

**MODEL REGULATION TO IMPLEMENT THE SMALL EMPLOYER HEALTH
INSURANCE AVAILABILITY MODEL ACT
(Prospective Reinsurance With or Without an Opt-out)**

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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 “Act”). 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 an 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 current or former employee, or a beneficiary of such employee, of:
 - (a) The sponsoring employee organization;
 - (b) 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

- (c) The employee benefit plan (or of a related plan).
- B. “Covered employee” means an eligible employee who is or was provided coverage under a group health plan.
- C. (1) “New entrant” means an eligible employee, or the dependent of an eligible employee, who becomes part of a small employer group after the initial period for enrollment in a health benefit plan.
(2) “New entrant” includes an eligible employee, or the dependent of an eligible employee, who becomes part of a small employer group in accordance with the special provisions under Section 7C(6) or (7) of the Act.
- D. (1) “Qualified beneficiary” means, with respect to a covered employee under a group health plan, an individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:
 - (a) As the spouse of the covered employee; or
 - (b) As the dependent child of the covered employee.(2) “Qualified beneficiary” includes a child who is born to or placed for adoption with the covered employee during the period of COBRA continuation coverage.
- E. “Qualifying event” means, with respect to a covered employee, any of the following events that, but for COBRA continuation coverage, would result in the loss of coverage of a qualified beneficiary:
 - (1) The death of the covered employee;
 - (2) The termination, except for the employee’s gross misconduct, or reduction of hours, of the covered employee’s employment;
 - (3) The divorce or legal separation of the covered employee from the employee’s spouse;
 - (4) The covered employee becoming entitled to benefits under Title XVIII of the Social Security Act; or
 - (5) A dependent child ceasing to be a dependent child under the requirements of the health benefit plan.
- F. “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.

Section 3. Applicability and Scope

- A. (1) Except as provided in Paragraph (2) and Section 11 of this regulation, 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 4D 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 3PP of the Act and the small employer carrier shall be subject to Section 7A(2) of the Act (relating to guaranteed issue of coverage) if:
 - (a) The small employer has at least two (2) 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 [insert the size of employer to correspond with the definition of small employer in Section 3PP or the Act] eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than [insert the size of employer to correspond with the definition of small employer in Section 3PP of the Act] 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) of this paragraph shall, within sixty (60) days of becoming aware that the employer has [insert the size of employer to correspond with the definition of small employ in Section 3PP of the Act] 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) of this paragraph, 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. 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) days 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 whether the health benefit plans being assumed are currently available for purchase by small employers;
 - (ii) Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed;
 - (iii) Describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed;

- (iv) 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
 - (v) Include any other information required by the commissioner.
- (b) A small employer carrier required to make a filing under Paragraph (2) also shall 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) of this paragraph for the small employer health benefit plans in that state.
- (4) A small employer carrier shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering a small employer in this state unless it has provided a notice to the commissioner at least sixty (60) days prior to the date of the proposed assumption that contains the information specified in Paragraph (3) for the health benefit plans covering small employers in this state.
- B. A small employer carrier making a transfer pursuant to this section may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier into which the health benefit plans have been transferred.
- C. 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.
- D. 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 5. Restrictions Relating to Premium Rates

- A. (1) A small employer carrier shall develop a rate manual for health benefits plans subject to the Act and this regulation based on an adjusted community rate that may only vary the adjusted community rate for the following case characteristics:
 - (a) Geographic area;
 - (b) Family composition; and
 - (c) Age.

Drafting Note: The provisions of Paragraph (1) above are consistent with the requirements of the Act. However, some states may permit small employer carriers to consider other case characteristics that are not listed in Paragraph (1).

- (2) Renewal 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.
- (3)
 - (a)
 - (i) A small employer carrier shall not modify the rating method used in the rate manual for a health benefit plan until the change has been approved as provided in this paragraph.
 - (ii) 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 health benefit plan only with prior approval of the commissioner.
 - (c)
 - (i) A carrier requesting to change the rating method for a health benefit plan shall make a filing with the commissioner at least thirty (30) days prior to the proposed date of the change.
 - (ii) 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 health benefit plan, 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 5 of the Act.
 - (d) 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 health benefit plan;
 - (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;
 - (iii) A change in the method of allocating expenses among health benefit plans; 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) A small employer carrier shall not use case characteristics other than those specified in Section 5A 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(3).
- (2) A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan 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.
- (3) Differences among base premium rates for health benefit plans shall be based solely on case characteristics and 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.

