

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL ACT

Editor's Note: Provided for your convenience are references to the corresponding sections of the federal Public Health Service Act (PHSA). A key to the PHSA section titles appears at the end of the model. Any references to PHSA sections, including the key, are not intended to be adopted in legislation.

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Section 1. Short Title

This Act shall be known and may be cited as the [Individual Market Health Insurance Coverage Model Act].

Section 2. Purpose and Intent

The purpose and intent of this Act is to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the individual market and provide for the establishment of coverage and other benefit requirements in the individual market.

Drafting Note: The provisions of this Act are consistent with the provisions of the federal Patient Protection and Affordable Care Act (ACA) Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (and with Title XXVII of the PHSA as amended by those statutes) and, as applicable, the regulations issued related to provisions of the ACA. However, states should be aware that the federal preemption standards permit states to impose more stringent, consumer protection requirements.

Section 3. Definitions

For purposes of this Act:

- A. “Bona fide 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 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 association.

Drafting Note: This definition of “bona fide association” is narrower than the definition of “bona fide association” contained in Section 2791(d)(3) of the (PHSA) because of the requirement of Paragraph (1) above that the professional association serve a single profession. Specifically, Section 2791(d)(3) of the PHSA defines “bona fide association,” 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 Section 2791(d)(3) explicitly permits the states to impose additional requirements, the narrower definition of “bona fide association” used in this Act does not conflict with or prevent the application of the federal law. Therefore, the states can elect to adopt either version of this definition.

Drafting Note: States should be aware that the term “bona fide association” is used in this Act in connection with providing an exception to the guaranteed renewability requirements in Section 7B(6) of this Act. Section 7B(6) of this Act only permits a health carrier to non-renew health coverage for an individual whose association membership ceases if the association is a “bona fide association” the individual’s membership was the basis of which the coverage is provided, and the coverage is terminated uniformly for all individuals leaving the association without regard to any health status-related factor relating to any covered person. Associations that are not “bona fide associations” are not eligible for this exception. The definition of “bona fide association” does not impact how states have chosen to define “associations” for other purposes.

- B. “Carrier” or “health carrier” means any entity licensed, or required to be licensed, by the Department of Insurance that offers health benefit plans covering eligible individuals 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.
- C. “Commissioner” means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “Commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- D. “Converted policy” means a health benefit plan issued pursuant to [insert reference in state law comparable to the Group Health Insurance Mandatory Conversion Privilege Model Act].
- E. “Covered benefits” or “benefits” mean those health care services to which an individual is entitled under the terms of a health benefit plan.
- F. “Covered person” means a policyholder or enrollee participating in a health benefit plan.
- G. “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:
 - (1) A group health plan;
 - (2) A health benefit plan;
 - (3) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (4) 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);
 - (5) 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. 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);
 - (6) A medical care program of the Indian Health Service or of a tribal organization;
 - (7) A state health benefits risk pool;
 - (8) A health plan offered under Chapter 89 of Title 5, United States Code (Federal

Employees Health Benefits Program (FEHBP));

- (9) A public health plan, which for purposes of this act, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan;
 - (10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or
 - (11) Title XXI of the Social Security Act (State Children’s Health Insurance Program).
- H. Except as otherwise may be defined for purposes of Section 8 of this Act, “dependent” shall be defined in the same manner as in [insert reference in state law defining dependent].
- I. “Employee” has the meaning given such term under Section 3(6) of ERISA.
- J. “Enrollee” means an individual who is covered by a health benefit plan providing individual health insurance coverage.
- K.
 - (1) “Essential health benefits” has the meaning under Section 1302(b) of the Federal Act and applicable regulations.
 - (2) “Essential health benefits” include:
 - (a) Ambulatory patient services,
 - (b) Emergency services;
 - (c) Hospitalization;
 - (d) Laboratory services;
 - (e) Maternity and newborn care;
 - (f) Mental health and substance abuse disorder services, including behavioral health treatment;
 - (g) Pediatric services, including oral and vision care;
 - (h) Prescription drugs;
 - (i) Preventive and wellness services and chronic disease management; and
 - (j) Rehabilitative and habilitative services and devices.
- L. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

