of coverage through the program.

B. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for placing small employers with the small employer carrier through the program.

C. No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer because the producer has placed small employers with the small employer carrier through the program.

D. No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee’s employment.

E. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

F. The commissioner may promulgate by regulation additional standards to provide for the availability of health benefit plans to small employers through the program.
G. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under Section [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Section 17. Separability

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

Section 18. Restoration of Terminated Coverage

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

Section 19. Effective Date

The Act shall be effective on [insert date].

Legislative History (all references are to the Proceedings of the NAIC).

Section 1. Short Title

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

Section 2. Purpose

The purpose and intent of this Act are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of “basic” and “standard” health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

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

Section 3. Definitions

As used in this Act:

A. “Actuarial certification” means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 6 of this Act, based upon the person’s examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

B. “Affiliate” or “affiliated” means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
C. “Base premium rate” means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

D. “Basic health benefit plan” means a lower cost health benefit plan developed pursuant to Section 12.

E. “Board” means the board of directors of the program established pursuant to Section 11.

F. “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.

Drafting Note: The term “multiple employer welfare arrangement” should be added to the list of carriers in those states that have separate certificates of authority for such arrangements. In states that do not have separate licenses for self-funded multiple employer welfare arrangements, such arrangements should be treated as unauthorized insurers. States should enforce their laws against transaction of unauthorized insurance against such unauthorized self-funded multiple employer welfare arrangements.

G. “Case characteristics” means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this Act.

H. “Class of business” means all or a separate grouping of small employers established pursuant to Section 5.

I. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Where the word “commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

J. “Committee” means the Health Benefit Plan Committee created pursuant to Section 12.

K. “Control” shall be defined in the same manner as in Section [insert reference to state law corresponding to NAIC Model Holding Company Act].

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

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

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

Drafting Note: If using suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law.
M. “Eligible employee” means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis.

N. “Established geographic service area” means a geographic area, as approved by the commissioner and based on the carrier’s certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

O. (1) “Health benefit plan” means any hospital or medical policy or certificate, major medical expense insurance, [insert reference to subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan], or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker’s compensation or similar insurance, or automobile medical payment insurance.

(2) “Health benefit plan” shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

(a) The carrier files on or before March 1 of each year a certification with the commissioner that contains the statement and information described in Subparagraph (b).

(b) The certification required in Subparagraph (a) shall contain the following:

(i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

(ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this state.

(c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the commissioner the information and statement required in Subparagraph (b) at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.

P. “Index rate” means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Q. “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.

R. “New business premium rate” means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

S. “Plan of operation” means the plan of operation of the program established pursuant to Section 11.

T. “Premium” means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

U. “Producer” means [incorporate reference to definition in state’s law for licensing producers].

Drafting Note: States that have not adopted the NAIC Single License Procedure Model Act should substitute the terms “agent” and/or “broker” for the term “producer” as appropriate.

V. “Program” means the [State] Small Employer Reinsurance Program created by Section 11.

W. “Qualifying previous coverage” and “qualifying existing coverage” mean 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.

X. “Rating period” means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

Y. “Reinsuring carrier” means a small employer carrier participating in the reinsurance program pursuant to Section 11.
Z. “Restricted network provision” means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.

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

AA. “Risk-assuming carrier” means a small employer carrier whose application is approved by the commissioner pursuant to Section 10.

Drafting Note: Delete Subsections Y and AA if participation in the reinsurance program is mandatory.

BB. “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.

CC. “Small employer carrier” means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

DD. “Standard health benefit plan” means a health benefit plan developed pursuant to Section 12.

Section 4. Applicability and Scope

This Act shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

A. Any portion of the premium or benefits is paid by or on behalf of the small employer;

B. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

C. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code.

Drafting Note: In some cases, individual health benefit plans sold to small employers could be subject both to the provisions of this Act and to the provisions of the state’s laws for individual health insurance. A state should consider whether inconsistencies in regulatory standards would result, especially in the provisions relating to premium rates. A state may wish to consider exempting individual health benefit plans from the rating provisions of this Act.

D. (1) Except as provided in Paragraph (2), for the purposes of this Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this Act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.

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(2) An affiliated carrier that is a health maintenance organization having a certificate of authority under Section [insert reference to state health maintenance organization licensing act] may be considered to be a separate carrier for the purposes of this Act.

(3) Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. [The provisions of (insert applicable reference to state law on assumption reinsurance) shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.]

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

E. (1) A Taft Hartley trust, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Section 6A with respect to a health benefit plan provided to the trust.

(2) The commissioner may grant such a waiver if the commissioner finds that application of Section 6A with respect to the trust would:

(a) Have a substantial adverse effect on the participants and beneficiaries of such trust; and

(b) Require significant modifications to one or more collective bargaining arrangement under which the trust is established or maintained.

(3) A waiver granted under this section shall not apply to an individual if the person participates in such a trust as an associate member of an employee organization.

Section 5. Establishment of Classes of Business

A. A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) The small employer carrier has acquired a class of business from another small employer carrier; or

(3) The small employer carrier provides coverage to one or more association groups that meet the requirements of [insert appropriate statutory reference to Section 1E of the NAIC Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act].

B. A small employer carrier may establish up to nine (9) separate classes of business under Subsection A.

C. The commissioner may establish regulations to provide for a period of transitions in order for a small employer carrier to come into compliance with Subsection B in the instance of acquisition of an additional class of business from another small employer carrier.
D. The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

Section 6. Restrictions Relating to Premium Rates

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

A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(b) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier’s rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier’s rate manual for the class of business.

(4) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to Section 11.

(6) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry...
classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent (15%).

(7) In the case of health benefit plans delivered or issued for delivery prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges set forth in Subsections A(l) and (2) for a period of three (3) years following the effective date of this Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier’s rate manual for the class of business.

(8) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(a) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(b) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(9) For the purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

(10) The small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition and group size without prior approval of the commissioner.

(11) The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this Act, including regulations that:

(a) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design (not including differences due to the nature of the groups assumed to select particular health benefit plans); and

(b) Prescribe the manner in which case characteristics may be used by small employer carriers.

B. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business unless such offer is made to transfer all small employers in the class of business
without regard to case characteristics, claim experience, health status or duration of coverage since issue.

C. The commissioner may suspend for a specified period the application of Subsection A(l) as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

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

(1) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(2) The provisions of the health benefit plan concerning the small employer carrier’s right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(3) The provisions relating to renewability of policies and contracts; and

(4) The provisions relating to any preexisting condition provision.

E. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in Subsection E(l) available to the commissioner upon request. Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Section 7. Renewability of Coverage

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

A. A health benefit plan subject to this Act shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:
(1) Nonpayment of the required premiums;
(2) Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;
(3) Noncompliance with the carrier’s minimum participation requirements;
(4) Noncompliance with the carrier’s employer contribution requirements;
(5) Repeated misuse of a provider network provision;
(6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:
   (a) Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and
   (b) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected small employers; or
(7) The commissioner finds that the continuation of the coverage would:
   (a) Not be in the best interests of the policyholders or certificate holders; or
   (b) Impair the carrier’s ability to meet its contractual obligations.
   In such instance the commissioner shall assist affected small employers in finding replacement coverage.

B. A small employer carrier that elects not to renew a health benefit plan under Subsection A(6) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the commissioner.

C. In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier’s operations in that service area.

Section 8. Availability of Coverage

A. (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan.
(2) (a) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act.
   (b) In the case of a small employer carrier that establishes more than one class of business pursuant to Section 5, the small employer carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at
least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(i) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(ii) The criteria are not related to the health status or claim experience of the small employer;

(iii) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(iv) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of this subparagraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(3) A small employer is eligible under Paragraph (2) if it employed at least three (3) or more eligible employees within this state on at least fifty percent (50%) of its working days during the preceding calendar quarter.

Drafting Note: The minimum group size of three (3) is included to protect small employer carriers from excessive adverse selection.

(4) The provisions of this subsection shall be effective 180 days after the commissioner’s approval of the basic health benefit plan and the standard health benefit plan developed pursuant to Section 12; provided, that if the Small Employer Health Reinsurance Program created pursuant to Section 11 is not yet operative on that date, the provisions of this paragraph shall be effective on the date that the program begins operation.

B. A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.

The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this Act.

C. 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.

(2) A small employer carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(3) A health benefit plan may exclude coverage for late enrollees for the greater of eighteen (18) months or for an eighteen-month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months from the date the individual enrolls for coverage under the health benefit plan.

(4) (a) Except as provided in Subparagraph (d), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(b) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(c) (i) Except as provided in Item (ii), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(ii) With respect to a small employer [with ten (10) or fewer eligible employees], a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

Drafting Note: In determining whether to include the bracketed language, states should consider the impact of dual choice on small employer carriers in relationship to both the number of health maintenance organizations in the state and the effect on small employers and their employees.

(d) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(5) (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small
employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in Paragraph (3).

(b) Except as permitted under Paragraphs (1) and (3), a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

D. (1) A small employer carrier shall not be required to offer coverage or accept applications pursuant to Subsection A in the case of the following:

(a) To a small employer, where the small employer is not physically located in the carrier’s established geographic service area;

(b) To an employee, when the employee does not work or reside within the carrier’s established geographic service area; or

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to Paragraph (1)(c) may not offer coverage in the applicable area to new cases of employer groups with more than twenty-five (25) eligible employees or to any small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

E. A small employer carrier shall not be required to provide coverage to small employers pursuant to Subsection A for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of Subsection A would place the small employer carrier in a financially impaired condition.

Section 9. Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier

A. (1) Within thirty (30) days after the plan of operation is approved by the commissioner under Section 11, each small employer carrier shall notify the commissioner of the carrier’s intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 10.

(2) The decision shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The commissioner may permit a carrier to modify its decision at any time for good cause shown.

(3) The commissioner shall establish as application process for small employer carrier seeking to change their status under this subsection. In the case of a small employer carrier that has been acquired by another such carrier, the commissioner may waive or modify the time periods established in Paragraph (2).

B. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay
a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

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

Section 10. Application to Become a Risk-Assuming Carrier

A. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

B. The commissioner shall consider the following factors in evaluating an application filed under Subsection A:

(1) The carrier’s financial condition;
(2) The carrier’s history of rating and underwriting small employer groups;
(3) The carrier’s commitment to market fairly to all small employers in the state or its established geographic service area, as applicable; and
(4) The carrier’s experience with managing the risk of small employer groups.

C. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the commissioner, the carrier may request a hearing.

D. The commissioner may rescind the approval granted to a risk-assuming carrier under this section if the commissioner finds that:

(1) The carrier’s financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with Section 8 without the protection afforded by the program;
(2) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or
(3) The carrier has failed to provide coverage to eligible small employers as required in Section 8.

E. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of Section 11.

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

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

Section 11. Small Employer Carrier Reinsurance Program

A. A reinsuring carrier shall be subject to the provisions of this section.

Drafting Note: Delete Subsection A if participation in the reinsurance program is mandatory.
B. There is hereby created a nonprofit entity to be known as the [insert name of state] Small Employer Health Reinsurance Program.

C. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of Paragraph (2), the board shall consist of [eight] members appointed by the commissioner plus the commissioner or his or her designated representative, who shall serve as an ex officio member of the board.

(2) (a) In selecting the members of the board, the commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the commissioner. At least five (5) members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the commissioner.

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

(b) In the event that the program becomes eligible for additional financing pursuant to Subsection L(3), the board shall be expanded to include two (2) additional members who shall be appointed by the commissioner. In selecting the additional members of the board, the commissioner shall choose individuals who represent [include reference to representatives of sources for additional financing identified in Subsection L(3)(d)(ii)]. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing under Subsection L(3).

(3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member’s term shall continue until his or her successor is appointed.

(4) A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.

D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the commissioner containing the carrier’s net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

E. Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the commissioner.

F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.
G. The plan of operation shall:

1. Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;
2. Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;
3. Establish procedures for reinsuring risks in accordance with the provisions of this section;
4. Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;
5. Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers through capitation or salary; and
6. Provide for any additional matters necessary for the implementation and administration of the program.

H. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;
2. Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;
3. Take any legal action necessary to avoid the payment of improper claims against the program;
4. Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act;
5. Establish rules, conditions and procedures for reinsuring risks under the program;
6. Establish actuarial functions as appropriate for the operation of the program;
7. Assess reinsuring carriers in accordance with the provisions of Subsection L, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;
8. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;
(9) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets;

I. A reinsuring carrier may reinsure with the program as provided for in this subsection:

(1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group’s coverage under a health benefit plan.

(3) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.

(4) (a) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next $50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carriers’ liability under this subparagraph shall not exceed a maximum limit of $10,000 in any one calendar year with respect to any reinsured individual.

(b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the “Consumer Price Index for All Urban Consumers” of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(5) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(6) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in Paragraph (4), shall be reduced to reflect that portion of the risk above the amount set forth in Paragraph (4) that may not be ceded to the program, if any.]

Drafting Note: Federal law prohibits federally-qualified health maintenance organizations from reinsuring the first $5,000 of covered benefits. States that adopt an initial retention level of less than $5,000 under Paragraph (4) should include the above language.

(7) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

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J. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in Paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan (adjusted to reflect retention levels required under this Act).

(2) Premiums for the program shall be as follows:

(a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this paragraph.

(b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph.

(3) The board periodically shall review the methodology established under Paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

(4) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

K. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 6.

L. (1) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(i) Each reinsuring carrier’s share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(ii) Each reinsuring carrier’s share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.
(b) The formula established pursuant to Subparagraph (a) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150 percent of an amount which is based on the proportion of (i) the reinsuring carrier’s total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (ii) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(c) The board may, with approval of the commissioner, change the assessment formula established pursuant to Subparagraph (a) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year’s premium to vary during a transition period.

(d) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(3) (a) Prior to March 1 of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in Subparagraph (c), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety (90) days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.

(c) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) (i) If assessments in each of two (2) consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Item (ii).

(ii) The additional funding provided for in Item (i) shall be obtained from [the state should specify one or more sources of additional revenue to fund the program. States may wish to consider the alternative revenue sources provided in the NAIC Model Health Plan for Uninsurable Individuals Model Act]. The amount of additional financing to be provided to the program shall be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five percent.
(5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two (2) previous calendar years pursuant to this subparagraph, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose of the calculation in the previous sentence.

(iii) Additional financing received by the program pursuant to this subparagraph shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two (2) calendar years.

Drafting Note: The purpose of the 5% limitation is to prevent the program from placing too heavy of a burden on the small employer marketplace. States could also consider suspending the guarantee issue provision in Section 8 if assessments exceed the 5% threshold.

(4) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, “future losses” includes reserves for incurred but not reported claims.

(5) Each reinsuring carrier’s proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

(6) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(7) A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

M. Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

N. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

O. The program shall be exempt from any and all taxes.

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Section 12. Health Benefit Plan Committee

A. The [commissioner/governor] shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, small employers and employees, health care providers and producers.

Drafting Note: A state may wish to add a representative of third-party administrators to the committee membership.

B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Section 8.

C. The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(1) The plans recommended by the committee may include cost containment features such as:

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services;
(b) Case management;
(c) Selective contracting with hospitals, physicians and other health care providers;
(d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and
(e) Other managed care provisions.

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

Section 13. Periodic Market Evaluation

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

Section 14. Waiver of Certain State Laws

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

Drafting Note: States should carefully examine how broadly or narrowly they allow the mandate preemption to apply. Specifically, several mandates (e.g., newborn coverage, adoptive children coverage, and conversion requirements) may reinforce the goals of access and continuity of coverage and hence should be maintained. States which have overly burdensome benefit mandates may want to consider their exclusion from other health benefit plans.
Section 15. Administrative Procedures

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

Section 16. Standards to Assure Fair Marketing

A. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

B. (1) Except as provided in Paragraph (2), no small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of Paragraph (1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

C. (1) Except as provided in Paragraph (2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

D. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

E. No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation or geographic location of the small employers placed by the producer with the small employer carrier.

F. No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee’s employment.
G. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

H. The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Section 17. Separability

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

Section 18. Restoration of Terminated Coverage

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

Section 19. Effective Date

The Act shall be effective on [insert date].

Legislative History (all references are to the Proceedings of the NAIC).

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Section 1. Short Title

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

Section 2. Purpose

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

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

Drafting Note: This revised model act provides guidance to states interested in reforming their group health insurance laws, particularly as they affect small employers, in order to promote the availability of health insurance coverage to those employers. It is the intent of the NAIC to consider further amendments of this act to deal with the availability of health insurance for individuals as well. In addition, the NAIC believes that the reform of the individual market is critical to achieving the purpose of this model, which is prevention of the segmentation of the market based on health risk.

Section 3. Definitions

As used in this Act:
A. “Actuarial certification” means a written statement signed by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 5 of this Act, based upon the person’s examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

B. “Adjusted community rating” means a method used to develop a carrier’s premium which spreads financial risk across the carrier’s entire small group population in accordance with the requirements in Section 5 of this Act.

C. “Affiliate” or “affiliated” means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

D. “Affiliation period” means a period of time that must expire before health insurance coverage provided by a carrier becomes effective, and during which the carrier is not required to provide benefits.

E. “Basic health benefit plan” means a lower cost health benefit plan developed pursuant to Section 13 of this Act.

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

F. “Board” means the board of directors of the program established pursuant to Section 12 of this Act.

G. “Carrier” or “small employer carrier” means all entities licensed, or required to be licensed, by the Department of Insurance that offer health benefit 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.

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

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

H. “Church plan” has the meaning given this term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

I. “Commissioner” means the insurance commissioner of this state.

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

J. “Committee” means the health benefit plan committee created pursuant to Section 13 of this Act.

K. “Control” shall be defined in the same manner as in Section [insert reference to state law corresponding to the National Association of Insurance Commissioners (NAIC) Model Insurance Holding Company System Regulatory Act].

L. (1) “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:

(a) A group health plan;

(b) A health benefit plan;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);

(e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents (Civilian Health and Medical Program of the Uniformed Services) (CHAMPUS). For purposes of Title 10, U.S.C. Chapter 55, “uniformed services” means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));

(i) A public health plan, which for purposes of this act, means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan; or

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

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

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

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

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

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

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

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

P. “Established geographic service area” means a geographic area, as approved by the commissioner and based on the carrier’s certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

Q. “Family composition” means:

(1) Enrollee;
(2) Enrollee, spouse and children;
(3) Enrollee and spouse; or
(4) Enrollee and children.

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

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

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

S. “Geographic area” is an area established by the commissioner used for adjusting the rates for a health benefit plan.

T. “Governmental plan” has the meaning given the term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

U. (1) “Group health plan” means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in Subsection BB, and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

   (2) For purposes of this Act:

   (a) Any plan, fund or program that would not be, but for PHSA Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b), as an employee welfare benefit plan that is a group health plan;

   (b) In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner; and

   (c) In the case of a group health plan, the term “participant” also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual’s beneficiary who is, or may become, eligible to receive a benefit under the plan, if:

      (i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or

      (ii) In connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the individual is the self-employed individual.

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

V. (1) “Health benefit plan” means any hospital or medical policy or certificate, major medical expense insurance, [insert reference to subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan], or health maintenance
organization subscriber contract. Health benefit plan does include short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

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

(2) “Health benefit plan” shall not include one or more, or any combination of, the following:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;
(b) Coverage issued as a supplement to liability insurance;
(c) Liability insurance, including general liability insurance and automobile liability insurance;
(d) Workers’ compensation or similar insurance;
(e) Automobile medical payment insurance;
(f) Credit-only insurance;
(g) Coverage for on-site medical clinics; and
(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) “Health benefit plan” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;
(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) “Health benefit plan” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or
(b) Hospital indemnity or other fixed indemnity insurance.

(5) “Health benefit plan” shall not include the following if offered as a separate policy, certificate or contract of insurance:
(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

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

(6) A carrier offering policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance shall comply with the following:

(a) The carrier files on or before March 1 of each year a certification with the commissioner that contains the statement and information described in Subparagraph (b);

(b) The certification required in Subparagraph (a) shall contain the following:

(i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance; and

(ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for such policies and certificates in this state; and

(c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the commissioner the information and statement required in Subparagraph (b) at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.

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

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

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

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;
(4) Receipt of health care;
(5) Medical history;
(6) Genetic information;
(7) Evidence of insurability, including conditions arising out of acts of domestic violence; or
(8) Disability.