Drafting Note: The provisions of Paragraph (3) above are consistent with the requirements of the Act and this regulation, as provided in Subsection A(1). However, some states may permit small employer carriers to consider other case characteristics that are not listed in Subsection A(1).

- (4) A small employer carrier shall apply case characteristics and rate factors 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.
- (5) (a) Except as provided in Subparagraph (b) of this paragraph, 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 \$5 per month per employee and is applied in a uniform manner to each health benefit plan.
- (6) 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. The rate manual developed pursuant to Subsection A shall describe the method of allocating administrative expenses to the health benefit plans for which the manual was developed.
- (7) The 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.
- (8) 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 rating compliance manual to provide guidance to states and insurers with respect to the rate limitations contained in the Act and this regulation.

- C. A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change premium rates for each health benefit plan for each rating period.

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 6 of the Act. Concerns about problems with compliance monitoring and enforcement related to such a provision also were raised.

Section 6. 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), 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 7C of the Act, with respect to exclusions for preexisting conditions, the choice among benefit plans shall not be limited, restricted or conditioned based upon the risk characteristics or a health status-related factor 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 requires carriers when issuing coverage to a small employer to include all eligible employees and dependents for coverage under the health benefit plan, 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 N of the Act. The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) to verify the information required under this paragraph.
- (2) (a) 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.
- (b) 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.
- (c) The waiver form shall:
- (i) Require that the reason for declining coverage be stated on the form;
 - (ii) Include a written warning of the penalties imposed on late enrollees; and
 - (iii) Include a statement informing the eligible employee of their special enrollment rights, if any, under Section 7C(6) or (7) of the Act.

Drafting Note: Appendix A contains a form that may be used to comply with Subparagraph (c)(iii) in regard to providing notice to employees of their special enrollment rights. Because this form is derived from federal regulations, states should review the federal regulations prior to adopting this form to determine whether any future modifications of the regulations affect the language contained in the form.

- (d) Waivers shall be maintained by the small employer carrier for a period of six (6) years.

ALTERNATIVE TWO

- B.
 - (1) Except as provided in Paragraph (2), when issuing coverage to a small employer, a small employer carrier shall include all eligible employees and all dependents of eligible employees as defined in Sections 3L and M of the Act, for coverage under the health benefit plan.
 - (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 3L and 3M 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 excluded individual does not have a health status-related that would cause the carrier to make a decision with respect to eligibility for a health benefit plan;
 - (d) 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.

- (e) 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 3L and 3M 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)
 - (i) 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.
 - (ii) 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.

- (iii) The waiver form shall:
 - (I) Require that the reason for declining coverage be stated on the form;
 - (II) Include a written warning of the penalties imposed on late enrollees; and
 - (III) Include a statement informing the eligible employee of their special enrollment rights under Section 7C(6) or (7) of the Act.
- (iv) 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) of this paragraph, information sufficient to establish that the waiver is permitted under Paragraph (2).
- (c) A producer shall notify a small employer carrier 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 a health status-related factor of the individual.
- C. (1) (a) 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.
- (b) A new entrant that is a special enrollee pursuant to Section 7C(6) or (7) of the Act shall not be treated as a late enrollee.
- (2) A small employer carrier shall not apply a waiting period, affiliation period, elimination period or other similar limitation of coverage, other than an exclusion for preexisting medical conditions consistent with Section 7C(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 any health status-related factor of the employees or their dependents, except that a carrier may exclude coverage for preexisting medical conditions, consistent with the provisions provided in Section 7C of the Act.
- D. (1) (a) In the case of an eligible employee, or dependent of an eligible employee) who, prior to the effective date of Section 7A 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, 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 and consistent with the requirements of Section 7C of the Act.
 - (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 7. Application to Reenter State