- M. “Family member” means with respect to an individual:
- (1) A dependent of the individual; and
 - (2) Any other individual who is a first-degree, second-degree, third-degree or fourth-degree relative of the individual or an individual described in Paragraph (1).
- N. (1) “Federal Act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (ACA), and any amendments thereto, or regulations or guidance issued under, those Acts.
- (2) “Federal Act” includes Title XXVII of the Public Health Service Act (PHSA), as amended by the ACA.
- O. (1) “Genetic information” means, with respect to any individual, information about:
- (a) The individual’s genetic tests;
 - (b) The genetic tests of the individual’s family members; and
 - (c) The manifestation of a disease or disorder in family members of the individual.
- (2) “Genetic information” includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research, which includes genetic services, by the individual or any family member of the individual.
- (3) “Genetic information” does not include information about the sex or age of any individual.
- P. “Genetic services” means:
- (1) A genetic test;
 - (2) Genetic counseling, including obtaining, interpreting or assessing genetic information; or
 - (3) Genetic education.
- Q. (1) “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations or chromosomal changes.
- (2) “Genetic test” does not mean:
- (a) An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes; or
 - (b) An analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of

medicine involved.

- R. “Geographic rating area” is an area established in accordance with Section 2701(a)(2) of the PHSA, or any federal regulation adopted thereunder, for purposes of adjusting the rates for a health benefit plan.
- S. “Grandfathered health plan coverage” means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations, and includes any extension of coverage to individuals who become dependents of grandfathered enrollees after March 23, 2010.
- T. “Group health insurance plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to an employer or group of employers to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- U. “Group health plan” has the meaning given such term under Section 2791(a) of the PHSA.
- V. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Federal Act uses the terms “health plan” and “health insurance coverage.” “Health benefit plan,” as defined above, is intended to be consistent with the definition of “health insurance coverage” contained in Title XXVII of the PHSA, as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and amended by the Federal Act.

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

- (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
 - (4) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
 - (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
 - (5) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
 - (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health insurance plan.
 - W. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.
- Drafting Note:** States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not “corporate persons.”
- X. “Health care provider” or “provider” means a health care professional or facility.
 - Y. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a medical condition, illness, injury or disease.
 - Z. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of health care services to covered persons on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.
 - 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 services;
 - (5) Medical history;
 - (6) Genetic information;
 - (7) Evidence of insurability, including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities;
 - (8) Disability; or
 - (9) Any other health status-related factor determined appropriate by the Secretary.
- BB. (1) “Individual market health insurance coverage” means health insurance coverage, other than a converted policy, offered to individuals in the individual market, but does not include short-term limited duration insurance.
- (2) For purposes of this Act, “student health insurance coverage,” as defined in Subsection MM of this Act, shall be considered a type of individual health insurance coverage.
- CC. “Individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.
- DD. “Network plan” means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, 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.
- EE. “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.
- FF. (1) “Preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date of the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.
- (2) 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.
- GG. “Policyholder” means an individual who has paid premium for himself or herself and his or her dependents, if any, who are also covered under a health benefit plan providing individual health insurance coverage, and is responsible for continued premium payments under the terms of the health benefit plan.

HH. “Premium” means all moneys paid by a policyholder as a condition of receiving individual health insurance coverage from a health carrier, including any fees or other contributions associated with the health benefit plan and includes any portion of premium paid on behalf of a policyholder.

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

Drafting Note: States that have not adopted the NAIC Producer Licensing Model should substitute the term “agent” or “broker” for the term “producer,” as appropriate.

JJ. (1) “Rescission” means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(2) “Rescission” does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

KK. “Secretary” means the Secretary of the federal Department of Health and Human Services.