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

Y. (1) “Late enrollee” means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days.

(2) “Late enrollee” shall not mean an eligible employee or dependent:

(a) Who meets each of the following:

(i) The individual was covered under creditable coverage at the time of the initial enrollment;

(ii) The individual lost creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of a spouse, divorce or legal separation; and

(iii) The individual requests enrollment within thirty (30) days after termination of the creditable coverage or the change in conditions that gave rise to the termination of coverage;

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

(c) If the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

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

(e) If the individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within thirty (30) days after the change in status;

(f) If the individual had coverage under a COBRA continuation provision and the coverage under that provision has been exhausted; or

(g) Who meets the requirements for special enrollment pursuant to Section 7C(7) and (8) of this Act.
“Limited benefit health insurance” means that form of coverage that pays stated predetermined amounts for specific services or treatments or pays a stated predetermined amount per day or confinement for one or more named conditions, named diseases or accidental injury.

“Medical care” means amounts paid for:

1. The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
2. Transportation primarily for and essential to medical care referred to in Paragraph (1); and
3. Insurance covering medical care referred to in Paragraphs (1) and (2).

“Network plan” means a health benefit plan issued by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

“Plan of operation” means the plan of operation of the program established pursuant to Section 12 of this Act.

“Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

“Plan sponsor” has the meaning given this term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

“Preexisting condition” means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage.

1. “Preexisting condition” shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the health benefit plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

“Premium” means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

“Producer” means [incorporate reference to definition in state’s law for licensing producers].

Drafting Note: States that have not adopted the NAIC Producer Licensing Model Act should substitute the term “agent” or “broker” for the term “producer” as appropriate.

“Program” means the [State] Small Employer Reinsurance Program created by Section 12 of this Act.

“Rating period” means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.
KK. “Reinsuring carrier” means a small employer carrier participating in the reinsurance program pursuant to Section 12 of this Act.

LL. “Restricted network provision” means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.

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

MM. “Risk adjustment mechanism” means the mechanism established pursuant to Section 20 of this Act.

NN. “Risk-assuming carrier” means a small employer carrier whose application is approved by the commissioner pursuant to Section 10 of this Act.

Drafting Note: Delete Subsections KK and NN if participation in the reinsurance program is mandatory.

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

PP. “Significant break in coverage” means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

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

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

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

RR. “Standard health benefit plan” means a health benefit plan developed pursuant to Section 13 of this Act.

SS. “Waiting period” means, with respect to a group health plan and an individual, who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to Subsection L(2), a waiting period shall not be considered a gap in coverage.

Section 4. Applicability and Scope

This Act shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

A. Any portion of the premium or benefits is paid by or on behalf of the small employer;

B. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

C. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code; or

D. The health benefit plan is marketed to individual employees through an employer.

Drafting Note: In some cases, individual health benefit plans could be subject both to the provisions of this Act and to the provisions of the state’s laws for individual health insurance. A state should consider whether inconsistencies in regulatory standards would result, especially in the provisions relating to premium rates. A state may wish to consider exempting individual health benefit plans covered by this Act from the rating provisions of existing state statutes.

E. (1) Except as provided in Paragraph (2), for the purposes of this Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this Act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.

(2) An affiliated carrier that is a health maintenance organization having a certificate of authority under Section [insert reference to state health maintenance organization licensing act] may be considered to be a separate carrier for the purposes of this Act.

(3) Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit

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plans being retained by the ceding carrier. [The provisions of {insert applicable reference to state law on assumption reinsurance} shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.]

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

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

A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:

1. The small employer carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:
   - (a) Geographic area;
   - (b) Family composition; and
   - (c) Age.

2. The adjustment for age in Paragraph(1)(c) may not use age brackets smaller than five-year increments and these shall begin with age thirty (30) and end with age sixty-five (65).

3. The small employer carriers shall be permitted to develop separate rates for individuals age sixty-five (65) or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

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

**Drafting Note:** The limitations on premium rate variations contained above represent one of several viable approaches that might be considered by a state and should be viewed in that way rather than as a recommended approach. The state may wish to include a provision for a recommendation to postpone the subsequent steps if a study determines the rate compression is producing unanticipated effects. In particular, there is a potential for adverse results from timing issues relative to implementing these rate limitations prior to the inclusion of individual insurance.

B. The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect:

1. Changes to the enrollment of the small employer;
2. Changes to the family composition of the employee; or
3. Changes to the health benefit plan requested by the small employer.
C. Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to Section 12 of this Act.

D. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

E. For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

F. The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this Act, including regulations that:

1. Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design or coverage (not including differences due to the nature of the groups assumed to select particular health benefit plans or separate claim experience for individual health benefit plans); and

2. Prescribe the manner in which geographic territories are designated by all small employer carriers.

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

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

1. The provisions of the health benefit plan concerning the small employer carrier’s right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

2. The provisions relating to renewability of policies and contracts;

3. The provisions relating to any preexisting condition provision; and

4. A listing of and descriptive information, including benefits and premiums, about all benefit plans for which the small employer is qualified.

H. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.
Each small employer carrier shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the small employer carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

A small employer carrier shall make the information and documentation described in Subsection E(1) available to the commissioner upon request. Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

I. The requirements of this section shall apply to all health benefit plans issued or renewed on or after the effective date of this Act.

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

**Section 6. Renewability of Coverage**

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

A. A health benefit plan subject to this Act shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

1. The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the carrier has not received timely premium payments;

2. The plan sponsor or, with respect to coverage of individual insureds under the health benefit plan, the insured or the insured’s representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

3. Noncompliance with the carrier’s minimum participation requirements;

4. Noncompliance with the carrier’s employer contribution requirements;

5. The small employer carrier elects to discontinue offering all of its health benefit plans delivered or issued for delivery to small employers in this state if the carrier:

   a. Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

   b. Provides notice of the decision to:

      i. All affected small employers and enrollees and their dependents; and

      ii. The commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provided the notice to the
commissioner under this subparagraph is sent at least three (3) working
days prior to the date the notice is sent to the affected small employers
and enrollees and their dependents;

(6) The commissioner:

(a) Finds that the continuation of the coverage would not be in the best interests of
the policyholders or certificate holders or would impair the carrier’s ability to
meet its contractual obligations; and

(b) Assists affected small employers in finding replacement coverage;

(7) The commissioner finds that the product form is obsolete and is being replaced with
comparable coverage and the small employer carrier decides to discontinue offering that
particular type of health benefit plan (obsolete product form) in the state’s small
employer market if the carrier:

(a) Provides advance notice of its decision under this paragraph to the
commissioner in each state in which it is licensed;

(b) Provides notice of the decision not to renew coverage at least 180 days prior to
the nonrenewal of any health benefit plans to:

(i) All affected small employers and enrollees and their dependents; and

(ii) The commissioner in each state in which an affected insured individual
is known to reside, provided the notice sent to the commissioner under
this subparagraph is sent at least three (3) working days prior to the
date the notice is sent to the affected small employers and enrollees and
their dependents;

(c) Offers to each small employer issued that particular type of health benefit plan
(obsolete product form) the option to purchase all other health benefit plans
currently being offered by the carrier to small employers in the state; and

(d) In exercising this option to discontinue that particular type of health benefit plan (obsolete product
form) and in offering the option of coverage pursuant to Subparagraph (c) acts uniformly without regard
to the claims experience of those small employers or any health status-related factor relating to any
enrollee or dependent of an enrollee or enrollees and their dependents covered or new enrollees and their
dependents who may become eligible for coverage; or

(8) In the case of health benefit plans that are made available in the small group market
through a network plan, there is no longer an employee of the small employer living,
working or residing within the carrier’s established geographic service area and the
carrier would deny enrollment in the plan pursuant to Section 7D(1)(b) of this Act.

B. (1) A small employer carrier that elects not to renew health benefit plan coverage pursuant to
Subsection A(2) because of the small employer’s fraud or intentional misrepresentation
of material fact under the terms of coverage may choose not to issue a health benefit plan
to that small employer for one (1) year after the date of nonrenewal.

(2) This paragraph shall not be construed to affect the requirements of Section 7 of this Act
as to other small employer carriers to issue any health benefit plan to the small employer.

C. (1) A small employer carrier that elects to discontinue offering health benefit plans under
Subsection A(5) shall be prohibited from writing new business in the small employer
market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

(2) In the case of a small employer carrier that ceases offering new coverage in this state pursuant to Subsection A(5), the small employer carrier, as determined by the commissioner, may renew its existing business in the small employer market in the state or may be required to nonrenew all of its existing business in the small employer market in the state.

D. In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier’s operations in that service area.

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

Section 7. Availability of Coverage

A. (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state including at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan from such small employer carrier.

(2) Subject to Paragraph (1), a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act. However, no carrier shall be required to issue a health benefit plan to any self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

Drafting Note: States may also want to consider the implications of possible duplicate coverages of public programs, such as Medicare and Medicaid, and authorize the commissioner to promulgate regulations to preclude undesired duplication or the prospect of unintended dumping.

(3) (a) Subject to Subparagraph (b), the provisions of this subsection shall be effective 180 days after the commissioner’s approval of the basic health benefit plan and the standard health benefit plan developed pursuant to Section 13.

(b) If the Small Employer Health Reinsurance Program created pursuant to Section 12 is not yet operative on the date provided in Subparagraph (a), the provisions of this paragraph shall be effective on the date that the program begins operation.

B. (1) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.
The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this Act.

C. Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than six (6) months following the enrollment date of the individual’s coverage due to a preexisting condition, or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more restrictively than as defined in Section 3FF of this Act.

(2) (a) Except as provided in Paragraph (3), a small employer carrier shall reduce the period of any preexisting condition exclusion without regard to the specific benefits covered during the period of creditable coverage, provided that the last period of creditable coverage ended on a date not more than ninety (90) days prior to the enrollment date of new coverage.

(b) The aggregate period of creditable coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier, or for the normal application and enrollment process following employment or other triggering event for eligibility.

(c) A carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period that:

(i) Does not exceed sixty (60) days for new entrants and not to exceed ninety (90) days for late enrollees;

(ii) During which the carrier charges no premiums and the coverage issued is not effective; and

(iii) Is applied uniformly, without regard to any health status-related factor.

(d) This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(3) (a) Instead of as provided in Paragraph (2)(a), a small employer carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations.

(b) A small employer electing to reduce the period of any preexisting condition exclusion using the alternative method described in Subparagraph (a) shall:

(i) Make the election on a uniform basis for all enrollees; and

(ii) Count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(c) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described under Subparagraph (a) shall:
Prominently state that the election has been made in any disclosure statements concerning coverage under the health benefit plan to each enrollee at the time of enrollment under the plan and to each small employer at the time of the offer or sale of the coverage; and

Include in the disclosure statements the effect of the election.

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

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

A small employer carrier shall reduce the period of any preexisting condition exclusion pursuant to Paragraph (2) or Paragraph (3).

A small employer carrier shall not impose a preexisting condition exclusion:

- Relating to pregnancy as a preexisting condition; or
- With regard to a child who is covered under any creditable coverage within thirty (30) days of birth, adoption or placement for adoption, provided that the child does not experience a significant break in coverage, and provided that the child was adopted or placed for adoption before attaining eighteen (18) years of age.

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

A small employer carrier shall not impose a preexisting condition exclusion in the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis, care or treatment was a covered benefit under the plan, provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

A small employer carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group health plan of the small employer during a special enrollment period if:

- The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;
- The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time;
(iii) The employee’s or dependent’s coverage described under Item (i):

(I) Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or

(II) Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated; and

(iv) Under terms of the group health plan, the employee requests enrollment not later than thirty (30) days after the date of exhaustion of coverage described in Item (iii)(I) or termination of coverage or employer contribution described in Item (iii)(II).

(b) If an employee requests enrollment pursuant to Item (iv), the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(8) (a) A small employer carrier that makes coverage available under a group health plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in Subparagraph (b) during which the person or, if not otherwise enrolled, the individual may be enrolled under the group health plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage if:

(i) The individual is a participant under the health benefit plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan, but for a failure to enroll during a previous enrollment period; and

(ii) A person becomes a dependent of the individual through marriage, birth or adoption or placement for adoption.

(b) The special enrollment period for individuals that meet the provisions of Subparagraph (a) shall be a period of not less than thirty (30) days and begins on the later of:

(i) The date dependent coverage is made available; or

(ii) The date of the marriage, birth or adoption or placement for adoption described in Subparagraph (a)(ii).

(c) If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under Subparagraph (b), the coverage of the dependent shall be effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent’s birth, as of the date of birth; and
In the case of a dependent’s adoption or placement for adoption, the date of the adoption or placement for adoption.

Except as provided in this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier.

A small employer carrier shall not require a minimum participation level greater than:

(i) One hundred percent (100%) of eligible employees working for groups of three (3) or less employees; and

(ii) Seventy-five percent (75%) of eligible employees working for groups with more than three (3) employees.

In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met.

A small employer carrier shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

A small employer carrier shall not place any restriction in regard to any health status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.

Except as permitted under Paragraphs (1) and (4) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

Subject to Paragraph (3), a small employer carrier shall not be required to offer coverage or accept applications pursuant to Subsection A in the case of the following:

(a) To a small employer, where the small employer is not physically located in the carrier’s established geographic service area;

(b) To an employee, when the employee does not live, work or reside within the carrier’s established geographic service area; or

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the
capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to Paragraph (1)(c) may not offer coverage in the applicable area to new cases of employer groups with more than [insert the size of employer to correspond with the definition of small employer in Section 3] eligible employees or to any small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

(3) A small employer carrier shall apply the provisions of this subsection uniformly to all small employers without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

E. (1) A small employer carrier shall not be required to provide coverage to small employers pursuant to Subsection A if:

(a) For any period of time the commissioner determines, the small employer carrier does not have the financial reserves necessary to underwrite additional coverage; and

(b) The small employer carrier is applying this subsection uniformly to all small employers in the small group market in this state consistent with applicable state law and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

(2) A small employer carrier that denies coverage in accordance with Paragraph (1) may not offer coverage in the small group market for the later of:

(a) A period of 180 days after the date the coverage is denied; or

(b) Until the small employer has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

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

F. (1) A small employer carrier shall not be required to provide coverage to small employers pursuant to Subsection A if the small employer carrier elects not to offer new coverage to small employers in this state.

(2) A small employer carrier that elects not to offer new coverage to small employers under this subsection may be allowed, as determined by the commissioner, to maintain its existing policies in this state.

(3) A small employer carrier that elects not to offer new coverage to small employers under Paragraph (1) shall provide notice of its election to the commissioner and shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.
Section 8. Certification of Creditable Coverage

A. Small employer carriers shall provide written certification of creditable coverage to individuals in accordance with Subsection B.

B. The certification of creditable coverage shall be provided:

(1) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(2) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Paragraph (1) or (2), whichever is later.

C. Small employer carriers may provide the certification of creditable coverage required under Subsection B(1) at a time consistent with notices required under any applicable COBRA continuation provision.

D. The certificate of creditable coverage required to be provided pursuant to Subsection A shall contain:

(1) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(2) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

E. To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under Subsection A if the carrier offering the coverage provides for certification in accordance with Subsection B.

F. (1) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to Section 7C(3) of this Act and the individual provides a certificate of coverage that was provided to the individual pursuant to Subsection B, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity’s health benefit plan.

(2) The entity providing the information pursuant to Paragraph (1) may charge the requesting group health plan the reasonable cost of disclosing the information.

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

Section 9. Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier

A. (1) Within thirty (30) days after the plan of operation is approved by the commissioner under Section 12 of this Act, each small employer carrier shall notify the commissioner of the carrier’s intention to operate as a risk-assuming carrier or a reinsuring carrier. A small
employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 10 of this Act.

(2) The decision shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The commissioner may permit a carrier to modify its decision at any time for good cause shown.

(3) The commissioner shall establish an application process for small employer carrier seeking to change their status under this subsection. In the case of a small employer carrier that has been acquired by another such carrier, the commissioner may waive or modify the time periods established in Paragraph (2).

B. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

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

Section 10. Application to Become a Risk-Assuming Carrier

A. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

B. The commissioner shall consider the following factors in evaluating an application filed under Subsection A:

(1) The carrier’s financial condition;

(2) The carrier’s history of rating and underwriting small employer groups;

(3) The carrier’s commitment to market fairly to all small employers in the state or its established geographic service area, as applicable; and

(4) The carrier’s experience with managing the risk of small employer groups.

C. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the commissioner, the carrier may request a hearing.

D. The commissioner may rescind the approval granted to a risk-assuming carrier under this section if the commissioner finds that:

(1) The carrier’s financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with Section 9 of this Act without the protection afforded by the program;

(2) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or

(3) The carrier has failed to provide coverage to eligible small employers as required in Section 7 of this Act.

E. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of Section 12 of this Act.
Drafting Note: States should consider establishing special rules for carriers whose charter and bylaws place limits on the types or kinds of individuals that can be insured by the carrier. Such carriers should be permitted to operate as risk-assuming carriers, provided that they accept all eligible small employers, regardless of the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents, that would be eligible for coverage pursuant to the charter and bylaws of the carrier.

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

Section 11. Prohibited Activities

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

Section 12. Small Employer Carrier Reinsurance Program

A. A reinsuring carrier shall be subject to the provisions of this section.

Drafting Note: Delete Subsection A if participation in the reinsurance program is mandatory.

B. There is hereby created a nonprofit entity to be known as the [insert name of state] Small Employer Health Reinsurance Program.

C. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of Paragraph (2), the board shall consist of [eight] members appointed by the commissioner plus the commissioner or his or her designated representative, who shall serve as an ex officio member of the board.

(2) (a) In selecting the members of the board, the commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the commissioner. At least five (5) members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the commissioner.

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

(b) In the event that the program becomes eligible for additional financing pursuant to Subsection L(4), the board shall be expanded to include two (2) additional members who shall be appointed by the commissioner. In selecting the additional members of the board, the commissioner shall choose individuals who represent [include reference to representatives of sources for additional financing identified in Subsection L(4)(d)(ii)]. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing under Subsection L(4).

(3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member’s term shall continue until his or her successor is appointed.
A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.

D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the commissioner containing the carrier’s net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

E. Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the commissioner.

F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

G. The plan of operation shall:

(1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;

(2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(3) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;

(5) Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers though capitation or salary; and

(6) Provide for any additional matters necessary for the implementation and administration of the program.

H. (1) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals.

(2) In addition to Paragraph (1), the program shall have the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;
(b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) Take any legal action necessary to avoid the payment of improper claims against the program;

(d) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act;

(e) Establish rules, conditions and procedures for reinsuring risks under the program;

(f) Establish actuarial functions as appropriate for the operation of the program;

(g) Assess reinsuring carriers in accordance with the provisions of Subsection L, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and

(i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

I. A reinsuring carrier may reinsure with the program as provided for in this subsection:

(1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group’s coverage under a health benefit plan.

(3) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.

(4) (a) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next $50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carriers’ liability under this subparagraph shall not exceed a maximum limit of $10,000 in any one calendar year with respect to any reinsured individual.

(b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the
standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the “Consumer Price Index for All Urban Consumers” of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(5) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(6) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in Paragraph (4), shall be reduced to reflect that portion of the risk above the amount set forth in Paragraph (4) that may not be ceded to the program, if any.]

Drafting Note: Federal law prohibits federally-qualified health maintenance organizations from reinsuring the first $5,000 of covered benefits. States that adopt an initial retention level of less than $5,000 under Paragraph (4) should include the above language.

(7) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

J. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in Paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan (adjusted to reflect retention levels required under this Act).

(2) Premiums for the program shall be as follows:

(a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this paragraph.

(b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph.

(3) The board periodically shall review the methodology established under Paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

(4) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.
K. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 5 of this Act.

L. (1) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(3) (a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers.

(b) The assessment formula shall be based on:

   (i) Each reinsuring carrier’s share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

   (ii) Each reinsuring carrier’s share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

(c) The formula established pursuant to Subparagraph (b) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150 percent of an amount which is based on the proportion of (i) the reinsuring carrier’s total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (ii) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(d) The board may, with approval of the commissioner, change the assessment formula established pursuant to Subparagraph (b) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year’s premium to vary during a transition period.

(e) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations, which are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(4) (a) Prior to March 1 of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in Subparagraph (c), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety (90) days following the end of the year.
calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety (90) days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.

(c) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) 
(i) If assessments in each of two (2) consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Item (ii).

(ii) The additional funding provided for in Item (i) shall be obtained from [the state should specify one or more sources of additional revenue to fund the program. States may wish to consider the alternative revenue sources provided in the NAIC Model Health Plan for Uninsurable Individuals Model Act]. The amount of additional financing to be provided to the program shall be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five percent (5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two (2) previous calendar years pursuant to this subparagraph, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose of the calculation in the previous sentence.

(iii) Additional financing received by the program pursuant to this subparagraph shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two (2) calendar years.

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

(5) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, “future losses” includes reserves for incurred but not reported claims.

(6) Each reinsuring carrier’s proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

(7) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(8) A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the
assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

M. Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

N. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

O. The program shall be exempt from any and all taxes.

Section 13. Health Benefit Plan Committee

A. The commissioner or governor] shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, small employers and employees, health care providers and producers.