- A. A carrier that has been prohibited from writing coverage for small employers in this state pursuant to Section 6C 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 geographical service area of the state, if the small employer carrier elects to discontinue offering a health benefit plan under Section 6A(5) 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 beginning on the date the carrier ceased offering new coverage in that established geographic service area of the state. In addition, the small employer carrier shall not offer health benefit plans to small employers in any other geographic 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 8. Certification and Disclosure of Prior Creditable Coverage

- A.
 - (1) Small employer carriers shall provide certificates of creditable coverage to individuals in accordance with this section.
 - (2) A small employer carrier shall be deemed to have satisfied Paragraph (1) if another person provides the certificate, but only to the extent that the certificate contains the information required in Subsection E(3).
 - (a) A small employer carrier is not required to provide information regarding coverage provided to an individual by another person.

- (b) (i) If an individual's coverage under a small employer carrier's policy ceases before the individual's coverage under a group health plan, the carrier shall provide sufficient information to the plan or another party designated by the plan to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate of creditable coverage that reflects the period of the individual's coverage under the carrier policy.
 - (ii) (I) By providing the information under Item (i), the carrier satisfies its obligation under Subsection C to provide an automatic certificate of creditable coverage to the individual.
 - (II) However, a carrier shall provide an automatic certificate under Subsection C if the individual's coverage under the plan ceases at the time the individual's coverage under the carrier's policy ceases.
 - (III) If an individual's coverage under a carrier's policy ceases on the effective date for changing enrollment options under the plan, the carrier may presume, absent information to the contrary, that the individual's coverage under the plan continues. The carrier shall provide the information in accordance with Item (i) and is not required to provide an automatic certificate under Subsection C.
 - (iii) The carrier is still required to provide a certificate to the individual upon request under Subsection D and cooperate with the plan in responding to any request made under Subsection I.
- B. A small employer carrier shall provide a certificate of creditable coverage, without charge, to participants or dependents who are or were covered under a health benefit plan automatically in accordance with Subsection C or upon request in accordance with Subsection D.
- C. (1) (a) For an individual who is a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the health benefit plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage.
 - (b) A carrier satisfies Subparagraph (a) of this paragraph if the automatic certificate is provided no later than the time a notice is required to be provided at the time the individual ceases to be covered under the health benefit plan.
- (2) (a) For an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the health benefit plan.
 - (b) A carrier satisfies this paragraph for providing an automatic certificate if the carrier provides the certificate within a reasonable time after coverage ceases or after the expiration of any grace period for nonpayment of premiums.
 - (c) For an individual who is entitled to elect to continue coverage under a state program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the state program, for purposes of this paragraph, the certificate shall be deemed to have been provided within a reasonable time after the cessation of coverage under the health benefit plan.

- (d) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, for purposes of this paragraph and providing an automatic certificate, coverage shall be considered to have ceased on the earliest date that a claim is denied due to the operation of the lifetime limit.
- (3)
 - (a) For an individual who is a qualified beneficiary and has elected COBRA continuation coverage, or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage, an automatic certificate shall be provided at the time the individual's COBRA coverage under the plan ceases.
 - (b) A carrier satisfies Subparagraph (a) of this paragraph if the carrier provides the certificate within a reasonable time after the coverage ceases or after the expiration of any grace period for nonpayment of premiums.
 - (c) An automatic certificate shall be provided to the individual regardless of whether the individual previously has received an automatic certificate under Paragraph (1).
- D.
 - (1) A small employer carrier shall provide a certificate in response to a request for a certificate made by, or on behalf of, an individual at any time while the individual is covered under the health benefit plan and up to twenty-four (24) months after the date the individual's coverage has ceased under the health benefit plan.
 - (2) Upon receipt of a request, a small employer carrier shall provide the certificate by the earliest date that the carrier, acting in a reasonable and prompt fashion, can provide the certificate.
 - (3) A small employer carrier shall provide a certificate under this subsection even if the individual previously received a certificate under this subsection or an automatic certificate under Subsection C.
- E.
 - (1) Except as provided in Paragraph (2), a certificate shall be provided in writing or other approved medium.
 - (2) A written certificate is not required to be provided under this subsection in accordance with Subsection C or D if:
 - (a) An individual who is entitled to receive a certificate requests that the certificate be sent to another carrier instead of the individual;
 - (b) The carrier that would otherwise receive the certificate agrees to accept the information described in this subsection through means other than a written certificate; and
 - (c) The receiving carrier receives the information from the sending carrier through such means within the time periods required under Subsection C or D.
 - (3) A certificate provided pursuant to this subsection shall include the following:
 - (a) The date the certificate is issued;
 - (b) The name of the health benefit plan that provided the coverage described in the certificate;
 - (c) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for, or includes, a dependent;