Drafting Note: A state may wish to add a representative of third-party administrators to the committee membership.

B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Section 7 of this Act.

C. (1) The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan.

(2) The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(3) The plans recommended by the committee may include cost containment features such as:

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(b) Case management;

(c) Selective contracting with hospitals, physicians and other health care providers;

(d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(e) Other managed care provisions.
(4) The committee shall submit the health benefit plans described in Paragraph (3) to the commissioner for approval within 180 days after the appointment of the committee.

Section 14. Periodic Market Evaluation

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

Section 15. Waiver of Certain State Laws

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

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

Section 16. Administrative Procedures

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

Section 17. Standards to Assure Fair Marketing

A. Subject to Section 7A(1) of this Act, each small employer carrier shall actively market all health benefit plans sold by the carrier to eligible small employers in the state.

B. (1) Except as provided in Paragraph (2), no small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the any health status-related factor, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of the any health status-related factor, industry, occupation or geographic location of the small employer.

(2) The provisions of Paragraph (1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

C. (1) Except as provided in Paragraph (2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health
benefit plan to be varied because of any initial or renewal health status-related factor, industry, occupation or geographic location of the small employer.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of any health status-related factor, industry, occupation or geographic area of the small employer.

D. No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to any initial or renewal health status-related factor, occupation or geographic location of the small employers placed by the producer with the small employer carrier.

E. A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee or dependent from health coverage or benefits provided in connection with the employee’s employment.

F. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

G. The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

H. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Section 18. Separability

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

Section 19. Restoration of Terminated Coverage

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

Section 20. Risk Adjustment Mechanism

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

Drafting Note: Upon satisfactory development of a risk adjustment mechanism, states should consider phasing out the use of the reinsurance pool established in Section 12 of this Act.

June 20, 2003   167
Section 21. Effective Date

The Act shall be effective on [insert date].

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Legislative History (all references are to the Proceedings of the NAIC).

1994 Proc. 4th Quarter 17, 30, 763, 835-849 (amended and most of model reprinted).
2000 Proc. 3rd Quarter 13, 14, 163, 200, 235-257 (amended and reprinted).
Section 1. Short Title

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

Section 2. Purpose

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

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

Drafting Note: This revised model act provides guidance to states interested in reforming their health insurance laws, particularly as they affect small employers and individuals, in order to promote the availability of health insurance coverage to those employers and individuals. In adopting this model, states should be mindful of cost implications for initial and renewal premiums on both the individual and small group markets.
Section 3. Definitions

As used in this Act:

A. “Actuarial certification” means a written statement signed by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer or individual carrier is in compliance with the provisions of Section 5 of this Act, based upon the person’s examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer or individual carrier in establishing premium rates for applicable health benefit plans.

B. “Adjusted community rating” means a method used to develop a carrier’s premium which spreads financial risk in accordance with the requirements in Section 5 of this Act.

C. “Affiliate” or “affiliated” means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

D. “Affiliation period” means a period of time that must expire before health insurance coverage provided by a health maintenance organization becomes effective, and during which the health maintenance organization is not required to provide benefits.

E. “Basic health benefit plan” means a lower cost health benefit plan developed pursuant to Section 15.

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

F. “Board” means the board of directors of the program established pursuant to Section 12 of this Act.

G. “Church plan” has the meaning given this term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

H. “Commissioner” means the insurance commissioner of this state.

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

I. “Committee” means the health benefit plan committee created pursuant to Section 15 of this Act.

J. “Control” shall be defined in the same manner as in [insert reference to state law corresponding to the National Association of Insurance Commissioners (NAIC) Model Insurance Holding Company System Regulatory Act].

K. “Converted policy” means a basic or standard health benefit plan issued pursuant to Section 13 of this Act.

L. (1) “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:

   (a) A group health plan;
(b) A health benefit plan;
(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);
(e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents (Civilian Health and Medical Program of the Uniformed Services) (CHAMPUS). For purposes of Title 10, U.S.C. Chapter 55, “uniformed services” means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
(f) A medical care program of the Indian Health Service or of a tribal organization;
(g) A state health benefits risk pool;
(h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
(i) A public health plan, which for purposes of this act, means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan; or
(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

2 A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a ninety (90) day period during all of which the individual was not covered under any creditable coverage.

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

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

Drafting Note: States without a statutory definition of dependent may wish to use the definition below. If using the suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child below is not intended to be limited to natural children of the enrollee.

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

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

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

O. “Eligible person” means a person who is a resident of this state who is not eligible to be insured under an employer-sponsored group health benefit plan.

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

Q. “Established geographic service area” means a geographic area, as approved by the commissioner and based on the carrier’s certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

R. “Family composition” means:

1. Enrollee;
2. Enrollee, spouse and children;
3. Enrollee and spouse;
4. Enrollee and children; or
5. Child only.

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

S. “Federally defined eligible individual” means:

1. An individual:
   
   a. For whom, as of the date on which the individual seeks coverage under this Act, the aggregate of the periods of creditable coverage, as defined in Subsection L, is eighteen (18) or more months;
(b) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan;

(c) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a state plan under Title XIX (Medicaid) of the Act or any successor program, and who does not have other health insurance coverage;

(d) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; and

(e) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, both elected and exhausted such coverage; or

(2) A child who is covered under any creditable coverage within [thirty (30)] days of birth, adoption, or placement for adoption, provided that the child does not experience a significant break in coverage.

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

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

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

U. “Geographic area” is an area established by the commissioner used for adjusting the rates for a health benefit plan.

V. “Governmental plan” has the meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

W. (1) “Group health plan” means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in Subsection HH, and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(2) For purposes of this Act:

(a) Any plan, fund or program that would not be, but for PHSA Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b), as an employee welfare benefit plan that is a group health plan;
(b) In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner; and

(c) In the case of a group health plan, the term “participant” also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual’s beneficiary who is, or may become, eligible to receive a benefit under the plan, if:

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or

(ii) In connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the individual is the self-employed individual.

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

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

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

(2) “Health benefit plan” shall not include one or more, or any combination of, the following:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers’ compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
(3) “Health benefit plan” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) “Health benefit plan” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) “Health benefit plan” shall not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

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

(6) A carrier offering policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance shall comply with the following:

(a) The carrier files on or before March 1 of each year a certification with the commissioner that contains the statement and information described in Subparagraph (b);

(b) The certification required in Subparagraph (a) shall contain the following:

(i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance; and

(ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of...
premium rates in cases where premiums vary by age or other factors) charged for such policies and certificates in this state and

(c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the commissioner the information and statement required in Subparagraph (b) at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.

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

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

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

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

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

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; or

(8) Disability.

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

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

CC. “Individual health benefit plan” means:

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

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

DD. “Individual reinsuring carrier” means an individual carrier that is eligible to reinsure eligible persons in the reinsurance program pursuant to Section 12 of this Act.

EE. “Individual risk-assuming carrier” means an individual carrier whose application is approved by the commissioner pursuant to Section 11 of this Act.

FF. (1) “Late enrollee” means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days.

(2) “Late enrollee” shall not mean an eligible employee or dependent:

(a) Who meets each of the following:

(i) The individual was covered under creditable coverage at the time of the initial enrollment;

(ii) The individual lost coverage under creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of a spouse, divorce or legal separation; and

(iii) The individual requests enrollment within thirty (30) days after termination of the creditable coverage or the change in conditions that gave rise to the termination of coverage;

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

(c) If the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

(d) If a court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee’s health benefit plan and a request for enrollment is made within thirty (30) days after issuance of the court order;
(e) If the individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within thirty (30) days after the change in status;

(f) If the individual had coverage under a COBRA continuation provision and the coverage under that provision has been exhausted; or

(g) Who meets the requirements for special enrollment pursuant to Section 7E(7) and (8) of this Act.

GG. “Limited benefit health insurance” means that form of coverage that pays stated predetermined amounts for specific services or treatments or pays a stated predetermined amount per day or confinement for one or more named conditions, named diseases or accidental injury.

HH. “Medical care” means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and

(3) Insurance covering medical care referred to in Paragraphs (1) and (2).

II. “Network plan” means a health benefit plan issued by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

JJ. “Plan of operation” means the plan of operation of the program established pursuant to Section 12 of this Act.

KK. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

LL. “Plan sponsor” has the meaning given this term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

MM. (1) “Preexisting condition” means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months for small group coverage, or twelve (12) months for individual or professional association plan coverage, preceding the enrollment date of the coverage.

(2) “Preexisting condition” shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

(3) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

NN. “Premium” means all moneys paid by a small employer, eligible employees or eligible persons as a condition of receiving coverage from a carrier subject to this Act, including any fees or other contributions associated with the health benefit plan.
OO. "Producer" means [incorporate reference to definition in state’s law for licensing producers].

**Drafting Note:** States that have not adopted the NAIC Producer Licensing Model Act should substitute the term “agent” or “broker” for the term “producer” as appropriate.

PP. "Professional association” means an association that meets all of the following criteria:

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

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

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

(1) Conforms with the provisions of Section 5 of this Act concerning rates as they apply to individual carriers and individual health benefit plans. If the health benefit plan offered by the professional association covers at least 2,000 members of the professional association, then that association’s experience pool can be the basis for setting rates. If the professional association plan covers fewer than 2,000 members of the professional association, the carrier shall community rate the experience of that professional association with the experience of other professional associations covered by the carrier;

(2) Provides renewability of coverage for the members and dependents of members of the professional association which meets the criteria set forth in Section 6B of this Act as they apply to individual health benefit plans;

(3) Provides availability of coverage for the members and dependents of members of the professional association in conformance with the provisions of Section 7B(1), (2) and (3) of this Act as they apply to individual health benefit plans and individual carriers, except that the professional association shall not be required to offer basic and standard health benefit plan coverage;

(4) Is offered by a carrier that offers health benefit plan coverage to any professional association seeking health benefit plan coverage from the carrier; and

(5) Conforms with the preexisting condition provisions of Section 7F of this Act as they apply to individual health benefit plans.

RR. “Program” means the [State] Small Employer and Individual Reinsurance Program created by Section 12 of this Act.

SS. “Rating period” means the calendar period for which premium rates established by a carrier subject to this Act are assumed to be in effect.

TT. “Reinsuring carrier” means a small employer carrier participating in the reinsurance program pursuant to Section 12 of this Act.

UU. “Restricted network provision” means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.

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

VV. “Risk adjustment mechanism” means the mechanism established pursuant to Section 22 of this Act.

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

Drafting Note: Delete Subsections DD, EE, TT and WW if participation in the reinsurance program is mandatory.
XX. “Self-employed individual” means an individual or sole proprietor who derives a substantial portion of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

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

YY. “Significant break in coverage” means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

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

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

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

AAA. “Small employer carrier” means a carrier that issues or offers to issue health benefit plans covering eligible employees of one or more small employers pursuant to this Act, regardless of whether coverage is offered through an association or trust or whether the policy or contract is situated out of state.
Drafting Note: The term “multiple employer welfare arrangement” should be added to the list of carriers in those states that have separate certificates of authority for such arrangements. In states that do not have separate licenses for self-funded multiple employer welfare arrangements, such arrangements should be treated as unauthorized insurers. States should enforce their laws against transaction of unauthorized insurance against such unauthorized self-funded multiple employer welfare arrangements. This language does not contain any exemption for health benefit plans covering eligible employees of small employers when these plans are sold through the vehicle of associations and is intended to include such plans. States should examine the definitions in their statutes to determine whether more explicit language is necessary.

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

CCC. “Waiting period” means, with respect to a group health plan and an individual, who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to Subsection L(2), a waiting period shall not be considered a gap in coverage.

Section 4. Applicability and Scope

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

(1) A portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for a portion of the premium;

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code; or

(4) The health benefit plan is marketed to individual employees through an employer.

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

C. (1) Except as provided in Paragraph (2), for the purposes of this Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this Act shall apply as if all health benefit plans delivered or issued for delivery to small employers or eligible persons in this state by affiliated carriers were issued by one carrier.

(2) An affiliated carrier that is a health maintenance organization having a certificate of authority under Section [insert reference to state health maintenance organization licensing act] may be considered to be a separate carrier for the purposes of this Act.

(3) Unless otherwise authorized by the commissioner, a small employer or individual carrier shall not enter into one or more ceding arrangements with respect to health benefit plans...
delivered or issued for delivery to small employers or eligible persons in this state if the arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for those health benefit plans being retained by the ceding carrier. [The provisions of {insert applicable reference to state law on assumption reinsurance} shall apply if a small employer or individual carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers or eligible persons in this state.]

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

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

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

A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions:

1. The small employer carrier and individual carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:
   - Geographic area;
   - Family composition; and
   - Age.

2. With respect to small employer carriers, the adjustment for age in Paragraph (1)(c) above may not use age brackets smaller than five-year increments and these shall begin with age thirty (30) and end with age sixty-five (65).

3. With respect to individual carriers, the adjustment for age in Paragraph (1)(c) above may use one-year increment age brackets beginning at age nineteen (19).

4. Small employer and individual carriers may charge the lowest allowable adult rate for child only coverage.

5. Small employer carriers shall be permitted to develop separate rates for individuals age sixty-five (65) or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates shall be subject to the requirements of this Subsection A.

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

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

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

B. The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect:

(1) Changes to the enrollment of the small employer;

(2) Changes to the family composition of the employee or eligible person; or

(3) Changes to the health benefit plan requested by the small employer or eligible person.

C. Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer or individual carriers pursuant to Sections 9 or 12 of this Act.

D. Rating factors shall produce premiums for identical groups, and for identical eligible persons in the case of individual health benefit plans, that differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups or eligible persons assumed to select particular health benefit plans.

E. For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

F. The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer and individual carriers are consistent with the purposes of this Act, including regulations that:

(1) Assure that differences in rates charged for health benefit plans by small employer and individual carriers are reasonable and reflect objective differences in plan design or coverage (not including differences due to the nature of the groups or individuals assumed to select particular health benefit plans or separate claim experience for individual health benefit plans); and

(2) Prescribe the manner in which geographic territories are designated by all small employer and individual carriers.

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

G. In connection with the offering for sale of a health benefit plan to a small employer or eligible person, a small employer or individual carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:
(1) The provisions of the health benefit plan concerning the small employer or individual carrier’s right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(2) The provisions relating to renewability of policies and contracts;

(3) The provisions relating to any preexisting condition provision; and

(4) A listing of and descriptive information, including benefits and premiums, about all benefit plans for which the small employer or eligible person is qualified.

H. (1) Each small employer and individual carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer and individual carrier shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the small employer or individual carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer or individual carrier at its principal place of business.

(3) A small employer or individual carrier shall make the information and documentation described in Subsection F(1) available to the commissioner upon request. Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the Department except as agreed to by the small employer or individual carrier or as ordered by a court of competent jurisdiction.

I. The requirements of this section shall apply to:

(1) All small employer health benefit plans issued or renewed on or after the effective date of this Act; and

(2) All individual health benefit plans issued after the effective date of this Act.

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

Section 6. Renewability of Coverage

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

A. For small employer health benefit plans:

(1) A health benefit plan subject to this Act shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:
(a) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(b) The plan sponsor or, with respect to coverage of individual insureds under the health benefit plan, the insured or the insured’s representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) Noncompliance with the carrier’s minimum participation requirements;

(d) Noncompliance with the carrier’s employer contribution requirements;

(e) The small employer carrier elects to discontinue offering all of its health benefit plans delivered or issued for delivery to small employers in this state if the carrier:

   (i) Provides advance notice of its decision under this subparagraph to the commissioner in each state in which it is licensed; and

   (ii) Provides notice of the decision to:

      (I) All affected small employers and enrollees and their dependents; and

      (II) The commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provided the notice to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;

(f) The commissioner:

   (i) Finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier’s ability to meet its contractual obligations; and

   (ii) Assists affected small employers in finding replacement coverage;

(g) The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the small employer carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the state’s small employer market if the carrier:

   (i) Provides advance notice of its decision under this subparagraph to the commissioner in each state in which it is licensed;

   (ii) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:

      (I) All affected small employers and enrollees and their dependents; and
The commissioner in each state in which an affected insured individual is known to reside, provided the notice sent to the commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected small employers and enrollees and their dependents;

Offers to each small employer issued that particular type of health benefit plan (obsolete product form) the option to purchase all other health benefit plans currently being offered by the carrier to small employers in the state; and

In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to Item (iii), acts uniformly without regard to the claims experience of those small employers or any health status-related factor relating to any enrollee or dependent of the enrollee or enrollees and their dependents covered or new enrollees and their dependents who may become eligible for coverage;

In the case of health benefit plans that are made available in the small employer market only through one or more professional associations, the membership of an employer in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated under this subparagraph uniformly without regard to any health status-related factor relating to any covered individual; or

In the case of health benefit plans that are made available in the small group market through a network plan, there is no longer an employee of the small employer living, working or residing within the carrier’s established geographic service area and the carrier would deny enrollment in the plan pursuant to Section 7G(1)(b) of this Act.

A small employer carrier that elects not to renew health benefit plan coverage pursuant to Paragraph (1)(b) because of the small employer’s fraud or intentional misrepresentation of material fact under the terms of coverage may choose not to issue a health benefit plan to that small employer for one (1) year after the date of nonrenewal.

This paragraph shall not be construed to affect the requirements of Section 7 of this Act as to other small employer carriers to issue any health benefit plan to the small employer.

A small employer carrier that elects to discontinue offering health benefit plans under Paragraph (1)(e) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

In the case of a small employer carrier that ceases offering new coverage in this state pursuant to Paragraph (1)(e), the small employer carrier, as determined by the commissioner, may renew its existing business in the small employer market in the state or may be required to nonrenew all of its existing business in the small employer market in the state.

In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier’s operations in that service area.
B. For individual health benefit plans:

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

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

(a) The individual has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(b) The individual or the individual’s representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) The individual carrier elects to discontinue offering all of its health benefit plans delivered or issued for delivery to individuals in this state if the carrier:

   (i) Provides advance notice of its decision to the commissioner in each state in which it is licensed; and

   (ii) Provides notice of the decision to all affected individuals and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provided the notice to the commissioner is sent at least three (3) working days prior to the date the notice is sent to the affected individuals;

(d) The commissioner:

   (i) Finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders or would impair the carrier’s ability to meet its contractual obligations; and

   (ii) Assists affected individuals in finding replacement coverage;

(e) The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the individual carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the state’s individual insurance market if the carrier:

   (i) Provides advance notice of its decision under this subparagraph to the commissioner in each state in which it is licensed;

   (ii) Provides notice of the decision not to renew coverage to at least 180 days prior to the nonrenewal of any health benefit plans to:

      (I) All affected individuals; and
The commissioner in each state in which an affected insured individual is known to reside, provided the notice to the commissioner is sent at least three (3) working days prior to the date the notice is sent to the affected individuals;

Offers to each individual provided that particular type of health benefit plan (obsolete product form) the option to purchase all other health benefit plans currently being offered by the carrier to individuals in the state; and

In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to Item (iii), acts uniformly without regard to the claims experience of any affected individual or any health status-related factor relating to any covered individuals or beneficiaries who may become eligible for the coverage;

In the case of health benefit plans that are made available in the individual market only through one or more professional associations, the membership of an individual in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated under this subparagraph uniformly without regard to any health status-related factor relating to any covered individual; or

In the case of health benefit plans that are made available in the individual market through a network plan, the individual no longer resides, lives or works in the carrier’s established geographic service area, provided coverage is terminated under this subparagraph without regard to any health status-related factor relating to any covered individual.

An individual carrier that elects to discontinue offering health benefit plans under Paragraph (1)(c) shall be prohibited from writing new business in the individual market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in the state.

In the case of an individual carrier that ceases offering new coverage under Paragraph (1)(c), the individual carrier, as determined by the commissioner, may renew its existing business in the individual market in the state or may be required to nonrenew its business in the individual market in the state.

In the case of an individual carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier’s operations in that service area.

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

Drafting Note: Under HIPAA, “multiple employer welfare arrangements,” or MEWAs, are subject to the renewability requirements of the new Section 703 of the Employee Retirement Income Security Act of 1974 (ERISA). However, the new Section 731 of ERISA added by HIPAA specifies that this (new) part is not to be construed to affect or modify the provisions of ERISA Section 514 with respect to group health plans. It therefore appears that the states’ authority over MEWAs is preserved. The interaction with state renewability requirements merits further review.
Section 7. Availability of Coverage

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

A. For small employer health benefit plans:

(1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state including at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to a small employer not currently receiving a health benefit plan from that small employer carrier.

(2) Subject to Paragraph (1), a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act.

(3) A carrier shall not be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

B. For individual health benefit plans:

(1) Every individual carrier shall, as a condition of transacting business in this state with individuals, actively offer to individuals all health benefit plans it actively markets to individuals in this state including at least two (2) health benefit plans. One health benefit plan offered by each individual carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan. An individual carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to an individual not currently receiving a health benefit plan by that individual carrier.