- (d) The name, address, and telephone number of the carrier required to provide the certificate;
- (e) The telephone number to call for further information regarding the certificate if different from Subparagraph (d) of this paragraph;
- (f) Either:
 - (i) A statement that the individual has at least eighteen (18) months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or
 - (ii) The date any waiting period or affiliation period, if applicable, began and the date creditable coverage began;
- (g) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and
- (h) An educational statement that explains:
 - (i) The restrictions on the ability of a carrier to impose a preexisting condition exclusion, including an individual's ability to reduce a preexisting condition exclusion period by creditable coverage;
 - (ii) Special enrollment rights;
 - (iii) The prohibitions against discrimination based on any health status-related factor;
 - (iv) The right to individual health coverage;
 - (v) The fact that state law may require carriers to provide additional protections to individuals in that state; and
 - (vi) Where to obtain additional information.
- (4) (a) If an automatic certificate is provided pursuant to Subsection C, the period that is required to be included on the certificate is the last period of continuous coverage ending on the date the coverage ceased.
 - (b) (i) For a certificate requested pursuant to Subsection D, the certificate provided shall include each period of continuous coverage ending within the twenty-four (24) month period ending on the date of the request or continuing on the date of the request.
 - (ii) A separate certificate may be provided for each period of continuous coverage.
- (5) (a) A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual.
 - (b) If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.
- (6) Appendix B contains a model certificate that a small employer carrier may use to satisfy the requirements of Paragraph (3).

- (7) (a) Except as provided in Subparagraph (b) of this paragraph, a small employer carrier is not required to provide a certificate with respect to excepted benefits, as described in Section 3U(2), (3), (4) and (5) of the Act.
 - (b) If the excepted benefits are being provided concurrently with other creditable coverage such that the coverage does not consist solely of excepted benefits, a small employer carrier may be required to disclose information concerning the benefits under Subsection I.
- F. (1) Small employer carriers may provide a certificate required to be provided pursuant to this section by first-class mail.
 - (2) (a) If a small employer carrier provides the certificate or certificates to the participant and the participant's spouse at the participant's last known address, the carrier has satisfied the requirements of this subsection with respect to all individuals residing at that address.
 - (b) If the last known address of a dependent of the participant is different from the participant's last known address, a small employer carrier shall provide a separate certificate to the dependent at the dependent's last known address.
 - (c) If a small employer carrier is providing separate certificates by mail to individuals who reside at the same address, the carrier is not required to mail each certificate separately.
 - (3) (a) Each small employer carrier shall establish a written procedure for individuals to request and receive certificates pursuant to Subsection D.
 - (b) The written procedure shall include all contact information, such as a name and telephone number or address, necessary to request a certificate.
 - (4) (a) If a small employer carrier is required to provide a certificate automatically to an individual pursuant to Subsection C, and the individual entitled to receive the certificate designates another individual or person to receive the certificate, the carrier may provide the certificate to the designated individual or person.
 - (b) If a small employer carrier is required to provide a certificate upon request pursuant to Subsection D and the individual entitled to receive the certificate designates another individual or person to receive the certificate, the carrier shall provide the certificate to the designated individual or person.
- G. (1) A small employer carrier shall use reasonable efforts to determine the information needed for a certificate relating to dependent coverage.
 - (2) For certificates required to be provided automatically pursuant to Subsection C, a small employer carrier is not required to provide an individual certificate until carrier knows or, using reasonable efforts, should know of the dependent's cessation of coverage under the health benefit plan.
 - (3) (a) If a certificate provided by a small employer carrier does not provide the name of any dependent covered by the certificate, the procedures described in Subsection J(5) may be used to demonstrate dependent status.
 - (b) The procedures described in Subsection J(5) may be used to demonstrate that a child was covered under any creditable coverage within [insert the number of days to correspond with the number of days allowed for special enrollment for a child who satisfies the provisions of Section 7C(5)(b) of the Act] days of birth, adoption or placement for adoption.

- H. (1) Small employer carriers shall provide certificates of creditable coverage to individuals under this section even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because the entity or program is not subject to the Act.
- (2) Paragraph (1) applies to coverage provided in connection with:
 - (a) Creditable coverage described in Section 3K(1)(g) through (j) of the Act; and
 - (b) Coverage subject to Section 2721(b)(1)(B) of the Public Health Service Act (PHSA).
- I. (1) After an individual provides a certificate of creditable coverage to a carrier using the alternative method of counting creditable coverage described in Section 7C(3) of the Act, that carrier (requesting entity) shall request that the carrier that issued the certificate (prior entity) disclose the information set forth in Paragraph (2). The prior entity shall disclose the information promptly.
- (2) The prior entity shall identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to a category.
- (3) The prior entity may charge the requesting entity for the reasonable cost of providing the information.
- J. (1) An individual may demonstrate creditable coverage and waiting or affiliation periods through the presentation of documents or other means other than a certificate if:
 - (a) The accuracy of a certificate is contested; or
 - (b) A certificate is unavailable at the time the certificate is needed by the individual.
- (2) An individual may make such a demonstration under, but is not limited to, the following circumstances:
 - (a) A carrier has failed to provide a certificate within the required time period;
 - (b) The individual has creditable coverage provided by an entity that is not required to provide a certificate of coverage under this section;
 - (c) The individual has an urgent medical condition that requires a determination as to creditable coverage prior to the time the individual can provide a certificate to the health benefit plan; or
 - (d) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.
- (3) (a) A small employer carrier shall take into account all of the information that obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage.
- (b) A small employer carrier shall treat the individual as having provided a certificate pursuant to this section if the individual:
 - (i) Attests to the period of creditable coverage;
 - (ii) Presents relevant corroborating evidence of some creditable coverage during the period; and

- (iii) Cooperates with the carrier's efforts to verify the individual's coverage.
 - (c) A small employer carrier may refuse to credit coverage where an individual fails to cooperate with the carrier's efforts to verify the individual's coverage, but the carrier shall not consider the individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.
 - (d) For the purpose of Subparagraphs (b)(iii) and (c) of this paragraph, "cooperate" includes providing, upon request of the small employer carrier, a written authorization for the carrier to request a certificate on behalf of the individual and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage.
- (4) (a) Documents that corroborate creditable coverage and waiting or affiliation periods include:
- (i) Explanations of benefits claims (EOB) or other correspondence from a carrier indicating coverage;
 - (ii) Pay stubs showing a payroll deduction for health coverage;
 - (iii) A health insurance identification card;
 - (iv) A certificate of coverage under a health benefit plan;
 - (v) Records from health care providers, indicating coverage;
 - (vi) Third party statements verifying periods of coverage; and
 - (vii) Any other relevant documents that evidence periods of coverage.
- (b) In addition to Subparagraph (a) of this paragraph, creditable coverage and waiting or affiliation period information may be corroborated through means other than documentation, such as by a telephone call from the carrier or provider to a third party verifying creditable coverage.
- (5) If, in the course of providing evidence of creditable coverage, including a certificate of creditable coverage, an individual is required to demonstrate dependent status, the small employer carrier shall treat the individual as having furnished a certificate showing the dependent status if the individual:
- (a) Attests to the dependency and period of dependency; and
 - (b) The individual cooperates with the carrier's efforts to verify dependent status.
- (6) The procedures used by a small employer carrier pursuant to this subsection to determine an individual's creditable coverage with respect to any category under Subsection I relating to determining creditable coverage under the alternative method.