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

Option 1.

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

Option 2.

(2) Subject to Paragraph (1), an individual carrier shall issue any individual health benefit plan to any eligible person that applies for the plan during the designated open enrollment period or in accordance with subparagraphs (b), (c) and (d) below and agrees to make the
required premium payments and to satisfy the other reasonable provisions of the health
benefit plan not inconsistent with this Act, except as provided in Paragraph (3).

(a) The open enrollment period shall be based on the month of the applicant’s birth
so that during the month of the applicant’s birth, the applicant can apply for and
be issued coverage from any individual carrier issuing individual health benefit
plans in this state.

(b) If an eligible person other than a federally defined eligible individual applying
for an individual health benefit plan had creditable coverage, an individual
carrier shall issue an individual health benefit plan to that eligible person if the
eligible person applies for coverage within thirty-one (31) days of termination of
the prior coverage.

(c) If a federally defined eligible individual applies for an individual health benefit
plan, an individual carrier shall issue an individual health benefit plan to that
federally defined eligible individual if he or she applies for coverage within
ninety (90) days of termination of the prior coverage.

(d) Whenever the commissioner finds that an individual carrier shall cease issuing
health benefit plans pursuant to Section 6A(1)(e) or B(1)(c) of this Act, which
may cause eligible persons to lose coverage issued pursuant to this Subsection
B, the commissioner may order an emergency open enrollment period.

(3) An individual carrier shall not be required to issue an individual health benefit plan to an
eligible person if:

(a) The individual is covered, or is eligible for coverage, through a benefit plan that
provides health care coverage which is provided by the individual’s employer. A
converted policy is not considered a benefit plan provided by an employer for
purposes of this paragraph;

(b) The individual is covered, or is eligible for coverage, through a benefit plan that
provides health care coverage in which the individual’s spouse, parent or
guardian is enrolled or eligible to be enrolled;

(c) The individual already has coverage under an individual health benefit plan or
converted policy; except that an individual may purchase a new individual
health benefit plan or converted policy and terminate coverage under the prior
health benefit plan on the renewal date of the prior health benefit plan or
converted policy;

(d) The individual is covered, or is eligible for coverage, under any other private or
public health benefits arrangements, including a Medicare supplement policy or
the Medicare program established under Title XVIII of the Social Security Act,
49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or any other act of Congress or
law of any state, except for a Medicare-eligible individual who is eligible for
Medicare for reasons other than age; or

(e) The individual is covered, or is eligible for any continued group coverage under
Section 4980B of the Internal Revenue Code of 1986, Sections 601 through 608
of the Employee Retirement Income Security Act of 1974, or pursuant to
Sections 2201 through 2208 of the Public Health Service Act, as amended, or
any state-required continued group coverage. For purposes of this subsection, an
individual who would have been eligible for continuation coverage, but is not
eligible solely because the individual or other responsible party failed to make
the required coverage election during the applicable time period, shall be deemed to be eligible for group coverage until the date on which the individual’s continuing group coverage would have expired had an election been made.

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

C. The provisions of Subsection B shall be effective 180 days after the commissioner’s approval of the basic health benefit plan and the standard health benefit plan developed pursuant to Section 15 of this Act.

D. (1) A small employer or individual carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer or individual carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.

(2) The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer or individual carrier, disapprove the continued use by a small employer or individual carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this Act.

E. Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than six (6) months following the enrollment date of the individual’s coverage due to a preexisting condition, or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more restrictively than as defined in Section 3MM of this Act.

(2) (a) Except as provided in Paragraph (3), a small employer carrier shall reduce the period of any preexisting condition exclusion without regard to the specific benefits covered during the period of creditable coverage by the aggregate of the period of creditable coverage, provided that the last period of creditable coverage ended on a date not more than ninety (90) days prior to the enrollment date of new coverage.

(b) The aggregate period of creditable coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier, or for the normal application and enrollment process following employment or other triggering event for eligibility.

(c) A carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period that:

(i) Does not exceed sixty (60) days for new entrants and does not exceed ninety (90) days for late enrollees;

(ii) During which the carrier charges no premiums and the coverage issued is not effective; and
(iii) Is applied uniformly, without regard to any health status-related factor.

(d) This paragraph does not preclude application of a waiting period applicable to all new enrollees under the health benefit plan.

(3) (a) Instead of as provided in Paragraph (2)(a), a small employer carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of benefits within each of several classes or categories of benefits specified by federal regulations.

(b) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described in Subparagraph (a) shall:

(i) Make the election on a uniform basis for all enrollees; and

(ii) Count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(c) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described under Subparagraph (a) shall:

(i) Prominently state that the election has been made in any disclosure statements concerning coverage under the health benefit plan to each enrollee at the time of enrollment under the plan and to each small employer at the time of the offer or sale of the coverage; and

(ii) Include in the disclosure statements the effect of the election.

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

(4) (a) A health benefit plan shall accept late enrollees, but may exclude coverage for late enrollees for preexisting conditions for a period not to exceed twelve (12) months.

(b) A small employer carrier shall reduce the period of any preexisting condition exclusion pursuant to Paragraph (2) or Paragraph (3).

(5) A small employer carrier shall not impose a preexisting condition exclusion:

(a) Relating to pregnancy as a preexisting condition; or

(b) With regard to a child who is covered under any creditable coverage within [thirty (30)] days of birth, adoption or placement for adoption, provided that the child does not experience a significant break in coverage, and provided that the child was adopted or placed for adoption before attaining eighteen (18) years of age.

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

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(6) A small employer carrier shall not impose a preexisting condition exclusion in the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis, care or treatment was a covered benefit under the plan, provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

(7) (a) A small employer carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group health plan of the small employer during a special enrollment period if:

(i) The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the employee or dependent;

(ii) The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time;

(iii) The employee’s or dependent’s coverage described under Item (i):

(I) Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or

(II) Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated; and

(iv) Under terms of the group health plan, the employee requests enrollment not later than thirty (30) days after the date of exhaustion of coverage described in Item (iii)(I) or termination of coverage or employer contribution described in Item (iii)(II).

(b) If an employee requests enrollment pursuant to Item (iv), the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

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

(8) (a) A small employer carrier that makes coverage available under a group health plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in Subparagraph (b) during which the
person or, if not otherwise enrolled, the individual may be enrolled under the group health plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage if:

(i) The individual is a participant under the health benefit plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan, but for a failure to enroll during a previous enrollment period; and

(ii) A person becomes a dependent of the individual through marriage, birth or adoption or placement for adoption.

(b) The special enrollment period for individuals that meet the provisions of Subparagraph (a) shall be a period of not less than thirty (30) days and begins on the later of:

(i) The date dependent coverage is made available; or

(ii) The date of the marriage, birth or adoption or placement for adoption described in Subparagraph (a)(ii).

(c) If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under Subparagraph (b), the coverage of the dependent shall be effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent’s birth, as of the date of birth; and

(iii) In the case of a dependent’s adoption or placement for adoption, the date of the adoption or placement for adoption.

(9) (a) Except as provided in this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier.

(b) A small employer carrier shall not require a minimum participation level greater than:

(i) One hundred percent (100%) of eligible employees working for groups of three (3) or less employees; and

(ii) Seventy-five percent (75%) of eligible employees working for groups with more than three (3) employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met.

(d) A small employer carrier shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer
contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(10) (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group.

(b) A small employer carrier shall not place any restriction in regard to any health status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.

(c) Except as permitted under Paragraphs (1) and (4) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

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

(1) A health carrier shall not impose on a federally defined eligible individual any exclusion because of a preexisting condition as defined in Section 3MM of this Act;

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

(3) An individual health benefit plan shall not deny, exclude or limit benefits for a covered eligible person for losses incurred more than twelve (12) months following the effective date of the eligible person’s coverage due to a preexisting condition. An individual health benefit plan shall not define a preexisting condition more restrictively than as defined in Section 3MM of this Act, and shall not impose on a federally defined eligible individual any exclusion because of a preexisting condition.

(4) (a) An individual carrier shall waive any carrier waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time an eligible person was covered by creditable coverage provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of new coverage. The period of continuous coverage shall not include any waiting period for the enrollment date of the new coverage applied by the carrier, or for the normal application and enrollment process.

(b) An individual carrier that does not use preexisting condition limits in any of its health benefit plans may impose or apply one or more of the following terms or conditions. However, if more than one term or condition is used, the combination of terms or conditions may not exceed the actuarial value of the twelve-month preexisting condition limit permitted by this section:
(i) A rating surcharge not to exceed fifty percent (50%) of the rate permitted under Section 5 for a period not to exceed twelve (12) months; or

(ii) An affiliation period that does not exceed ninety (90) days and during which no premiums are charged and the coverage issued is not effective and is applied uniformly without regard to any health status-related factors.

c) This paragraph does not preclude application of a waiting period applicable to any new enrollee under the health benefit plan, provided that any carrier-imposed waiting period shall be no longer than ninety (90) days and shall be used in lieu of a preexisting condition exclusion.

d) An affiliation period shall be waived for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of new coverage.

(5) Except as permitted under Paragraphs (3) and (4) of this subsection, an individual carrier shall not modify a health benefit plan with respect to an individual or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

G. (1) Subject to Paragraph (3), a small employer or individual carrier shall not be required to offer coverage or accept applications pursuant to Subsection A or B in the case of the following:

(a) To a small employer or eligible person, where the small employer or eligible person is not physically located in the carrier’s established geographic service area;

(b) To an employee of a small employer, when the employee does not live, work or reside within the carrier’s established geographic service area; or

(c) Within an area where the small employer or individual carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups or eligible persons because of its obligations to existing group or individual policyholders and enrollees.

(2) A small employer or individual carrier that cannot offer coverage pursuant to Paragraph (1)(c) may not offer coverage in the applicable area to new cases of employer groups with more than [insert the size of employer to correspond with the definition of small employer in Section 3], eligible employees, to any small employer groups or to eligible persons until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups or eligible persons.

(3) A small employer or individual carrier shall apply the provisions of this subsection uniformly to all small employers and eligible persons without regard to:

(a) The claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents; or
(b) Any health status-related factor relating to any eligible person and without regard to whether the person is a federally defined eligible individual.

H. (1) A small employer or individual carrier shall not be required to provide coverage to small employers and eligible persons pursuant to Subsections A and B if:

(a) For any period of time the commissioner determines, the small employer or individual carrier does not have the financial reserves necessary to underwrite additional coverage; and

(b) The small employer or individual carrier is applying this subsection uniformly to all small employers in the small group market and all eligible persons in the individual market in this state consistent with applicable state law and without regard to:

(i) The claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents; or

(ii) Any health status-related factor relating to any eligible person and without regard to whether the person is a federally defined eligible individual.

(2) A small employer or individual carrier that denies coverage in accordance with Paragraph (1) may not offer coverage in the small group market or individual market for the later of:

(a) A period of 180 days after the date the coverage is denied; or

(b) Until the small employer or individual carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

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

I. (1) A small employer or individual carrier shall not be required to provide coverage to small employers and eligible persons pursuant to Subsections A and B if the small employer or individual carrier elects not to offer new coverage to small employers and individuals in this state. However, a small employer or individual carrier that elects not to offer new coverage to small employers and individuals under this subsection may be allowed, as determined by the commissioner, to maintain its existing policies in the state.

(2) A small employer or individual carrier that elects not to offer new coverage to small employers and eligible persons under Paragraph (1) shall provide notice of its election to the commissioner and shall be prohibited from writing new business in the small employer or individual market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

J. A small employer carrier shall not be required to provide coverage to small employers pursuant to Subsection A if the carrier makes coverage available to small employers only through one or more professional associations.

K. This section shall not be construed to require that a health carrier offering health benefit plans only in connection with group health plans or through one or more professional associations, or both, offer health insurance coverage in the individual market.
Section 8. Certification of Creditable Coverage

A. Small employer and individual carriers shall provide written certification of creditable coverage to individuals in accordance with Subsection B.

B. The certification of creditable coverage shall be provided:

1. At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

2. In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

3. At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Paragraph (1) or (2), whichever is later.

C. Small employer and individual carriers may provide the certification of creditable coverage required under Subsection B(1) at a time consistent with notices required under any applicable COBRA continuation provision.

D. The certificate of creditable coverage required to be provided pursuant to Subsection A shall contain:

1. Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

2. The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

E. To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under Subsection A if the health carrier offering the coverage provides for certification in accordance with Subsection B.

F. (1) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to Section 7E(3) of this Act and the individual provides a certificate of coverage that was provided to the individual pursuant to Subsection B, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity’s health benefit plan.

(2) The entity providing the information pursuant to Paragraph (1) may charge the requesting group health plan the reasonable cost of disclosing the information.

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

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

Section 9. Individual Market Risk-Spreading Mechanisms

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

Option 1.

A. No later than 180 days after the effective date of this Act, a carrier shall, as a condition of issuing health benefit plans in this state, offer health benefit plans in the individual market. A carrier shall be deemed to have satisfied its obligation to provide individual health benefit plans by paying an assessment pursuant to Subsection C(2) of this section.

B. The commissioner shall have the authority to assess carriers their proportionate share of individual market losses and administrative expenses in accordance with the provisions of Subsection C of this section, and make advance interim assessments as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year.

C. The commissioner shall by regulation establish procedures for the equitable sharing of program losses among all carriers in accordance with their total market share as follows:

(1) By March 1, [insert here year after first year of implementation] and following the close of the calendar year thereafter, on a date established by the commissioner:

(a) A carrier issuing health benefit plans in this state shall file with the commissioner its net earned premium for the preceding calendar year ending December 31; and

(b) A carrier issuing individual health benefit plans in this state shall file with the commissioner the net earned premium on individual health benefit plans and the claims paid and the administrative expenses attributable to those plans. If the claims paid and reasonable administrative expenses for that calendar year exceed the net earned premium and any investment income thereon, the amount of the excess shall be the net paid loss for the carrier that shall be reimbursable under this Act. For purposes of this subsection, “reasonable administrative expenses shall be the actual expenses or a maximum of [insert 100 minus percentage required by state law providing for minimum loss ratios for individual health insurance policies] percent, whichever is less.

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

(2) A carrier shall be liable for an assessment to reimburse carriers issuing individual health benefit plans in this state that sustain net paid losses for the previous year, unless the carrier has received an exemption from the commissioner pursuant to Paragraph (5) of this subsection and has written a minimum number of nongroup persons as provided for in that subsection. The assessment of each carrier shall be in the proportion that the net

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earned premium of the carrier for the calendar year preceding the assessment bears to the net earned premium of all carriers for the calendar year preceding the assessment excluding premium for converted policies.

(3) A carrier that is financially impaired may seek from the commissioner a deferment in whole or in part from any assessment issued by the commissioner. The commissioner may defer, in whole or in part, the assessment of the carrier if, in the opinion of the commissioner, the payment of the assessment would endanger the ability of the carrier to fulfill its contractual obligations. If an assessment against a carrier is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving the deferment shall remain liable for the amount deferred.

(4) Payment of an assessment made under this section shall be a condition of issuing health benefits plans in this state for a carrier. Failure to pay the assessment shall be grounds for forfeiture of a carrier’s authorization to issue health benefit plans of any kind in this state, as well as any other penalties permitted by law.

(5) (a) Notwithstanding the provisions of this Act to the contrary, a carrier may apply to the commissioner, by a date established by the commissioner, for an exemption from the assessment and reimbursement for losses provided for in this section. A carrier that applies for an exemption shall agree to enroll or insure a minimum number of nongroup persons under a managed care or indemnity plan. For purposes of this subsection, nongroup persons include individually enrolled persons, conversion policies, Medicare cost and risk lives and Medicaid recipients, except that in determining whether the carrier meets the minimum number of nongroup persons required pursuant to this subsection, the number of Medicaid recipients and Medicare cost and risk lives shall not exceed fifty percent (50%) of the carrier’s minimum number of nongroup persons.

(b) Notwithstanding the provisions of Subparagraph (a) of this paragraph to the contrary, a health maintenance organization qualified pursuant to the “Health Maintenance Organization Act of 1973,” Pub. L. 93-222 (42 U.S.C. § 300e et seq.) and tax exempt pursuant to 26 U.S.C. § 501(c)(3), the federal Internal Revenue Code of 1986, may include up to one-third Medicaid recipients and up to one-third Medicare recipients in determining whether it meets the minimum number of nongroup persons.

(c) The minimum number of nongroup persons, as determined by the commissioner, shall equal the total number of individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid lives, of all carriers in this state subject to this Act as of the end of the calendar year, multiplied by the proportion that that carrier’s net earned premium bears to the net earned premium of all carriers for that calendar year, including those carriers that are exempt from the assessment.

(d) Within 180 days after the effective date of this Act and on or before March 1 of each year thereafter, a carrier seeking an exemption pursuant to this subsection shall file with the commissioner a statement of its net earned premium for the preceding calendar year. The commissioner shall determine each carrier’s minimum number of nongroup persons in accordance with this subsection.

(e) On or before March 1 of every year, a carrier that was granted an exemption for the preceding calendar year shall file with the commissioner the number of nongroup persons, by category, enrolled or insured as of December 31 of the preceding calendar year. To the extent that the carrier has failed to enroll the
minimum number of nongroup persons established by the commissioner, the
carrier shall be assessed by the commissioner on a pro rata basis for any
differential between the minimum number established by the commissioner and
the actual number enrolled or insured by the carrier.

(f) A carrier that applies for the exemption shall be deemed to be in compliance
with the requirements of this section if:

(i) By the end of calendar year [insert first year of operation], it has
enrolled or insured at least forty percent (40%) of the minimum number
of nongroup persons required;

(ii) By the end of calendar year [insert year after year in Item (i) above], it
has enrolled or insured at least seventy-five percent (75%) of the
minimum number of nongroup persons required; and

(iii) By the end of calendar year [insert two years after year in Item (i)
above], it has enrolled or insured at least 100 percent of the minimum
number of nongroup persons required.

(g) A carrier that writes both managed care and indemnity business that is granted
an exemption pursuant to this subsection may satisfy its obligation to write a
minimum number of nongroup persons by writing either managed care or
indemnity business, or both.

(6) Notwithstanding the provisions of Section 7B(1) of this Act concerning the issuance of
individual health benefit plans, an individual carrier may, in any calendar year, with the
approval of the commissioner, suspend its duty to issue individual health benefit plans to
any eligible person who applies for individual coverage if:

(a) The eligible person has one or more of the high risk conditions associated with
high claims costs which appear on a list developed by the commissioner with
input from individual carriers, providers, and other interested parties, and
updated annually;

(b) At the time application is made by an individual carrier, the number of eligible
persons with one or more high risk conditions covered by the carrier when
divided by the total number of eligible persons covered by contracts, policies,
and plans of the health carrier in force covering eligible persons in this state is
equal to or exceeds five percent (5%) of the total number of the carrier’s
individuals covered by individual health benefit plans;

(c) The individual carrier applies to the commissioner, in a form and manner
determined by the commissioner, for an immediate suspension for a specified
time period of the requirement to issue an individual health benefit plan to any
eligible person who applies for coverage and has one or more high risk
conditions; and

(d) The individual carrier provides the commissioner with certified copies of the
information deemed necessary by the commissioner to make a determination
whether or not the health carrier has or is about to reach the five percent (5%)
cap described in Subparagraph (b) above.

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

**D. (1)** Rates shall be formulated on contracts or policies required pursuant to subsection A of this Section so that the anticipated minimum loss ratio for a contract or policy form shall not be less than [insert percentage required by state law providing for minimum loss ratios for individual health insurance policies] of the premium. The individual carrier shall submit with its rate filing supporting data, as determined by the commissioner, and certification by a member of the American Academy of Actuaries, or other individual acceptable to the commissioner, that the carrier is in compliance with the provisions of this subsection.

(2) Following the close of the third full calendar year an individual carrier has issued individual health benefit plans, and each calendar year thereafter, if the commissioner determines that a carrier’s loss ratio was less than [insert percentage required by state law providing for minimum loss ratios for individual health insurance policies] for that calendar year, the carrier shall be required to refund to policy or contract holders the difference between the amount of net earned premium it received that year and the amount that would have been necessary to achieve the [insert percentage required by state law providing for minimum loss ratios for individual health insurance policies] loss ratio. The loss ratio calculation made following the close of the third full calendar year a carrier has issued individual health benefit plans shall include all individual business written since [insert effective date of this Act] until the close of the third full calendar year.

(3) The commissioner by regulation shall prescribe the methodology to be used in determining the loss ratio.

Option 2.

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

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

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

**A. (1)** Within thirty (30) days after the plan of operation is approved by the commissioner under Section 12 of this Act, each small employer carrier shall notify the commissioner of the carrier’s intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 11 of this Act.