Section 9. Preexisting Condition Exclusion Notice and Determination Requirements

- A. A small employer carrier that imposes a preexisting condition exclusion shall provide written general notice of preexisting condition exclusion to participants under the health benefit plan and shall not impose a preexisting condition exclusion with respect to a participant or dependent until the notice is provided.
- B.
 - (1)
 - (a) The small employer carrier shall provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the carrier for enrollment in the health benefit plan.
 - (b) If the small employer carrier does not distribute materials, as described in Subparagraph (a) of this paragraph, the notice shall be provided by the earliest date following a request for enrollment that the carrier, acting in a reasonable and prompt fashion, can provide the notice.
 - (2) The general notice of preexisting condition exclusion shall notify participants of the following:
 - (a) The existence and terms of any preexisting condition exclusion under the health benefit plan, which shall include:
 - (i) The length of the plan's look-back period;
 - (ii) The maximum preexisting condition exclusion period under the plan; and
 - (iii) How the plan will reduce the maximum preexisting condition exclusion period by creditable coverage;
 - (b) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage, as required by Section 8 of this regulation or through other means, as described in Section 8J of this regulation, which shall include a description of the right of the individual to request a certificate from a prior carrier, if necessary, and a statement that the current carrier will assist the individual in obtaining a certificate from any prior carrier, if necessary; and
 - (c) An individual contact, including an address or telephone number, for obtaining additional information or assistance regarding the preexisting condition exclusion.
 - (3) If a notice satisfying the requirements of this subsection is provided to an individual, the obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied.
- C.
 - (1)
 - (a) Within a reasonable time period following the date of receiving information under Section 8 of this regulation with respect to creditable coverage of an individual, the small employer carrier shall make a determination regarding the amount of the individual's creditable coverage and the length of any preexisting condition exclusion period, if any, that remains.
 - (b) Whether a determination is made within a reasonable time period shall be determined based on the relevant facts and circumstances, including whether the carrier's application of a preexisting condition exclusion would prevent the individual from having access to urgent medical care.

Drafting Note: Appendix C contains sample language that small employer carriers may use as a basis for preparing their own notices to satisfy the requirements of Subsection B. Because this sample language is derived from federal regulations, states should review the federal regulations prior to adopting this appendix to determine whether any future modifications of the regulations affect the language contained in the appendix.

- (2) A small employer carrier shall not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.
- D.
- (1)
 - (a) After an individual has presented evidence of creditable coverage and after the small employer carrier has made a determination of creditable coverage under Subsection C, the carrier shall provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage.
 - (b) The carrier is not required to identify in this individual any medical conditions specific to the individual that could be subject to the exclusion.
 - (c) A small employer carrier is not required to provide the notice under this paragraph if the carrier does not impose any preexisting condition exclusion on the individual in any of its health benefits plans or if the health benefit plan's preexisting condition exclusion period is completely offset by the individual's prior creditable coverage.
 - (2) The individual notice required under Paragraph (1) shall be provided by the earliest date following a determination that the small employer carrier, acting in a reasonable and prompt fashion, can provide the notice.
 - (3) The small employer carrier shall disclose in the notice:
 - (a) Its determination of any preexisting condition exclusion period that applies to the individual, including the last day on which the preexisting condition exclusion applies;
 - (b) The basis for the determination, including the source and substance of any information on which the carrier relied;
 - (c) An explanation of the individual's right to submit additional evidence of creditable coverage; and
 - (d) A description of any applicable appeal procedures established by the carrier.
 - (4) If a notice satisfying the requirements of this subsection is provided to an individual, the obligation to provide the individual notice of preexisting condition exclusion with respect to that individual is satisfied.
- E.
- Nothing in this section shall prevent a small employer carrier from modifying an initial determination of creditable coverage if the carrier determines that the individual did not have the claimed creditable coverage, provided that:
- (1) The carrier provides a notice of the new determination consistent with the requirements of Subsection D to the individual; and
 - (2) Until the notice of the new determination is provided, the carrier, for the purpose of approving access to medical care, acts in a manner consistent with the initial determination.