[(2) Within thirty (30) days after the plan of operation is approved by the commissioner under Section 12 of this Act, each individual carrier shall notify the commissioner of the carrier’s intent to operate as an individual risk-assuming carrier or an individual reinsuring carrier. An individual carrier seeking to operate as an individual risk-assuming carrier shall make application pursuant to Section 11 of this Act.]

**B.** The decisions in Subsection A shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The commissioner may permit a carrier to modify its decision at any time for good cause shown.

**C.** The commissioner shall establish an application process for small employer [or individual] carriers seeking to change their status under this subsection. In the case of a small employer [or individual]
carrier that has been acquired by another such carrier, the commissioner may waive or modify the
time periods established in this subsection.

D. (1) A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier
shall not be permitted to continue to reinsure any small employer health benefit plan with
the program. Such a carrier shall pay a prorated assessment based upon business issued as
a reinsuring carrier for any portion of the year that the business was reinsured.

(2) An individual reinsuring carrier that applies and is approved to operate as an individual
risk assuming carrier shall not be permitted to continue to reinsure any individual health
benefit plan with the program. Such a carrier shall pay a prorated assessment based upon
business issued as an individual reinsuring carrier for any portion of the year that the
business was reinsured.

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

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

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

A. (1) A small employer carrier may apply to become a risk-assuming carrier by filing an
application in a form and manner prescribed by the commissioner.

[(2) An individual carrier may apply to become an individual risk-assuming carrier by filing
an application in a form and manner prescribed by the commissioner.]

B. The commissioner shall consider the following factors in evaluating applications filed under
Subsection A:

(1) The carrier’s financial condition;

(2) The carrier’s history of rating and underwriting small employer groups [or individuals];

(3) The carrier’s commitment to market fairly to all small employers [or individuals] in the
state or its established geographic service area, as applicable;

(4) The carrier’s experience with managing the risk of small employer groups [or
individuals]; and

(5) The carrier’s business plan to comply with Sections 5 and 7 of this Act and Subsection E
of this section.

C. The commissioner shall provide public notice of an application by a small employer carrier to be a
risk-assuming carrier [or an individual carrier to become an individual risk assuming carrier] and
shall provide at least a sixty-day period for public comment prior to making a decision on the
application. If the application is not acted upon within ninety (90) days of the receipt of the
application by the commissioner, the carrier may request a hearing.

D. (1) The commissioner may rescind the approval granted to a risk-assuming carrier [or
individual risk assuming carrier] under this section if the commissioner finds that:

(a) The carrier’s financial condition will no longer support the assumption of risk
from issuing coverage to small employers [or eligible persons] in compliance
with Section 7 of this Act without the protection afforded by the program;
(b) The carrier has failed to market fairly to all small employers [or eligible persons] in the state or its established geographic service area, as applicable;

(c) The carrier has failed to provide coverage to eligible small employers [or eligible persons] as required in Section 7 of this Act; or

(d) The carrier fails to conform to the business plan submitted under Subsection B(5) above.

(2) The commissioner may request, on an annual basis, whatever information he or she deems necessary to determine whether a finding is warranted pursuant to Paragraph (1).

E. (1) A small employer [or individual] carrier electing to be a risk-assuming carrier [or an individual carrier electing to be an individual risk assuming carrier] shall not be subject to the provisions of Section 12 of this Act [, except that those carriers shall be subject to Section 12N of this Act.]

[(2) Risk assuming carriers and individual risk assuming carriers shall be subject to all the provisions of this Act applicable to either a small employer carrier or an individual carrier, including but not limited to:

(a) The requirements of Section 7A and B of this Act concerning availability of coverage;

(b) The requirements of Section 5 of this Act concerning premium rates, except that an individual risk assuming carrier shall comply with Section 5 of this Act by establishing rates for all the small employer and individual health benefit plans it issues that are uniform, subject only to the consistent application of factors for varying rates permitted under Section 5 of this Act.]

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

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

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

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

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

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

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

B. There is hereby created a nonprofit entity to be known as the [insert name of state] Small Employer [and Individual] Health Reinsurance Program.
C. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of Paragraph (2), the board shall consist of [eight] members appointed by the commissioner plus the commissioner or his or her designated representative, who shall serve as an ex officio member of the board.

(2) (a) In selecting the members of the board, the commissioner shall include representatives of small employers and small employer carriers, [eligible persons and individual carriers] and such other individuals determined to be qualified by the commissioner. At least five (5) members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the commissioner.

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

(b) In the event that the program becomes eligible for additional financing pursuant to Subsection P(3) [or N(1)], the board shall be expanded to include two (2) additional members who shall be appointed by the commissioner. In selecting the additional members of the board, the commissioner shall choose individuals who represent [include reference to representatives of sources for additional financing identified in Subsection P(3)(b)]. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing under Subsection P(3) [or N(1)].

(3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member’s term shall continue until his or her successor is appointed.

(4) A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.

D. Within sixty (60) days of the effective date of this Act, each small employer [and individual] carrier shall make a filing with the commissioner containing the carrier’s net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers [or eligible persons] in this state in the previous calendar year.

E. Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the commissioner.

F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

G. The plan of operation shall:

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Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;

Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

Establish procedures for reinsuring risks in accordance with the provisions of this section;

Establish procedures for collecting assessments to fund claims and administrative expenses incurred or estimated to be incurred by the program;

Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers though capitation or salary; and

Provide for any additional matters necessary for the implementation and administration of the program.

H. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals.

In addition to Paragraph (1), the program shall have the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) Take any legal action necessary to avoid the payment of improper claims against the program;

(d) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act;

(e) Establish rules, conditions and procedures for reinsuring risks under the program;

(f) Establish actuarial functions as appropriate for the operation of the program;

(g) Make assessments in accordance with the provisions of Subsection[s] P [and N], and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and
(i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

I. A reinsuring carrier [or individual reinsuring carrier] may reinsure with the program as provided for in this subsection:

(1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group’s coverage under a health benefit plan.

(3) (a) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.

(b) An individual reinsuring carrier may reinsure an eligible person within sixty (60) days following the effective date of coverage.

(4) (a) The program shall not reimburse a reinsuring carrier [or an individual reinsuring carrier] with respect to the claims of a reinsured employee or dependent [or eligible person] until the carrier has incurred an initial level of claims for such employee or dependent [or eligible person] of $5,000 in a calendar year for benefits covered by the program. In addition, the carrier shall be responsible for ten percent (10%) of the next $50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A carrier’s liability under this subparagraph shall not exceed a maximum limit of $10,000 in any one calendar year with respect to any reinsured individual.

(b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the “Consumer Price Index for All Urban Consumers” of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(5) A small employer [or individual] carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer[, or an eligible person,] on an anniversary of the health benefit plan.

(6) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in Paragraph (4), shall be reduced to reflect that portion of the risk above the amount set forth in Paragraph (4) that may not be ceded to the program, if any.

Drafting Note: Federal law prohibits federally-qualified health maintenance organizations from reinsuring the first $5,000 of covered benefits. States that adopt an initial retention level of less than $5,000 under Paragraph (4) should include the above language.
(7) A reinsuring carrier [or individual reinsuring carrier] shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

J. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers [and eligible persons] pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in Paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers [or eligible persons] by small employer carriers [and individual carriers] for health benefit plans with benefits similar to the standard health benefit plan (adjusted to reflect retention levels required under this Act).

(2) Premiums for the program shall be as follows:

(a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this paragraph.

(b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph.

(c) An eligible person covered by an individual health benefit plan may be reinsured for a rate that is 1.5 times the base reinsurance premium rate for the individual established pursuant to this paragraph.

(3) The board periodically shall review the methodology established under Paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

(4) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

K. If a health benefit plan for a small employer [or eligible person] is entirely or partially reinsured with the program, the premium charged to the small employer [or eligible person] for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 5 of this Act.

L. Prior to March 1 of each year, the board shall determine [, separately account for,] and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses [for:

(1) Reinsured small employer groups, eligible employees and their dependents, and

(2) Reinsured eligible persons].
M.  (1) Any net loss [from reinsuring small employer groups, eligible employees or their dependents] for the year shall be recouped by assessments of reinsuring carriers.

(2) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers.

(3) The assessment formula shall be based on:

(a) Each reinsuring carrier’s share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(b) Each reinsuring carrier’s share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

(4) The formula established pursuant to Paragraph (3)(a) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150 percent of an amount which is based on the proportion of (i) the reinsuring carrier’s total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (ii) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(5) The board may, with approval of the commissioner, change the assessment formula established pursuant to Paragraph (3)(a) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year’s premium to vary during a transition period.

(6) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

Option 1.

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

N.  (1) Any net loss from reinsuring eligible persons for the year shall be recouped by assessments on all carriers offering a health benefit plan or providing stop loss coverage for an employer-sponsored or Taft-Hartley health plan, except that individual risk assuming carriers shall be exempt from the assessment.

(2) The board shall establish as part of the plan of operation a formula by which to make assessments against the carriers described in Paragraph (1). The assessment formula shall be based on each carrier’s share of the total premiums earned in the preceding calendar year in this state from health benefit plans and stop loss policies described in Paragraph (1) excluding premium for converted policies.

(3) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other carriers.
Option 2.

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

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

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

(2) The following recipients of health care services are exempt from the assessment set forth in Paragraph (1):

(a) Medicare beneficiaries;

(b) Medicaid beneficiaries; and

(c) The uninsured.

O. Prior to March 1 of each year, the board shall determine[, separately account for] and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year[, for;

(1) Reinsured small employer groups, eligible employees and their dependents, and

(2) Reinsured eligible persons].

P. (1) If the board determines that the assessments of reinsuring carriers needed to fund the losses from reinsuring small employer groups incurred by the program in the previous calendar year will exceed the amount specified in Paragraph (2) the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety (90) days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.

(2) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers [or individuals] in this state by reinsuring carriers.

(3) (a) If assessments in each of two (2) consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Subparagraph (b).

(b) The additional funding provided for in Subparagraph (a) shall be obtained from [the state should specify one or more sources of additional revenue to fund the
States may wish to consider the alternative revenue sources provided in the NAIC Model Health Plan for Uninsurable Individuals Model Act. The amount of additional financing to be provided to the program shall be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five percent (5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two (2) previous calendar years pursuant to this subparagraph, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose of the calculation in the previous sentence.

(c) Additional financing received by the program pursuant to this subparagraph shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two (2) calendar years.

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

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

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

R. Each carrier’s proportion of an assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

S. The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

T. A carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a carrier if the commissioner determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

U. Neither the participation in the program as reinsuring carriers [or individual reinsuring carriers], the establishment of rates, forms or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

V. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer [or individuals,] the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

June 20, 2003
W. The program shall be exempt from any and all taxes.

Section 13. Special Rules Relating to Converted Policies

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

A. Effective 180 days after approval of the basic and standard health plans pursuant to Section 15 of this Act, all carriers required to offer to an individual a converted policy pursuant to [insert appropriate reference to the Group Health Insurance Mandatory Conversion Privilege Model Act] shall offer as a converted policy a choice of the basic and standard health benefit plans only.

B. Persons with a converted policy issued prior to the effective date of the requirement contained in Subsection A above shall have the right at each annual renewal of the converted policy to elect a basic or a standard health benefit plan as a substitute converted policy except that at the carrier’s option if the person has not made an election within three (3) years after the effective date of this Act, the carrier may require the person to make an election. Once a person has elected either the basic or the standard health benefit plan as a substitute converted policy, that person may not elect another converted policy.

C. For rating purposes only, basic and standard health benefit converted policies shall be rated pursuant to Section 5 of this Act as if they were small employer policies. Carriers that do not write in the small employer market shall set the premiums for their basic and standard health benefit plan converted policies at the average rates charged by the five largest small employer carriers (as measured by their premium volume) for their basic and standard health benefit plans. These averages shall be calculated each year by the commissioner.

D. New and renewal rates for persons with the same converted policies who have the same case characteristics shall be the same.

E. Carrier losses on their basic and standard health benefit plan converted policies shall be spread across the carrier’s entire book of small employer and large group health benefit plan business in the state.

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

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

Section 14. Prohibited Activities

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

Section 15. Health Benefit Plan Committee

A. The [commissioner or governor] shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, small employers and employees, eligible persons, health care providers and producers.

Drafting Note: A state may wish to add a representative of third-party administrators to the committee membership.

B. The committee shall recommend the form and level of coverages to be made available by small employer and individual carriers pursuant to Section 7 of this Act.
C. (1) The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan.

(2) The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(3) The plans recommended by the committee may include cost containment features such as:

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(b) Case management;

(c) Selective contracting with hospitals, physicians and other health care providers;

(d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(e) Other managed care provisions.

(4) The committee shall submit the health benefit plans described in Paragraph (3) to the commissioner for approval within 180 days after the appointment of the committee.

Section 16. Periodic Market Evaluation

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

Section 17. Waiver of Certain State Laws

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

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

Section 18. Administrative Procedures

The commissioner shall issue regulations in accordance with [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state’s administrative procedures act, if applicable] for the implementation and administration of the Small Employer and Individual Health Coverage Reform Act.
Section 19. Standards to Assure Fair Marketing

A. Subject to Section 7A(1) and 7B(1) of this Act, each small employer and individual carrier shall actively market all health benefit plans sold by the carrier to eligible small employers and individuals in the state.

B. (1) Except as provided in Paragraph (2), no small employer or individual carrier or producer shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers or individuals to refrain from filing an application for coverage with the small employer or individual carrier because of any health status-related factor, industry, occupation or geographic location of the small employer or individual;

(b) Encouraging or directing small employers or individuals to seek coverage from another carrier because of any health status-related factor, industry, occupation or geographic location of the small employer or individual.

(2) The provisions of Paragraph (1) shall not apply with respect to information provided by a small employer or individual carrier or producer to a small employer or individual regarding the established geographic service area or a restricted network provision of a small employer or individual carrier.

C. (1) Except as provided in Paragraph (2), no small employer or individual carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of any initial or renewal health status-related factor, industry, occupation or geographic location of the small employer or individual.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of any health status-related factor, industry, occupation or geographic area of the small employer or individual.

D. No small employer or individual carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the initial or renewal health status-related factor, occupation or geographic location of the small employers or individuals placed by the producer with the small employer or individual carrier.

E. A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee or dependent from health coverage or benefits provided in connection with the employee’s employment.

F. Denial by a small employer or individual carrier of an application for coverage from a small employer or individual shall be in writing and shall state the reason or reasons for the denial.

G. The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers and individuals in this state.

H. (1) A violation of this section by a small employer or individual carrier or a producer shall be an unfair trade practice under [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

(2) If a small employer or individual carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or
other services related to the offering of health benefit plans to small employers or individuals in this state, the third-party administrator shall be subject to this section as if it were a small employer or individual carrier.

Section 20. Separability

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

Section 21. Restoration of Terminated Coverage

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

Section 22. Risk Adjustment Mechanism

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

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

Section 23. Effective Date

The Act shall be effective on [insert date].
APPENDIX A

MODEL DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

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

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

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

NOTE: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.
CERTIFICATE OF
INDIVIDUAL HEALTH INSURANCE COVERAGE

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

1. Date of this certificate: _____________________________________________________
2. Name of policyholder: _____________________________________________________
3. Identification number of policyholder: ________________________________________
4. Name of any dependents to which this certificate applies: _________________________
   __________________________________________________________________________
5. Name, address, and telephone number of issuer responsible for providing this certificate:
   __________________________________________________________________________
6. For further information, call: ________________________________________________
7. If all individuals identified in lines 2 and 4 have at least 18 months of creditable coverage (disregarding periods of coverage before a 90-day break), check here _________ and skip lines 8 and 9.
8. Date coverage began: ______________________________________________________
9. Date that a substantially completed application was received from this policyholder: _________________________________________________________________
10. Date coverage ended: ___________________ (or check here if coverage is continuing as of the date of this certificate: _________).

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

Model for Categories of Benefits (Alternative Method)

INFORMATION ON CATEGORIES OF BENEFITS

1. Date of original certificate:

2. Name of group health plan providing the coverage:

3. Name of participant:

4. Identification number of participant:

5. Name of individuals to whom this information applies:

6. The following information applies to the coverage in the certificate that was provided to the individuals identified above:

   a. MENTAL HEALTH:

   b. SUBSTANCE ABUSE TREATMENT:

   c. PRESCRIPTION DRUGS:

   d. DENTAL CARE:

   e. VISION CARE:

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

Legislative History (all references are to the Proceedings of the NAIC).

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


2000 Proc. 3rd Quarter 13, 14, 163, 200, 276-310 (amended and reprinted).
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Section 1. Short Title
This Act shall be known and may be cited as the Individual Health Insurance Portability Act.

Section 2. Purpose
The purpose and intent of this Act are to promote the availability of health insurance coverage to recently insured individuals regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to limit the use of preexisting condition exclusions, to provide for development of individual basic and standard health benefit plans, to assure fair access to health plans, and to improve the overall fairness and efficiency of the individual health insurance market.

Drafting Note: This model act assumes that a state has enacted the NAIC Model Health Plan for Uninsurable Individuals Act. States implementing this model without the NAIC Model Health Plan for Uninsurable Individuals Act should be aware that this model addresses portability, renewability, and some rating problems in the individual health insurance market. This model does not address the availability problems of those persons who are uninsurable and do not have a qualifying event or qualifying previous coverage or prior creditable coverage.

Section 3. Definitions
As used in this Act:

A. “Actuarial certification” means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that an individual carrier is in compliance with the provisions of Section 5 of this Act, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable individual health benefit plans.

B. “Affiliate” or “affiliated” means an entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.
C. “Affiliation period” means a period of time that must expire before health insurance coverage becomes effective, and during which the carrier is not required to provide benefits.

D. “Age bracket” means ages of an individual in increments of no less than one year beginning at age nineteen (19). All individuals under age nineteen (19) shall constitute a single age bracket.

E. “Assessable loss” means the amount calculated pursuant to Section 12K of this Act.

F. “Association” means the nonprofit corporation established pursuant to Section 12 of this Act.

G. “Block of business” means a separate grouping of enrollees and dependents as allowed by regulation.

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

Drafting Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) uses the term “health insurance issuer” instead of “carrier” or “health carrier.” The definition of “health insurance issuer” contained in HIPAA is consistent with the term “carrier” or “health carrier,” as defined in Section 3H of this Act.

I. “Church plan” has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

J. “Commissioner” means the insurance commissioner of this state.

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

K. “Converted policy” means a basic or standard health benefit plan issued pursuant to [insert reference to state law comparable to the Group Health Insurance Mandatory Conversion Privilege Model Act].

L. (1) “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:

   (a) A group health benefit plan;

   (b) A health benefit plan;

   (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

   (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);

   (e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents (Civilian Health and Medical Program of the Uniformed Services) (CHAMPUS). For purposes of Chapter 55 of Title 10, United States Code, “uniformed services” means the armed forces and the Commissioned Corps of
the National Oceanic and Atmospheric Administration and of the Public Health Service);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under Chapter 89 of Title 5, U. S. Code (Federal Employees Health Benefits Program (FEHBP));

(i) A public health plan, which for purposes of this act, means a plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan; or

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Act, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

Drafting Note: It may be desirable to grant the commissioner rulemaking authority to further define that coverage which falls within the definition above. However, the commissioner’s authority is limited by HIPAA with respect to creditable coverage. The commissioner cannot define this term in a manner that would prevent the application of the federal law.

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

Drafting Note: States without a statutory definition of dependent may wish to use the definition below. If using the suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child below is not intended to be limited to natural children of the enrollee.

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

N. “Eligible person” means a person who is a resident of this state who is not eligible to be insured under an employer-sponsored group health benefit plan.

O. “Enrollee” means a person who:

(1) Is covered by an individual health benefit plan; and

(2) Has paid premium for himself or herself and his or her dependents, if any, who are also covered under the individual health benefit plan, and is responsible for continued premium payments under the terms of the individual health benefit plan.

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

Q. “Established geographic service area” means a geographic area, as approved by the commissioner and based on the carriers certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.
R. "Family composition" means:

(1) Enrollee;
(2) Enrollee, spouse and children;
(3) Enrollee and spouse;
(4) Enrollee and children; or
(5) Child only.

S. "Federally defined eligible individual" means:

(1) An individual:

(a) For whom, as of the date on which the individual seeks coverage under this Act, the aggregate of the periods of creditable coverage, as defined in Subsection L, is eighteen (18) or more months;

(b) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan;

(c) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or a state plan under Title XIX of the Act, or any successor program, and who does not have other health insurance coverage;

(d) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud; and

(e) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, both elected and exhausted such coverage; or

(2) A child who is covered under any creditable coverage within [thirty (30)] days of birth, adoption, or placement for adoption, provided that the child does not experience a significant break in coverage.

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

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

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

U. "Geographic area" is an area established by the commissioner used for adjusting the rates for a health benefit plan.
V. “Governmental plan” has the meaning given the term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

W. (1) “Group health benefit plan” means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in Subsection DD and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

(2) For purposes of this Act:

(a) Any plan, fund or program that would not be, but for PHSA Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b), as an employee welfare benefit plan that is a group health benefit plan;

(b) In the case of a group health benefit plan, the term “employer” also includes the partnership in relation to any partner; and

(c) In the case of a group health benefit plan, the term “participant” also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual’s beneficiary who is, or may become, eligible to receive a benefit under the plan, if:

(i) In connection with a group health benefit plan maintained by a partnership, the individual is a partner in relation to the partnership; or

(ii) In connection with a group health benefit plan maintained by a self-employed individual, under which one or more employees are participants, the individual is the self-employed individual.

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

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

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

(2) “Health benefit plan” shall not include one or more, or any combination of, the following:
(a) Coverage only for accident, or disability income insurance, or any combination thereof;
(b) Coverage issued as a supplement to liability insurance;
(c) Liability insurance, including general liability insurance and automobile liability insurance;
(d) Workers’ compensation or similar insurance;
(e) Automobile medical payment insurance;
(f) Credit-only insurance;
(g) Coverage for on-site medical clinics; and
(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) “Health benefit plan” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;
(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
(c) Such other similar, limited benefits as are specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) “Health benefit plan” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or
(b) Hospital indemnity or other fixed indemnity insurance.

(5) “Health benefit plan” shall not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
(b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
(c) Similar supplemental coverage provided to coverage under a group health plan.
Drafting Note: States should examine the exemptions already provided in this definition before adopting any additional exemptions.

(6) A carrier offering policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance shall comply with the following:

(a) The carrier files on or before March 1 of each year a certification with the commissioner that contains the statement and information described in Subparagraph (b);

(b) The certification shall contain the following:

(i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance; and

(ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age or other factors) charged for these policies and certificates in this state; and

(c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the commissioner the information and statement required in Subparagraph (b) at least thirty (30) days prior to the date the policy or certificate is issued or delivered in this state.

Drafting Note: It may be desirable to provide the commissioner with discretion to implement regulations to delineate the suitability of these products in the health insurance market reformed pursuant to this Act. For example, the commissioner might conclude that the sale of certain specified disease or other policies is inappropriate in the context of a reformed health insurance market. Furthermore, states may wish to consider whether the information filed pursuant to the requirement in paragraph (6) is necessary for effective regulation of those products in light of the market conduct of limited benefit carriers in their states.

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

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

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; or
(8) Disability.

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

AA. “Individual basic or standard health benefit plan” means the core group of health benefits developed pursuant to Section 9 of this Act.

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

CC. (1) “Individual health benefit plan” means:

(a) A health benefit plan other than a converted policy or a professional association plan for individuals and their dependents; and

(b) A certificate issued to an enrollee that evidences coverage under a policy or contract issued to a trust or association or other similar grouping of individuals, regardless of the situs of delivery of the policy or contract, if the enrollee pays the premium and is not being covered under the policy or contract pursuant to continuation of benefits provisions applicable under federal or state law.

(2) “Individual health benefit plan” shall not include a certificate issued to an enrollee that evidences coverage under a professional association plan.

**Drafting Note:** In reforming the individual health insurance market, it is important that state insurance departments have jurisdiction over policies sold to individuals through trusts or associations situated outside the state. Paragraph (1)(b) clarifies that if the certificate holder lives within the state and pays the premium for the policy, that policy is an individual health benefit plan subject to this Act, even if the policy was marketed or purchased through an out-of-state trust or association. Also, under Section 4D, the commissioner has specific injunctive authority to enforce the provisions of this Act.

DD. “Medical care” means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and

(3) Insurance covering medical care referred to in Paragraphs (1) and (2).

EE. “Network plan” means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

FF. (1) “Preexisting condition” means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months preceding the enrollment date of the coverage.

(2) “Preexisting condition” shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and that was a covered benefit under the plan, provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.
(3) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information.

GG. “Premium” means all moneys paid by employers, employees or enrollees as a condition of receiving coverage from a carrier, including any fees or other contributions, associated with a health benefit plan.

HH. “Producer” means [incorporate reference to definition in state’s law for licensing producers].

Drafting Note: States that have not adopted the NAIC Producer Licensing Model Act or similar provision should substitute the term agent or broker for the term producer as appropriate.

II. “Professional association” means an association that meets all of the following criteria:

   (1) Serves a single profession that 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;

   (4) Has been formed and maintained in good faith for purposes other than obtaining insurance;

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

   (6) Does not condition membership in the association on any health status-related factor;

   (7) Has at least 1,000 members if it is a national association; 500 members if it is a state association; or 200 members if it is a local association;

   (8) All members and dependents of members are eligible for coverage regardless of any health status-related factor;

   (9) Does not make health benefit plan offered through the association available other than in connection with a member of the association;

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

   (11) Producers only market association memberships, accept applications for membership, or sign up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the professional association.

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

JJ. “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 associations 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;

Drafting Note: The purpose of this paragraph is to require a carrier to pool, for rating purposes, the experience of all of the professional association plans it offers, except those plans with 2,000 or more members which a carrier chooses to rate separately based on each plans experience.

(2) Provides renewability of coverage for the members and dependents of members of the professional association that meets the criteria set forth in Section 6 of this Act;

(3) Provides availability of professional association plan coverage for the members and dependents of members of the professional association who are eligible persons in conformance with the provisions of Section 7A and 8 of this Act, except that the professional association shall not be required to offer individual basic or 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 all of Section 7 E, F and G and Section 8 of this Act as they apply to individual health benefit plans.

Drafting Note: Subsections CC(1)(a) and JJ of this section exempt professional association plans and the carriers that offer them from certain rating and availability requirements of the model. This exemption was intended to be very narrow in scope to address a limited marketing issue. In considering these provisions, states should be mindful of the risk segmentation consequences.

KK. “Qualifying event” means any of the following:

(1) Loss or change of dependent status under qualifying previous coverage; or

(2) The attainment by an individual of the age of majority.

LL. “Qualifying previous coverage” or “qualifying existing coverage” means 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;
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;

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 13 of this Act; and

(b) The employer has complied with the requirements regarding participation set forth in the plan of operation of the Individual Health Benefit Plan Association.

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

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 encouraged 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 in Paragraph (5) 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.

**MM.** “Rating characteristics” means:

(1) Family composition;

(2) Geographic area;

(3) Age bracket; and

(4) Other characteristics as allowed by regulation.

**NN.** “Rating period” means the calendar period for which premium rates established by a carrier subject to this Act are in effect.

**OO.** “Recently insured individual” means an individual who is a resident of this state and who had qualifying previous coverage within the past thirty-one (31) days, or an individual who has had a qualifying event occur within the past thirty-one (31) days.

**PP.** “Restricted network provision” means a provision of an individual health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate...
reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.

QQ. “Significant break in coverage” means a period of ninety (90) consecutive days during all which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

Section 4. Applicability and Scope

A. The provisions of this Act concerning individual health benefit plans and the individual carriers that offer them shall apply to:

(1) An individual health benefit plan offered to eligible persons or that covers enrollees and their dependents who are residents of this state at the time of issue who are not eligible to be insured under an employer-sponsored group health benefit plan;

(2) A certificate issued to an enrollee that evidences coverage under a policy or contract issued to a trust or association or other similar grouping of individuals, regardless of the situs of delivery of the policy or contract, if the enrollee pays the premium and is not covered under the policy or contract pursuant to continuation of benefits provisions applicable under federal or state law;

(3) Professional association plans as set forth in this Act; and

(4) Converted policies as set forth in this Act.

B. Except as provided in Subsection C, for purposes of this Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this Act shall apply as if all individual health benefit plans delivered or issued for delivery to residents of this state by the affiliated carriers were issued by one carrier.

C. An affiliated carrier that is a health maintenance organization having a certificate of authority under Section [insert reference to state health maintenance organization licensing act] may be considered to be a separate carrier for the purposes of this Act.

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

Section 5. Restrictions Relating to Premium Rates

A. The premium rates for an individual health benefit plan shall be subject to the following provisions:

(1) The individual carrier shall develop its rates based on rating characteristics. After adjustment for allowed rating characteristics and benefit design, the rate for any block of individual health benefit plan business written on or after [insert effective date of this Act] by a carrier subject to this Act shall not exceed the rate for any other block of individual health benefit plan business by more than 100 percent. Any differences in rating factors across blocks of business must be recognized in applying this test. A block of business shall have a single uniform rate that is adjusted for individuals within the block only by factors based on allowed rating characteristics. Rating characteristics shall not include durational or tier rating, or changes in health status or claim experience after issue.
(2) Individual carriers may charge the lowest allowable adult rate for child only coverage.

B. The annualized amount of rate change applied to a single block of business shall not exceed the annualized amount of rate change applied to any other block of business by more than fifteen percent (15%) due to the claim experience or health status of that block of business after adjustment for allowed rating characteristics and benefit design.

C. For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar benefit design to a health benefit plan that does not contain such a provision if the restriction of benefits to network providers results in substantial differences in claim costs.

D. Rates for individual basic and standard coverages as provided in this Act shall be determined by each carrier as the average of the lowest rate available for issuance by that carrier adjusted for rating characteristics other than health status or claims experience and benefits and the maximum rate allowable by law after adjustments for rate characteristics other than health status or claims experience and benefits.

E. A carrier shall not transfer an enrollee with an individual health benefit plan or the enrollee’s dependent involuntarily into or out of a block business.

F. The single uniform rate pursuant to Subsection A(1) of this section for a health benefit plan may not be changed more frequently than annually. The premium charged to an enrollee may not be changed more frequently than once in twelve (12) months except to reflect:

(1) Changes to the family composition of the enrollee; or

(2) Changes to the health benefit plan requested by the enrollee.

G. If a carrier adjusts premiums for a block of business to a higher level than permitted by loss ratio requirements in order to comply with this section, the carrier must meet those loss ratio requirements on its entire individual health benefit plan business.

Drafting Note: States should be mindful of the desirability of having consistent rating schemes in the small group and individual markets. Whatever the rating rules are for small employer health benefit plans in a state, they should be consistent with individual health benefit plans.

H. The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by individual carriers are consistent with the purposes of this Act, including regulations that prescribe the manner in which geographic territories are designated by all individual carriers.

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

I. In connection with the offering for sale of an individual health benefit plan to an individual, a carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:
(1) The extent to which premium rates for an individual and dependents are established or adjusted based upon rating characteristics;

(2) The carrier’s right to change premium rates, and the factors, other than claim experience, that affect changes in premium rates;

(3) The provisions relating to renewability of policies and contracts;

(4) Any provisions relating to any preexisting condition provision; and

(5) All individual health benefit plans offered by the carrier, the prices of the plans if available to the eligible person, and the availability of the plans to the individual.

J. A carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

K. A carrier shall file with the commissioner annually on or before [insert date], an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner, and shall contain information, as specified by the commissioner. A copy of the certification shall be retained by the carrier at its principal place of business.

L. A carrier shall make the information and documentation maintained pursuant to Subsection J of this section available to the commissioner upon request. Except in cases of violations of this Act, the information and documentation shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the [insert appropriate reference to department of insurance] except as agreed to by the carrier or as ordered by a court of competent jurisdiction. Notwithstanding the provisions of this section, premium rates charged by a carrier are not considered proprietary.

Section 6. Renewability of Coverage

A. An individual health benefit plan shall be renewable with respect to an enrollee or dependents at the option of the enrollee, except in any of the following cases:

(1) The enrollee has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(2) The enrollee or the enrollee’s representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) The carrier elects to discontinue offering all of its individual health benefit plans delivered or issued for delivery in the state if the carrier:

   (a) Provides advance notice of its decision to the commissioner in each state in which it is licensed to sell health benefit plans; and

   (b) Provides notice of the decision to all enrollees and to the commissioner in each state in which an enrollee is known to reside at least ninety (90) days prior to the nonrenewal of the health benefit plan by the carrier, provided the notice to the commissioner is sent at least three (3) working days prior to the date the notice is sent to enrollees.
The commissioner:

(a) Finds that the continuation of the coverage would not be in the best interests of the enrollees or would impair the carrier's ability to meet its contractual obligations; and

(b) Assists enrollees in finding replacement coverage;

The commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in the state's individual insurance market if the carrier:

(a) Provides advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed to sell health benefit plans;

(b) Provides notice of the decision not to renew coverage to at least 180 days prior to the nonrenewal of any health benefit plans to:

(i) All enrollees; and

(ii) The commissioner in each state in which an enrollee is known to reside, provided the notice to the commissioner is sent at least three (3) working days prior to the date the notice is sent to enrollees;

(c) Offers to each enrollee provided that particular type of health benefit plan (obsolete product form) the option to purchase all other health benefit plans currently being offered by the carrier to individuals in the state; and

(d) In exercising the option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to Subparagraph (c), acts uniformly without regard to the claims experience of any enrollee or any health status-related factor relating to any enrollee or beneficiaries who may become eligible for the coverage;

In the case of health benefit plans that are made available in the individual market only through one or more professional associations, the membership of an individual in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any enrollee; or

In the case of health benefit plans that are made available in the individual market through a network plan, the enrollee no longer resides, lives or works in the carrier's established geographic service area, provided coverage is terminated under this paragraph without regard to any health status-related factor relating to any enrollee.

B. (1) An individual carrier that elects to discontinue offering health benefit plans under Subsection A(3) shall be prohibited from writing new business in the individual market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in the state.

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

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

Section 7. Availability of Coverage

A. (1) An individual carrier shall, as a condition of transacting business in this state, make available the choice of an individual basic or standard health benefit plan to a recently insured individual who applies for an individual health benefit plan and agrees to make the required premium payments and to satisfy other reasonable provisions of the individual basic or standard health benefit plan.

(2) If a recently insured individual had qualifying previous coverage with benefits that are not comparable to or do not exceed the individual standard health benefit plan, a carrier may make available only the individual basic health benefit plan to that recently insured individual.

(3) A carrier is not required to issue an individual basic or standard health benefit plan to a recently insured individual who meets any of the following criteria:

(a) Who does not apply for an individual basic or standard health benefit plan within thirty one (31) days of a qualifying event or within thirty one (31) days after becoming ineligible for qualifying existing coverage;

(b) Who is covered, or is eligible for coverage through, a benefit plan that provides health care coverage that is provided by the recently insured individual’s employer. A converted policy is not considered a benefit plan provided by an employer for purposes of this paragraph;

(c) Who is covered, or is eligible for coverage, through a benefit plan that provides health care coverage in which the individual’s spouse, parent or guardian is enrolled or eligible to be enrolled;

(d) Who has coverage under an individual health benefit plan and does not terminate coverage under the prior health benefit plan by the effective date of the newly issued coverage;

(e) Who is covered, or is eligible for coverage, under any other private or public health benefits arrangements, including a Medicare supplement policy or the Medicare program established under Title XVIII of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or any other act of Congress or law of any state, except for a Medicare-eligible individual who is eligible for Medicare for reasons other than age; or

(f) Who is covered, or is eligible for any continued group coverage under Section 4980b of the Internal Revenue Code, sections 601 through 608 of the federal Employee Retirement Income Security Act of 1974, Section 2201 through 2208 of the federal Public Health Service Act as amended, or any state required
continued group coverage. For purposes of this subsection, an individual who would have been eligible for continuation coverage, but is not eligible solely because the individual or other responsible party failed to make the required coverage election during the applicable time period, shall be deemed to be eligible for group coverage until the date on which the individuals continuing group coverage would have expired had an election been made.

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

B. Upon a carrier notifying an enrollee, who is a resident of this state, of a premium rate increase on the enrollee’s individual health benefit plan, any carrier shall issue an individual basic or standard health benefit plan at the option of the enrollee, if the option is exercised within thirty-one (31) days of receiving the notification and the enrollee terminates the existing coverage.

C. A carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the individual basic and standard health benefit plans. An individual basic and standard health benefit plan filed pursuant to this subsection may be used by a carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.

D. After providing notice and an opportunity for a hearing to the carrier, the commissioner at any time may disapprove the continued use by a carrier of an individual basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this Act.

E. The individual basic or standard health benefit plan shall not deny, exclude or limit benefits for a covered person for losses incurred more than twelve (12) months following the effective date of the individual’s coverage due to a preexisting condition.

F. (1) An individual carrier that does not use preexisting condition limits in any of its health benefit plans in this state may impose or apply one or more of the following terms or conditions.

(2) However, if more than one term or condition is used, the combination of terms or conditions may not exceed the actuarial value of the twelve-month preexisting condition limit permitted by this section:

(a) A rating surcharge not to exceed fifty percent (50%) of the best new business rate for a period not to exceed twelve (12) months; or

(b) An affiliation period that:

(i) Does not exceed ninety (90) days; and

(ii) During which no premiums are charged and the coverage issued is not effective.

(3) An affiliation period shall be waived for the period of time an individual was covered by qualifying previous coverage, provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of new coverage.
G. (1) A carrier shall waive a rating surcharge, an affiliation period, or time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time an individual was covered by qualifying previous coverage that provided benefits with respect to those services, provided that the qualifying previous coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage. The length of the period following the termination of qualifying previous coverage shall not include any waiting period for the enrollment date of the new coverage applied by the carrier or for the normal application and enrollment process.

(2) A carrier shall not impose a surcharge as otherwise allowed in subsection F of this section if an individual was covered by qualifying previous coverage that was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage. The length of the period following the termination of qualifying previous coverage shall not include any waiting period for the enrollment date of the new coverage applied by the carrier or for the normal application and enrollment process.

H. A carrier is not required to offer coverage or accept applications pursuant to subsection A of this section from an eligible person not residing in the carrier's established geographic service area.

I. A carrier shall not modify an individual basic or standard health benefit plan with respect to an enrollee or dependent through riders, endorsements, rating surcharges based on health status or claim experience or otherwise restrict or exclude coverage or benefits for specific diseases, medical services or conditions otherwise covered by the health benefit plan.

Section 8. Availability of Coverage—Federally Defined Eligible Individuals

A. Notwithstanding Section 7 of this Act and subject to subsection B, if an eligible person who is a federally defined eligible individual, applies for coverage under an individual health benefit plan within ninety (90) days of termination of prior creditable coverage, the individual carrier may not:

(1) Decline to offer coverage to, or deny enrollment of, the individual; or

(2) Impose any exclusion because of a preexisting condition, as that term is defined in Section 3FF of this Act, with respect to the coverage.

B. (1) An individual carrier may elect to limit the coverage offered under subsection A if it chooses to offer at least two (2) different policy forms, both of which:

(a) Are designed for, made generally available to, and actively marketed to, and enroll both federally defined eligible individuals and other individuals; and

(b) Meet the requirements of subsection C, as elected by the carrier.

(2) For purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

C. (1) An individual carrier meets the requirements of subsection B(1)(b) if:

(a) The carrier elects to offer policy forms with the largest, and next to largest, premium volume of the policy forms offered by the carrier in the individual market in the state; or

(b) The carrier elects to offer a high level and a low level policy form, each of which:
(1) Includes benefits substantially similar to other individual health benefit plans offered by the carrier in the state; and

(ii) Is covered under a mechanism described in Paragraph (4), relating to risk adjustment, risk spreading or financial subsidization.

(2) For purposes of Paragraph (1)(b), a policy form shall be considered:

(a) A low level policy form if the actuarial value of its benefits under the coverage is at least eighty-five percent (85%), but not greater than 100 percent of a weighted average; and

(b) A high level policy form if:

(i) The actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of the coverage described in Subparagraph (a) offered by the carrier in the state; and

(ii) The actuarial value of the benefits under the coverage is at least 100 percent, but not greater than 120 percent of a weighted average.

(3) For purposes of Paragraph (2), the weighted average is the average actuarial value of the benefits provided, as elected by the carrier:

(a) By all of the health benefit plans issued by the carrier in the individual market during the previous year, weighted by enrollment for the different coverages; or

(b) By all carriers in the state in the individual market during the previous year, weighted by enrollment for the different coverages.

(4) A mechanism meets the requirements of Paragraph (1)(b)(ii) if:

(a) It provides for risk adjustment, risk spreading or a risk spreading mechanism or otherwise provides for some financial subsidization for federally defined eligible individuals, including through assistance to participating carriers; or

(b) It is a mechanism under which each federally defined eligible individual is provided a choice of coverage under all individual health benefit plans the carrier otherwise has available.