Section 10. Restrictive Riders

- A. A restrictive rider, endorsement or other provision that would violate the provisions of Section 7C(9)(c) 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 7C(9)(c) of the Model Act with respect to restrictive riders]

- B. Except as permitted in Section 7C(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 7C(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 7C(9)(c) 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 5 of the Act.

Section 11. 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) A small employer carrier shall actively offer all health benefit plans it actively markets in this state, including 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.
- (b) The offer may be provided directly to the small employer or delivered through a producer.
- (2) 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.

- (3) (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 shall 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.
 - (4) Subject to Section 7A(2) of the Act, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan.
 - (5) A carrier shall not directly or indirectly use group size or any health status-related factor as criteria for establishing eligibility for a health benefit plan.
- 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. (1) The small employer 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 or for the issuance of any health benefit plan offered by the small employer carrier.
- (2) A small employer carrier may modify the terms of a policy issued to a small employer that is not a member of the association provided the modifications do not affect the policy's benefit design or other substantive terms of coverage.

Drafting Note: The provisions of Paragraph (2) are intended to allow a carrier to make necessary technical or administrative modifications to a health benefit plan issued to a small employer that is not a member of an association.

- E. A small employer carrier shall 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.
- (2) 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.

- (3) If a small employer carrier fails to comply with Paragraph (2), 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 (2).
- 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);
 - (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 12. 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 12) 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; and
 - (c) The carrier complies with the requirements of Section 19 of the Act and Sections 10 and 13 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) For the purpose of Paragraph (1)(b), the provisions of the Act, except for Sections 9, 10 and 12 of the Act, and this regulation shall apply to the coverage issued to new entrants.
 - (3) A carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the reinsurance program established under Section 12 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 13. 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 6A 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 12A of this regulation. A small employer shall be given at least sixty (60) days to accept an offer made pursuant to Subsection A.
- C. (1) A health benefit plan provided to a terminated small employer pursuant to Subsection A shall be meet all of the following conditions in Paragraphs (2) through (7).
- (2) The health benefit plan shall contain benefits that are identical to the benefits in the health benefit plan that was terminated or nonrenewed.
- (3) 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 19 of the Act.
- (4) 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.
- (5) 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.

- (6) 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.
- (7) The health benefit plan shall not be eligible to be reinsured under the provisions of Section 12 of the Act, except that the carrier may reinsure new entrants to the health benefit plan who enroll after the restoration of coverage.

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

1993 Proc. IA and IB 7, 10 814, 878, 884, 890-903 (adopted).

2007 Proc. 1st Quarter 88-126 (adopted)

APPENDIX A

MODEL DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

APPENDIX B

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

- | | |
|---|---|
| 1. Date of this certificate: _____ | 7. For further information, call: _____
_____ |
| 2. Name of group health plan: _____
_____ | 8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10: _____ |
| 3. Name of participant: _____ | 9. Date waiting period or affiliation period (if any) began: _____ |
| 4. Identification number of participant: _____
_____ | 10. Date coverage began: _____
_____ |
| 5. Name of individuals to whom this certificate applies: _____
_____ | 11. Date coverage ended (or if coverage has not ended, enter "continuing"): _____ |
| 6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
_____ | |

[Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.]

Statement of HIPAA Portability Rights

IMPORTANT—KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable health coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse’s plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged to a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an “eligible individual,” you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for “Protecting Your Health Insurance Coverage”). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL’s interactive web pages – Health Elaws, or <http://www.cms.hhs.gov/hipaa1>.

APPENDIX C

GENERAL NOTICE OF PREEXISTING CONDITION EXCLUSION SAMPLE LANGUAGE

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days (or any longer period as provided in state law) after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior “creditable coverage.” Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days (or any longer period as provided in state law). To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be direct to Individual *B* at Address *M* or Telephone Number *N*.