(5) An election made under this subsection shall:

(a) Apply uniformly to all federally defined eligible individuals in the state for that individual carrier; and

(b) After expiration of the initial election period, and for the expiration of each subsequent election period, pursuant to Subparagraph (a)(ii), the carrier shall again make the elections in accordance with this subsection.
For purposes of Paragraph (2), the actuarial value of benefits provided under individual market coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

D. (1) An individual carrier that offers coverage in the individual market through a network plan may:

(a) Limit the individuals who may be enrolled under such coverage to those who live, reside or work within the established geographic service area of the network plan; and

(b) Within the established geographic service area of the network plan, deny coverage to individuals who live, reside or work with the established geographic service area, if the carrier demonstrates to the satisfaction of the commissioner, that:

(i) It will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group or individual policyholders and individual enrollees; and

(ii) It is applying this paragraph uniformly to all individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are federally defined eligible individuals.

(2) An individual carrier that cannot offer coverage pursuant to Paragraph (1)(b) may not offer coverage in the individual market within the established geographic service area until the later of:

(a) A period of 180 days after the date of each coverage denial; or

(b) The date on which the carrier notifies the commissioner that it has regained capacity to deliver services to individuals in the individual market.

E. (1) An individual carrier shall not be required to provide coverage to federally defined eligible individuals under this section if:

(a) For any period of time the commissioner determines, the individual carrier does not have the financial reserves necessary to underwrite additional coverage; and

(b) The individual carrier is applying this subsection uniformly to all individuals in the individual market in this state consistent with applicable state law and without regard to any health status-related factor relating to any individual and without regard to whether an individual is a federally defined eligible individual.

(2) An individual carrier that denies coverage in accordance with Paragraph (1) may not offer coverage in the individual market for the later of:

(a) A period of 180 days after the date the coverage is denied; or

(b) Until the individual carrier has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

Drafting Note: Under HIPAA, states may apply the provisions of Paragraph (2) on a service-area-specific basis.
F. This section shall not be construed to require that a health carrier offering health benefit plans only in connection with group health plans or through one or more professional associations, or both, offer coverage in the individual market.

Section 9. Health Benefit Plan Standards

The commissioner shall adopt by rule the form and level of coverage of the basic health benefit plan and the standard health benefit plan for the individual market that shall provide benefits substantially similar to those under the [insert reference to law corresponding to the NAIC Small Employer Health Insurance Availability Model Act] with respect to small employer coverage, but which shall be appropriately adjusted to reflect the individual market.

Section 10. Certification of Creditable Coverage

A. Individual carriers shall provide written certification of creditable coverage to individuals in accordance with Subsection B.

B. The certification of creditable coverage shall be provided:

(1) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(2) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Paragraph (1) or (2), whichever is later.

C. Individual carriers may provide the certification of creditable coverage required under Subsection B(1) at a time consistent with notices required under any applicable COBRA continuation provision.

D. The certificate of creditable coverage required to be provided pursuant to Subsection A shall contain:

(1) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(2) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

E. (1) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage and the individual provides a certificate of coverage that was provided to the individual pursuant to Subsection B, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity’s health benefit plan.

(2) The entity providing the information pursuant to Paragraph (1) may charge the requesting group health plan the reasonable cost of disclosing the information.

Drafting Note: Federal regulations to be issued pursuant to PHSA Section 2701(e) will establish rules to prevent an entity’s failure to provide the information under this Section 10 with respect to previous creditable coverage of an individual from adversely affecting any subsequent coverage of the individual under another health benefit plan. In

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addition, federal regulations to be issued pursuant to PHSA Section 2701(c)(3)(B) will provide further clarification on the operation of the alternative method for counting creditable coverage.

Section 11. Standards to Assure Fair Marketing

A. (1) If a carrier denies individual health benefit plan coverage to a recently insured individual who is an eligible person on the basis of the health status or claims experience of the recently insured individual, or the individual’s dependents, the carrier shall offer the recently insured individual the opportunity to purchase an individual basic or standard health benefit plan.

(2) Unless permitted under Section 8 of this Act, notwithstanding Paragraph (1), an individual carrier may not deny coverage to an applicant who is a federally defined eligible individual.

B. Except as provided in Subsection C, no carrier or producer shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct individuals to refrain from filing an application for coverage with the carrier because of the health status, claims experience, industry, occupation or geographic location of the individual; or

(2) Encourage or direct individuals to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the individual.

C. The provisions of Subsection B(1) shall not apply with respect to information provided by a carrier or producer to an individual regarding the established geographic service area of the carrier or the restricted network provision of the carrier.

D. Except as provided in Subsection E of this section, no carrier shall, directly or indirectly, enter into a contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of an individual basic or standard health benefit plan to be varied because of the health status or permitted rating characteristics of the individual or the individual’s dependents.

E. Subsection D shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of the health status or other permitted rating characteristics of the individual or the individual’s dependents.

F. Denial by a carrier of an application for coverage from an individual shall be in writing and shall state the reason or reasons for the denial.

G. A violation of this section by a carrier or producer shall be an unfair trade practice under [insert reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

H. If a carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of individual health benefit plans in this state, the third-party administrator is subject to this section as if it were a carrier.

Section 12. Individual Health Benefit Plan Association

A. (1) A nonprofit corporation is established to be known as the Individual Health Benefit Plan Association. All health carriers in this state shall be members of this association.
(2) The association shall be incorporated under state law, shall operate under a plan of operation, and shall exercise its powers through a board of directors established under this section.

B. The initial board of directors of the association shall consist of seven (7) members appointed by the commissioner as follows:

(1) Four (4) members shall be representatives of the four (4) largest domestic carriers based on individual health benefit premiums in the state as of the calendar year ending December 31, 20[ ].

Drafting Note: The requirement for four (4) representatives may need to be adjusted by the state to reflect the state's actual experience regarding the number of domestic carriers offering individual health benefit plans.

(2) Three (3) members shall be representatives of the three (3) largest carriers of health insurance in the state, excluding Medicare supplement coverage premiums, which are not otherwise represented. In the event a carrier to be represented pursuant to this paragraph does not appoint a representative, the board member shall be a representative of the next largest carrier that satisfies the criteria.

(3) The commissioner shall sit on the board as an ex-officio member.

C. After the initial term, board members shall be nominated and elected by the members of the association.

D. Members of the board may be reimbursed from the funds of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

E. (1) The association shall submit to the commissioner a plan of operation for the association and any amendments to the association’s articles of incorporation necessary and appropriate to assure the fair, reasonable, and equitable administration of the association.

(2) The plan shall provide for the sharing of losses related to individual basic or standard plans, if any, on an equitable and proportional basis among the members of the association.

(3) (a) If the association fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, the commissioner shall adopt rules necessary to implement this section.

(b) The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(4) In addition to other requirements, the plan of operation shall provide for all of the following:

(a) The handling and accounting of assets and funds of the association;

(b) The amount of and method for reimbursing the expenses of board members;

(c) Regular times and places for meetings of the board of directors;

(d) Records to be kept relating to all financial transactions, and annual fiscal reporting to the commissioner;
(e) Procedures for selecting the board of directors; and

(f) Additional provisions necessary or proper for the execution of the powers and duties of the association.

F. The plan of operation may provide that the powers and duties of the association may be delegated to a person who will perform functions similar to those of the association. A delegation under this subsection takes effect only upon the approval of the board of directors.

G. (1) The association has the general powers and authority enumerated by this section and executed in accordance with the plan of operation approved by the commissioner under Subsection E of this section.

(2) In addition to the general powers and authority enumerated by this section and executed in accordance with the plan of operation pursuant to Subsection E, the association may do any of the following:

(a) Enter into contracts as necessary or proper to administer this Act;

(b) Sue or be sued, including taking any legal action necessary or proper for recovery of any assessments for, on behalf of, or against members of the association or other participating persons;

(c) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, including the hiring of independent consultants as necessary; and

(d) Perform any other functions within the authority of the association.

H. Following the close of each calendar year, the association, in conjunction with the commissioner, shall require each carrier to report the amount of earned premiums and the associated paid losses for all individual basic and standard plans issued by the carrier. The reporting of these amounts shall be certified by an officer of the carrier.

I. The board shall develop procedures and make assessments and distributions as required so that each carrier issuing individual basic and standard health benefit plans receives the same ratio of paid claims to earned premiums on its individual basic and standard health benefit plans as the aggregate of all individual basic and standard plans insured by all carriers in the state.

J. If the statewide aggregate ratio of paid claims to earned premiums is greater than ninety percent (90%), the dollar difference between ninety percent (90%) of earned premiums and the paid claims shall represent an assessable loss.

Drafting Note: The 90% figure used here assumes no premium taxes will be paid on individual basic and standard health benefit plan premiums. The 90% figure should be adjusted if these premiums are not exempt from premium taxation.

K. (1) The assessable loss plus necessary operating expenses for the association, plus any additional expenses as provided by law, shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in the state during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year, or on any other equitable basis as provided in the plan of operation. In sharing losses, the association may abate or defer any part of the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the
ability of the member to fulfill its contractual obligations. The association may also provide for an initial or interim assessment against the members of the association to meet the operating expenses of the association until the next calendar year is complete.

(2) Health insurance premiums or payments for subscriber contracts as used in Paragraph (1) means those premiums or payments related to health benefit plans.

Drafting Note: States may wish to consider expanding the assessment base to health carriers that issue coverages not included in the definition of health benefit plan in order to spread the potential losses of the guaranteed issue basic and standard health benefit plans across a broader health insurance market.

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

Drafting Note: An assessment paid pursuant to this subsection should be allowed as a claims cost by the carrier in computing its loss ratio.

L. The board shall ensure that procedures for collecting and distributing assessments are as efficient as possible for carriers. The board may establish procedures that combine or offset the assessment from, and the distribution due to, a carrier.

M. A carrier may petition the association board to seek remedy from writing a significantly disproportionate share of individual basic or standard policies in relation to total premiums written in this state for health benefit plans. Upon a finding that a carrier has written a significantly disproportionate share, the board may agree to compensate the carrier either by paying to the carrier an additional fee not to exceed two percent (2%) of earned premiums from individual basic or standard policies for that carrier or by petitioning the commissioner for remedy.

N. The commissioner, upon a finding that the acceptance of the offer of individual basic or standard health benefit plan coverage by the individuals pursuant to this Act would place the carrier in a financially impaired condition, shall not require the carrier to offer coverage or accept applications for any period of time the financial impairment is deemed to exist. The commissioner by regulation shall establish the definition of significantly disproportionate share.

Section 13. Self-Funded Employer-Sponsored Health Benefit Plan Participation

A self-funded employer-sponsored health benefit plan qualified under the federal Employee Retirement Income Security Act of 1994 may voluntarily elect to participate in the Individual Health Benefit Plan Association established in Section 12 of this Act in accordance with the plan of operation and subject to the terms and conditions adopted by the board of the association to provide portability and continuity to its covered employees and their covered dependents subject to the same terms and conditions as a participating carrier.

Section 14. Special Rules Relating to Converted Policies

A. After approval of the basic and standard health benefit plans pursuant to Section 9 of this Act, all carriers that are required to offer a converted policy to a person pursuant to [insert reference to the state law equivalent to the Group Health Insurance Mandatory Conversion Privilege Model Act] may offer as a converted policy a choice of the individual basic and standard health benefit plans only.

B. If a carrier offers a choice of the individual basic and standard health benefit plans as conversion coverage pursuant to Subsection A, then the carrier shall be eligible to receive distributions under
the Individual Health Benefit Plan Association for its individual basic and standard converted policies pursuant to Section 12 of this Act.

C. If a carrier offers a choice of the individual basic and standard health benefit plans as conversion coverage pursuant to Subsection A, then persons with a converted policy issued prior to the effective date of the requirement contained in Subsection A above shall have the right at each annual renewal of the converted policy to elect an individual basic or a standard health benefit plan as a substitute converted policy, except that at the carrier’s option if the person has not made an election within three (3) years after the effective date of this Act, the carrier may require the person to make an election. Once a person has elected either the basic or the standard health benefit plan as a substitute converted policy, that person may not elect another converted policy.

D. (1) For rating purposes only, all converted policies shall be rated pursuant to this Act as if they were individual basic or standard health benefit plans.

(2) Carriers that do not write in the individual market:

(a) Shall set premiums for converted policies that provide coverage similar to or exceeding that of an individual standard health benefit plan at the average premium charged by the five (5) largest individual carriers (as measured by their premium volume) for their individual standard health benefit plans; and

(b) Shall set premiums for all other converted policies at the average premium charged by the five (5) largest individual carriers (as measured by their premium volume) for their individual basic health benefit plans.

(3) The averages in Paragraph (2) shall be calculated each year by the commissioner.

(4) New and renewal rates for persons with the same converted policies who have the same rating characteristics shall be the same.

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

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

Section 15. Separability

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

Section 16. Effective Date

The Act shall be effective on [insert date].

Legislative History (all references are to the Proceedings of the NAIC).

2000 Proc. 3rd Quarter 13, 14, 163, 200, 258-276 (amended and reprinted).
APPENDIX B
Model Regulation

119—MODEL REGULATION TO IMPLEMENT THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT (PROSPECTIVE REINSURANCE WITH OR WITHOUT AN OPT-OUT)
MODEL REGULATION TO IMPLEMENT THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT
(Prospective Reinsurance With or Without an Opt-out)

Section 1. Statement of Purpose

This regulation is intended to implement the provisions of the Small Employer Health Insurance Availability Model Act (Prospective Reinsurance with or without an Opt-Out). The general purposes of the Act and this regulation are to provide for the availability of health insurance coverage to small employers, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for development of “basic” and “standard” health insurance plans to be offered to all small employers; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small group health insurance market.

The Act and this regulation are intended to promote broader spreading of risk in the small employer marketplace. The Act and regulation are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this regulation.

Section 2. Definitions

As used in this regulation:

A. “Associate member of an employee organization” means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. §1002(1)) that is a multiemployer plan (as defined in 29 U.S.C. §1002(37A)), other than the following:

(1) An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or

(2) An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least
one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan).

B. “New entrant” means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.

C. “Risk characteristic” means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

D. “Risk load” means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

Section 3. Applicability and Scope

A. (1) Except as provided in Paragraph (2) and Section 14, this regulation shall apply to any health benefit plan, whether provided on a group or individual basis, which:

(a) Meets one or more of the conditions set forth in Section 4A through 4C of the Act;

(b) Provides coverage to one or more employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state; and

(c) Is in effect on or after the effective date of the Act.

(2) The provisions of the Act and this Regulation shall not apply to an individual health insurance policy delivered or issued for delivery prior to the effective date of the Act.

B. (1) A carrier that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of the Act and this regulation with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contribution.

(2) In the case of a carrier that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in Section 8A(3) of the Act and the small employer carrier shall be subject to Section 8A(2) of the Act (relating to guaranteed issue of coverage) if:

(a) The small employer has at least three (3) employees;

(b) The small employer contributes directly or indirectly to the premiums charged by the carrier; and

(c) The carrier is aware or should have been aware of the contribution by the employer.

C. The provisions of the Act and this regulation shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.
D. An individual health insurance policy shall not be subject to the provisions of the Act and this regulation solely because the policyholder elects a deduction under Section 162(l) of the Internal Revenue Code.

E. (1) If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this regulation shall continue to apply to the health benefit plan in the case that the small employer subsequently employs more than twenty-five (25) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than twenty-five (25) eligible employees but no later than the anniversary date of the employer’s health benefit plan, notify the employer that the protections provided under the Act and this regulation shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

(2) (a) If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of the Act shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer.

(b) A carrier providing coverage to an employer described in Subparagraph (a) shall, within sixty (60) days of becoming aware that the employer has twenty-five (25) or fewer eligible employees, notify the employer of the options and protections available to the employer under the Act, including the employer’s option to purchase a small employer health benefit plan from any small employer carrier.

F. (1) (a) If a small employer has employees in more than one state, the provisions of the Act and this regulation shall apply to a health benefit plan issued to the small employer if:

(i) The majority of eligible employees of such small employer are employed in this state; or

(ii) If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state.

(b) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subparagraph (a), the provisions of the paragraph shall be applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.

(2) If a health benefit plan is subject to the Act and this regulation, the provisions of the Act and this regulation shall apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state.

G. A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of the Act and this regulation solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state.
Section 4. Establishment of Classes of Business

A. A small employer carrier that establishes more than one class of business pursuant to the provisions of Section 5 of the Act shall maintain on file for inspection by the Commissioner the following information with respect to each class of business so established:

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

(2) A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in Section 5 of the Act; and

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

B. A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business.

Section 5. Transition for Assumptions of Business from Another Carrier

A. (1) A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless:

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

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

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

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

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

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

(ii) Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business (pursuant to Subsection C) or will incorporate them into an existing class of business (pursuant to Subsection D). If the assumed health benefit plans will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier into which the health benefit plans will be incorporated;
(iii) Describe whether the health benefit plans being assumed are currently available for purchase by small employers;

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

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

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

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

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

(4) A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it complies with the following provisions:

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

(b) If the assumption of a class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in Section 6A(1) of the Act, the assuming carrier shall make a filing with the Commissioner pursuant to Section 6C of the Act seeking suspension of the application of Section 6A(1) of the Act.

(c) An assuming carrier seeking suspension of the application of Section 6A(1) shall not complete the assumption of health benefit plans covering small employers in this state unless the Commissioner grants the suspension requested pursuant to Subparagraph (b).

(d) Unless a different period is approved by the Commissioner, a suspension of the application of Section 6A(1) shall, with respect to an assumed class of business, be for no more than fifteen (15) months and, with respect to each individual small employer, shall last only until the anniversary date of such employer’s coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business).

B. (1) Except as provided in Paragraph (2), a small employer carrier shall not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless
the transaction includes the ceding to the assuming carrier of the entire class of business which includes such health benefit plan.

(2) A small employer carrier may cede less than an entire class of business to an assuming carrier if:

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

(b) After a written request from the transferring carrier, the Commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business.

C. Except as provided in Subsection D, a small employer carrier that assumes one or more health benefit plans from another carrier shall maintain such health benefit plans as a separate class of business.

D. A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in Section 5B of the Act (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for a period of up to fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions:

(1) Upon assumption of the health benefit plans, such health benefit plans shall be maintained as a separate class of business. During the fifteen-month period following the assumption, each of the assumed small employer health benefit plans shall be transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans.

(2) The transfers authorized in Paragraph (1) shall occur with respect to each small employer on the anniversary date of the small employer’s coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business.

(3) A small employer carrier making a transfer pursuant to Paragraph (1) may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred.

(4) The premium rate for an assumed small employer health benefit plan shall not be modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to Paragraph (1). Upon transfer, the assuming small employer carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan shall be no higher than the risk load applicable to such health benefit plan prior to the assumption.

(5) During the fifteen-month period provided in this subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this
subsection shall not be considered a violation of the first sentence of Section 6B of the Act.

E. An assuming carrier may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

F. The Commissioner may approve a longer period of transition upon application of a small employer carrier. The application shall be made within sixty (60) days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

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

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

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

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

Section 6. Restrictions Relating to Premium Rates

A. (1) A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier’s discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

(2) (a) A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this paragraph. The Commissioner may approve a change to a rating method if the Commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this regulation.

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

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

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

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

(iv) A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(v) A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Section 6 of the Act.

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

(i) A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

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

(iii) A change in the method of allocating expenses among health benefit plans in a class of business; or

(iv) A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%).

• For the purpose of the first subclause, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test under the first subclause.

B. (1) The rate manual developed pursuant to Subsection A shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(2) A small employer carrier may not use case characteristics other than those specified in Section 6A(10) of the Act without the prior approval of the Commissioner. A small employer carrier seeking such an approval shall make a filing with the Commissioner for a change in rating method under Subsection A(2).

(3) A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

(4) The rate manual developed pursuant to Subsection A shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the
class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(5) Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(6) The rate manual developed pursuant to Subsection A shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 6 of the Act, to reflect the risk characteristics of the group.

(7) (a) Except as provided in Subparagraph (b), a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge.

(b) A carrier may charge a separate fee with respect a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than five dollars ($5.00) per month per employee and is applied in a uniform manner to each health benefit plan in a class of business.

(8) A small employer carrier shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to Subsection A shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

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

(10) The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Commissioner.

**Drafting Note:** The NAIC has developed a model compliance manual to provide guidance to states and insurers with respect to the rate limitations contained in the Act and regulation.

C. If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate factor associated with such a classification by more than twenty percent (20%).

D. The restrictions related to changes in premium rates in Sections 6A(3) and 6A(7) of the Act shall be applied as follows:

   (1) A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.
(2) (a) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of Sections 6A(3)(c) and 6A(7)(a) of the Act.

(b) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Section 6A(3) and 6A(7) of the Act.

(3) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier shall make a filing with the Commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within thirty (30) days of the beginning of the rating period.