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

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

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KEY:

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

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

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

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. ADMIN. CODE r. 116 (1997).
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas	NO CURRENT ACTIVITY	
California		CAL. CODE REGS. tit. 10, §§ 2233 to 2233.99 (1993/1994).
Colorado		3 COLO. CODE REGS. § 2-12 (1995); § 702-4:4-6-7 (1995/2011); § 702-4:4-6-8 (1995/2013); § 702-4:4-6-12 (1995/2014).
Connecticut		BULLETIN HC-88 (2011).
Delaware	18 DEL. CODE REGS. § 1308 (1993/2003).	BULLETIN 11 (1993).
District of Columbia		D.C. CODE 31-4712 (2011).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Florida		FLA. ADMIN. CODE ANN. r. 69O-149.043 to 69O-149.043 (1993/2005); 69O-154.512 (1998).
Georgia		Directive 12-Ex-1 (2012).
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho	IDAHO ADMIN. CODE r. 18.01.69 (1995/2002).	IDAHO ADMIN. CODE r. 18.01.70 (1995/2002); 18.01.73.000 to 18.01.73.022 (1995/2009).
Illinois		ILL. ADMIN. CODE tit. 50, §§ 5100.10 to 5100.50 (1996).
Indiana	NO CURRENT ACTIVITY	
Iowa	IOWA ADMIN. CODE r. 191-71.1 to 191-71.22 (1993/2000).	
Kansas	NO CURRENT ACTIVITY	
Kentucky	NO CURRENT ACTIVITY	
Louisiana	NO CURRENT ACTIVITY	
Maine		940 ME. CODE R. (2000/2005).
Maryland		MD. CODE REGS. 31.11.06.1 to 31.11.06.12 (1994/1996).
Massachusetts		211 MASS. CODE REGS. §§ 66:00 to 66:90 (1992/2011); BULLETIN 92-02 (1992).
Michigan	NO CURRENT ACTIVITY	
Minnesota	NO CURRENT ACTIVITY	
Mississippi	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Missouri	NO CURRENT ACTIVITY	
Montana		MONT. ADMIN. R. 6.6.5001 to 6.6.5125 (1994/1998).
Nebraska	NO CURRENT ACTIVITY	
Nevada		NEV. ADMIN. CODE §§ 689C.100 to 689C.240 (1996/2013).
New Hampshire	NO CURRENT ACTIVITY	
New Jersey		N.J. ADMIN. CODE §§ 11:21-1.1 to 11:21-20.2 (1993/2013); BULLETIN 6-1-2010 (2010).
New Mexico	NO CURRENT ACTIVITY	
New York	NO CURRENT ACTIVITY	
North Carolina		11 N.C. ADMIN. CODE §§ 12.1300 to 12.1309 (1992); §§ 16.0300 to 16.0303 (1993).
North Dakota	N.D. ADMIN. CODE 45-06-06.1-01 to 45-06-06.1-14 (1994/2001).	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	NO CURRENT ACTIVITY	
Oklahoma	NO CURRENT ACTIVITY	
Oregon		OR. ADMIN. R. 836-053-0010 to 836-053-0250 (1992/2014).
Pennsylvania	NO CURRENT ACTIVITY	
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island	11 R.I. CODE R. §§ 1 to 16 (2008/2011).	BULLETIN 2008-3 (2008).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
South Carolina		BULLETIN 11-2011 (2011).
South Dakota		BULLETIN 2011-7 (2011).
Tennessee		TENN. CODE ANN. § 56-7-2209 (2011).
Texas		28 TEX. ADMIN. CODE §§ 26.1 to 26.27 (1993/2001).
Utah	UTAH ADMIN. CODE r. 590-167 (1996/2013) (portions of model).	
Vermont		91 VT. CODE R. § 4A (1991); § 4B (1992).
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	NO CURRENT ACTIVITY	
Washington		WASH. ADMIN. CODE §§ 284-49-020 to 284-49-999 (1990/2005).
West Virginia		W. VA. CODE R. §§ 114-73-1 to 114-73-4 (2004/2005).
Wisconsin		WIS. ADMIN. CODE INS. 8.40 to 8.69 (1991/1994).
Wyoming	49 WYO. CODE R. (1993/1998).	