(4) A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

E. (1) Except as provided in Paragraphs (2) through (4), a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(a) The base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by

(b) One plus the sum of:

   (i) The risk load applicable to the small employer during the previous rating period, and

   (ii) Fifteen percent (15%) (prorated for periods of less than one year).

(2) In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(a) The base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by

(b) One plus the lesser of:

   (i) The change in the base rate or

   (ii) The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by

(c) One plus the sum of:
(i) The risk load applicable to the small employer during the previous rating period and

(ii) Fifteen percent (15%) (prorated for periods of less than one year).

(3) In the case of a health benefit plan described in Section 6A(6) of the Act, if the current premium rate for the health benefit plan exceeds the ranges set forth in Section 6A of the Act, the formulae set forth in Paragraphs (1) and (2) will be applied as if the fifteen percent (15%) adjustment provided in Paragraph (1)(b)(ii) and Paragraph (2)(c)(ii) were a zero percent adjustment.

(4) Notwithstanding the provisions of Paragraphs (1) and (2), a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in Section 6A(2) of the Act.

F. (1) A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the Commissioner a request for the waiver of application of the provisions of Section 6A of the Act with respect to such trust.

(2) A request made under Paragraph (1) shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would:

(a) Adversely affect the participants and beneficiaries of the trust; and

(b) Require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

(3) A waiver granted under Section 4E of the Act shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual.

Drafting Note: Consideration was given to adding a provision that would permit carriers to make minor modifications to benefits at renewal for the purpose of incorporating cost containment provisions or updating policy provisions. Such a provision was not included because of concerns that it would not be consistent with the renewability provisions in Section 7 of the Act. Concerns about problems with compliance monitoring and enforcement related to such a provision also were raised.

Section 7. Requirement to Insure Entire Groups

A. (1) A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in Paragraphs (2) and (3), the small employer carrier shall provide the same health benefit plan to each such employee and dependent.

(2) A small employer carrier may offer the employees of a small employer the option of choosing among one or more health benefit plans, provided that each employee may choose any of the offered plans. Except as provided in Section 8C of the Act (with respect to exclusions for preexisting conditions), the choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the employees or their dependents.

Drafting Note: The following subsection is designed to discourage the exclusion from coverage of eligible employees and their dependents by the employer. Two alternatives are offered. Alternative One requires carriers to secure a waiver with respect to each eligible employee (or dependent) that declines coverage. Alternative Two is
more restrictive and prohibits carriers from issuing coverage to a small employer unless all eligible employees and dependents are included for coverage, subject to several enumerated exceptions.

ALTERNATIVE ONE

B. (1) A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees as defined in Sections 3M and 3N of the Act. The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.

(2) A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for a period of six (6) years.

(3) (a) A small employer carrier shall not issue coverage to a small employer that refuses to provide the list required under Paragraph (1) or a waiver required under Paragraph (2).

Drafting Note: The following subparagraph prohibits carriers from issuing a health benefit plan to a small employer if the carrier has reason to believe that the employer has induced or discouraged eligible employees or dependents from accepting an offer of coverage. States that wish to strongly discourage this behavior by employers can adopt the subparagraph or might consider adopting Alternative Two below.

(b) (i) A small employer carrier shall not issue coverage to a small employer if the carrier, or a producer for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual’s risk characteristics.

(ii) A producer shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual’s risk characteristics.

ALTERNATIVE TWO

B. (1) Except as provided in Paragraph (2), a small employer carrier may not issue a health benefit plan to a small employer unless the health benefit plan covers all eligible employees and all dependents of eligible employees as defined in Sections 3M and 3N of the Act.

(2) A small employer carrier may issue a health benefit plan to a small employer that excludes an eligible employee or the dependent of an eligible employee as defined in Sections 3M and 3N of the Act only if:
(a) The excluded individual has coverage under a health benefit plan or other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; 

**Drafting Note:** A state should consider whether coverage in a state health plan for uninsurable individuals should be considered as acceptable alternative coverage for the purposes of this provision.

(b) The excluded individual does not have a risk characteristic or other attribute that would cause the carrier to make a decision with respect to premiums or eligibility for a health benefit plan that is adverse to the small employer;

(c) The premium contribution to be paid by the eligible employee (on behalf of such employee or the dependent of such employee) would have exceeded [insert percentage] of the adjusted gross income of the eligible employee; or

**Drafting Note:** The intent of the provision is to recognize that some individuals may be unable to accept an offer of coverage (even those who need health insurance because of health problems) because they are unable to afford their share of the premium. States should insert a percentage of wages that could be contributed to health insurance that they find appropriate.

(d) The excluded individual states in a signed waiver that the individual has had coverage under a health benefit plan or other health benefit arrangement within the previous six (6) months and reasonably expects to have coverage within the succeeding six (6) months under a health benefit plan or other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(3) A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees as defined in Sections 3M and 3N of the Act. The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.

(4) (a) A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for a period of six (6) years.

(b) A small employer carrier shall obtain, with respect to each individual who submits a waiver under Subparagraph (a), information sufficient to establish that the waiver is permitted under Paragraph (2).

(5) (a) A small employer carrier shall not issue coverage to a small employer if the carrier is unable to obtain the list required under Paragraph (3), a waiver required under Paragraph (4) or the information required under Paragraph (4)(b) in circumstances required in this subsection.

(b) (i) A small employer carrier shall not offer coverage to a small employer if the carrier, or a producer for such carrier, has reason to believe that the
small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual’s risk characteristics.

(ii) A producer shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual’s risk characteristics.

C. (1) New entrants to a small employer group shall be offered an opportunity to enroll in the health benefit plan currently held by such group. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of his or her opportunity to enroll. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to Subsection A(2), the new entrant shall be offered the same choice of health benefit plans as the other members of the group.

(2) A small employer carrier shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for preexisting medical conditions consistent with Section 8C(2) of the Act) with respect to a new entrant that is longer than sixty (60) days.

(3) New entrants to a group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude coverage for preexisting medical conditions, consistent with the provisions provided in Section 8C of the Act.

(4) A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 6 of the Act. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

D. (1) (a) In the case of an eligible employee (or dependent of an eligible employee) who, prior to the effective date of Section 8A of the Act, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer (as defined in Section 8A(3) of the Act), the small employer carrier shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in the health benefit plan currently held by the small employer.

(b) A small employer carrier may require an individual who requests enrollment under this subsection to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that the coverage was not offered to the individual.

(2) The opportunity to enroll shall meet the following requirements:

(a) The opportunity to enroll shall begin [insert date 90 days after the effective date of this regulation] and shall last for a period of at least three (3) months.

(b) Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subsection shall be treated as new entrants.
Premium rates related to such individuals shall be set in accordance with Subsection C.

(c) The terms of coverage offered to an individual described in Paragraph (1)(a) may exclude coverage for preexisting medical conditions if the health benefit plan currently held by the small employer contains such an exclusion, provided that the exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this subsection.

(d) A small employer carrier shall provide written notice at least forty-five (45) days prior to the opportunity to enroll provided in Paragraph (1)(a) to each small employer insured under a health benefit plan offered by such carrier. The notice shall clearly describe the rights granted under this subsection to employees and dependents who were previously excluded from or denied coverage and the process for enrollment of such individuals in the employer’s health benefit plan.

Section 8. Consideration of Industry

A. Except as provided in Subsections B and C, a small employer carrier may not consider the trade or occupation of the employees of a small employer or the industry or type of business in which the small employer is engaged in determining whether to issue or continue to provide coverage to the small employer.

B. A small employer carrier may use industry as a case characteristic in establishing premium rates, subject to Section 6A(6) of the Act.

C. A small employer carrier may consider trade, occupation or industry as part of the eligibility criteria for a class of business, subject to Section 8A(2)(b) of the Act.

Section 9. Application to Reenter State

A. A carrier that has been prohibited from writing coverage for small employers in this state pursuant to Section 7B of the Act may not resume offering health benefit plans to small employers in this state until the carrier has made a petition to the Commissioner to be reinstated as a small employer carrier and the petition has been approved by the Commissioner. In reviewing a petition, the Commissioner may ask for such information and assurances as the Commissioner finds reasonable and appropriate.

B. In the case of a small employer carrier doing business in only one established geographic service area of the state, if the small employer carrier elects to nonrenew a health benefit plan under Section 7A(6) of the Act, the small employer carrier shall be prohibited from offering health benefit plans to small employers in any part of the service area for a period of five (5) years. In addition, the small employer carrier shall not offer health benefit plans to small employers in any other geographical area of the state without the prior approval of the Commissioner. In considering whether to grant approval, the Commissioner may ask for such information and assurances as the Commissioner finds reasonable and appropriate.

Section 10. Qualifying Previous and Qualifying Existing Coverages

A. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 3R, 8C(2) and 8C(5) of the Act, a small employer carrier shall interpret the Act no less favorably to an insured individual than the following:
(1) A health insurance policy, certificate or other health benefit arrangement shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement.

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

(a) Have an actuarial value (as considered for a normal distribution of groups) that is not substantially less than the actuarial value of the basic health benefit plan; or

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

In making a determination under this subsection, a small employer carrier shall evaluate the previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its decision solely on the fact that one portion of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the basic health benefit plan.

B. For the purposes of Section 8C(2) of the Act, an individual will be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement covering such individual met the definition of qualifying previous coverage contained in Section 3W of the Act and provided any benefit with respect to the service.

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

Section 11. Restrictive Riders

A. A restrictive rider, endorsement or other provision that would violate the provisions of Section 8C(5)(b) of the Act and that was in force on the effective date of this regulation may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this regulation. A small employer carrier shall provide written notice to those small employers whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan.

[Optional subsections for states that have not yet revised Section 8C(5)(b) of the Model Act with respect to restrictive riders]

B. Except as permitted in Section 8C(2) of the Act, a small employer carrier shall not modify or restrict a basic or standard health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

C. Except as permitted in Section 8C(2) of the Act, a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions or services otherwise covered by the plan.
Drafting Note: As originally adopted, Section 8C(5)(b) of the Act prohibited carriers from restricting the coverage offered in the basic and standard health benefit plans. Subsection B above clarifies the intent of the original provision. Subsection C above prohibits carriers from reducing coverage for individuals through restrictive riders. This provision is needed to ensure that (1) carriers cannot get around the open enrollment requirements by offering employers health benefit plans that reduce or exclude coverage for specific individuals and (2) regulators can accurately enforce the rating limitations in Section 6 of the Act.

Section 12. Rules Related to Fair Marketing

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

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

B. (1) A small employer carrier shall offer at least the basic and standard health benefit plans to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer shall be in writing and shall include at least the following information:

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

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

The offer may be provided directly to the small employer or delivered through a producer.

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

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

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

(i) A general description of the benefits contained in each such plan;
(ii) A price quote for each such plan; and

(iii) Information describing how the small employer may enroll in such plans.

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

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

C. A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

Drafting Note: Some states with smaller populations may determine that this provision is not necessary to assure fair marketing of small employer health benefit plans in their state.

D. The small group carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of Section 8A(2)(b) of the Act.

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

F. (1) Carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this regulation. Carriers shall elicit the following information from applicants for such plans at the time of application:

(a) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(b) Whether or not the prospective policyholder, certificateholder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162 (other than Section 162(l)), Section 125 or Section 106 of the United States Internal Revenue Code.

(2) If a small employer carrier fails to comply with Paragraph (1), the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with Paragraph (1).

G. (1) A small employer carrier shall file annually the following information with the Commissioner related to health benefit plans issued by the small employer carrier to small employers in this state:
(a) The number of small employers that were issued health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

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

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

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

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

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

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

Section 13. Status of Carriers as Small Employer Carriers

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

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

C. (1) If the filing made pursuant Subsection A indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state only if the carrier complies with the following provisions:

   (a) The carrier complies with the requirements of the Act (other than Sections 9, 10 and 11) with respect to each of the health benefit plans previously issued to small employers by the carrier.

   (b) The carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by the carrier. The provisions of the Act (other than Sections 9, 10 and 11) and this regulation shall apply to the coverage issued to such new entrants.

   (c) The carrier complies with the requirements of Section 18 of the Act and Sections 11 and 14 of this regulation as they apply to small employers whose coverage has been terminated by the carrier and to individuals and small employers whose coverage has been limited or restricted by the carrier.

   (2) A carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the reinsurance program established under Section 11 of the Act.
D. If the filing made pursuant to Subsection A indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state (except as provided for in Subsection C) for a period of five (5) years from the date of the filing. Upon a written request from such a carrier, the Commissioner may reduce the period provided for in the previous sentence if the Commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state.

Section 14. Restoration of Coverage

A. (1) Except as provided in Paragraph (2), a small employer carrier shall, as a condition of continuing to transact business in this state with small employers, offer to provide a health benefit plan as described in Subsection C to any small employer whose coverage was terminated or not renewed by such small employer carrier after [insert date 6 months prior to the date of enactment].

(2) The offer required under Paragraph (1) shall not be required with respect to a health benefit plan that was not renewed if:

(a) The health benefit plans was not renewed for reasons permitted in Section 7A of the Act, or

(b) The nonrenewal was a result of the small employer voluntarily electing coverage under a different health benefit plan.

B. The offer made under Subsection A shall occur not later than thirty (30) days after a carrier indicates its intention to operate as a small employer carrier in this state pursuant to Section 13A. A small employer shall be given at least sixty (60) days to accept an offer made pursuant to Subsection A.

C. A health benefit plan provided to a terminated small employer pursuant to Subsection A shall be meet the following conditions:

(1) The health benefit plan shall contain benefits that are identical to the benefits in the health benefit plan that was terminated or nonrenewed.

(2) The health benefit plan shall not be subject to any waiting periods (including exclusion periods for preexisting conditions) or other limitations on coverage that exceed those contained in the health benefit plan that was terminated or nonrenewed. In applying such exclusions or limitations, the health benefit plan shall be treated as if it were continuously in force from the date it was originally issued to the date that it is restored pursuant to this section and Section 18 of the Act.

(3) The health benefit plan shall not be subject to any provision that restricts or excludes coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

(4) The health benefit plan shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier shall offer coverage to each dependent of such eligible employees.

(5) The premium rate for the health benefit plan shall be no more than the premium rate charged to the small employer on the date the health benefit plan was terminated or nonrenewed; provided that, if the number or case characteristics of the eligible employees (or their dependents) of the small employer has changed between the date the health benefit plan was terminated or nonrenewed and the date that it is restored, the carrier may
adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may further be adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health benefit plan may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date of health benefit plan is restored. Any such increase shall be subject to the provisions of Section 6 of the Act.

(6) The health benefit plan shall not be eligible to be reinsured under the provisions of Section 10 of the Act, except that the carrier may reinsure new entrants to the health benefit plan who enroll after the restoration of coverage.

Legislative History (all references are to the Proceedings of the NAIC).

APPENDIX C
Summary of Model Rating Provisions
### APPENDIX C

**Summary of Model Rating Provisions**

(This chart is intended only for overview purposes. The model should be consulted for actual provisions.)

This chart does not reflect requirements resulting from HIPAA.

<table>
<thead>
<tr>
<th>Scope</th>
<th>Small Employer Availability (Model 118—1993 version)</th>
<th>Small Employer Availability (Model 118—1995 version)</th>
<th>Small Employer &amp; Individual Availability (Model 035)</th>
<th>Individual Portability Model 037</th>
</tr>
</thead>
</table>
|       | All small employer health benefit plans issued or renewed on/after effective date of Act with certain exceptions | All small employer health benefit plans issued or renewed on/after effective date of Act | 1. **Small Employer:** all health benefit plans issued or renewed on/after effective date of Act  
2. **Individual:** all health benefit plans issued after effective date of Act | Individual business written after effective date of Act |
| Availability | Guarantee Issue basic/standard | Guarantee Issue all plans actively marketed to small employers including basic/standard | 1. **Small Employer:** Guarantee Issue all plans actively marketed to small employers including basic/standard  
2. **Individual:** Guarantee Issue all plans actively marketed to small employers including basic/standard | 1. Guarantee Issue for basic or standard to recently insured individual  
2. If not comparable previously qualifying benefits—then only require basic to be guarantee issue |
| Case Characteristic Type Rules | 1. Case characteristics include:  
- Age  
- Gender  
- Industry  
- Geographic area  
- Family composition  
- Geographic area  
- Group size  
- Other as approved by commissioner  
2. No rate limits for case characteristics | 1. Adjusted community rate vary only by:  
- Geographic area  
- Family composition  
- Age  
2. Age brackets NOT< 5-years and begin at 30 and end at 65  
3. Separate rates for Medicare primary/secondary  
4. Rate variation attributable to age limited to be 4:1, 3:1, or 2:1 depending upon duration since effective date of Act | 1. Adjusted community rate vary only by:  
- Geographic area  
- Family composition  
- Age  
2. Age brackets:  
- **Small Employer:** Age brackets NOT< 5-years and begin at 30 and end at 65  
- **Individual:** May use one-year increments  
3. Rate variation attributable to age limited to be 4:1, 3:1, or 2:1 depending upon duration since effective date of Act | 1. Single Uniform rate adjusted by factors for rating characteristics and benefit design  
2. Rating characteristics include:  
- Family composition  
- Geographic area  
- Age bracket  
- Other as allowed by regulation |
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Summary of Model Rating Provisions

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<table>
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<th>Rate Limits Across Case Characteristics</th>
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<th>Small Employer &amp; Individual Availability (Model 035)</th>
<th>Individual Portability Model 037</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adjusted community rate</td>
<td>1. Index rates between classes not to exceed 20% of lowest class index rate</td>
<td>1. Adjusted community rate</td>
<td>1. Rate across blocks may not vary by more than 100%</td>
<td>1. Single Uniform rate—NOT more frequently than annually</td>
</tr>
<tr>
<td>2. Within a class all rates within 25% of index rate for given case characteristics.</td>
<td>2. Within a class all rates within 25% of index rate for given case characteristics.</td>
<td>2. Optional Section 11E(2)(b) of Act requires an individual risk assuming carrier to establish uniform rates for all small employer and individual health benefit plans</td>
<td>2. Enrollee rate—NOT more frequently than annually</td>
<td>2. Enrollee rate—NOT more frequently than annually</td>
</tr>
<tr>
<td>3. Annual 15% limit on adjustment within rate band</td>
<td>3. Annual 15% limit on adjustment within rate band</td>
<td>3. Professional Association provisions apply</td>
<td>3. Individual basic/standard = average of lowest available and maximum allowable</td>
<td>3. Individual basic/standard = average of lowest available and maximum allowable</td>
</tr>
</tbody>
</table>

| Frequency of Rating Adjustments for a Particular Health Benefit Plan | No specified limits | Not more frequently than annually except when: Changes in enrollment Change in family composition Change in health benefit plan requested by small employer | Not more frequently than annually except when: Changes in enrollment Change in family composition Change in health benefit plan requested by small employer | 1. Single Uniform rate—NOT more frequently than annually |

| Actuarial Certification & Documentation of Methods | Yes | Yes | Yes | Yes |

June 20, 2003
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Summary of Model Rating Provisions

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<th>Small Employer Availability (Model 118—1993 version)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Extent premium rates established/adjusted based upon actual/expected variation in claims costs etc.</td>
<td>1. Right to change premium rates and factors, other than claim experience, that affect changes in premium rates</td>
<td>1. Right to change premium rates and factors, other than claim experience, that affect changes in premium rates</td>
<td>1. Extent rates established/adjusted due to rating characteristics</td>
<td>1. Extent rates established/adjusted based upon actual/expected variation in claims costs etc.</td>
</tr>
<tr>
<td>2. Right to change premium rates and factors, other than claim experience, that affect premium rates</td>
<td>2. Renewability</td>
<td>2. Renewability</td>
<td>2. Right to change premium rates, and factors, other than claim experience affecting change in premium rates</td>
<td>2. Right to change premium rates and factors, other than claim experience, that affect changes in premium rates</td>
</tr>
<tr>
<td>4. Pre-existing</td>
<td>4. List of and descriptive information about all benefit plans for which small employer is qualified</td>
<td>4. List of and descriptive information about all benefit plans for which small employer or eligible person is qualified</td>
<td>4. List of and descriptive information about all benefit plans for which small employer or eligible person is qualified</td>
<td>4. List of and descriptive information about all benefit plans for which small employer or eligible person is qualified</td>
</tr>
<tr>
<td><strong>Transition</strong></td>
<td><strong>Specifies transition rules for a 3-year transition period</strong></td>
<td>Gradually narrows allowable rate variations attributable to age: 4:1, 3:1 and 2:1</td>
<td>Gradually narrows allowable rate variations attributable to age: 4:1, 3:1 and 2:1</td>
<td>If a carrier adjusts premiums for a block of business to higher level than permitted by loss ratio requirements in order to comply with this section, then must meet loss ratio requirements on entire individual health benefit business</td>
</tr>
</tbody>
</table>

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