LL. “Student administrative health fee” means a fee charged by an institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

MM. “Student health insurance coverage” means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health carrier and provided to students enrolled in that institution of higher education and their dependents, that meets the following:

(1) Does not make health insurance coverage available other than in connection with enrollment as student (or as a dependent of a student) in the institution of higher education;

(2) Does not condition eligibility for health insurance coverage on any health status-related factor related to a student (or a dependent of a student); and

(3) Meets any additional requirement that may be imposed under state law.

Drafting Note: On March 21, 2012, the U.S. Department of Health and Human Services (HHS) published in the *Federal Register* the final rule on the requirements for student health insurance coverage under the PHSA and the ACA. The final rule applied many, but not all, of the provisions of the PHSA and the ACA to student health insurance coverage. Therefore, it is important that states are aware of which provisions do and do not apply to these plans. Although HHS declined to regulate self-funded student health plans in the final regulation, HHS recognized that states may regulate these plans.

NN. “Underwriting purposes” means:

- (1) Rules for, or determination of, eligibility including enrollment and continued eligibility for benefits under the health benefit plan;
 - (2) The computation of premium or contribution amounts under the health benefit plan; and
 - (3) Other activities related to the creation, renewal or replacement of a contract of individual health insurance coverage.
- OO. “Waiting period” means the period of time that must pass before coverage for a covered person who is otherwise eligible to enroll under the terms of a health benefit plan can become effective.

Section 4. Applicability and Scope

- A. Subject to Subsection B, this Act shall apply to health carriers offering health benefit plans providing individual health insurance coverage in this state.
- B. Except for Sections 7, 8, 10C, 11A(1), 12, 17, 18 and 19 of this Act and to the extent provisions of other sections in this Act were in effect pursuant to Pub. L. No. 104-191 (HIPAA) and Pub. L. No. 110-233 (GINA) prior to the effective date of the Federal Act, this Act does not apply to any grandfathered health plan coverage.

Drafting Note: Generally, Section 1251 of the ACA exempts coverage from most reforms in Subtitles A and C of Title 1 of the ACA if the coverage was in force as of March 23, 2010, the date on which the ACA was signed into law, and the terms of coverage have not materially changed. This coverage is known as “grandfathered health plan coverage.” However, Section 1251 of the ACA specifically applies certain provisions of the ACA from which such coverage would otherwise be exempt. Some of these provisions apply to all grandfathered health plans, while other provisions apply only to grandfathered group health insurance plans. To the extent provisions of the PHSA, ERISA and the Internal Revenue Code (IRC) do not apply as amended by the ACA to a grandfathered plan, the pre-ACA versions of those provisions will continue to apply. In general, grandfathered plans must also comply with all applicable state laws; the only express preemption provision in the ACA is the prohibition against states including grandfathered plans in the rating pool for non-grandfathered plans. The standards for grandfathered plans, including the requirements for maintaining grandfathered status, are found in the interim final regulations on grandfathered plans (26 CFR 54.9815-1251T, 29 CFR 2590.715-1251 and 45 CFR 147.140), as published in the *Federal Register* June 17, 2010. In particular, HIPAA portability and nondiscrimination requirements and GINA requirements applicable prior to the effective date of the ACA continue to apply to grandfathered health plan coverage. The following table lists the new health coverage reforms in part A of title XXVII of the PHSA, as amended by the ACA, which apply to grandfathered health plan coverage:

List of New Health Coverage Reform ACA Provisions That Apply to Grandfathered Health Plan Coverage

PHSA Statutory Provisions	Application to Grandfathered Health Plan Coverage
§ 2704 of the PHSA—Prohibition of preexisting condition exclusion or other discrimination based on health status.	Applicable to grandfathered group health plans and group health insurance coverage. Not applicable to grandfathered individual health insurance coverage.
§ 2708 of the PHSA—Excessive waiting periods.	Applicable to grandfathered group health plan coverage.
§ 2711 of the PHSA—No lifetime or annual limits.	Lifetime limits applicable to grandfathered health plan coverage. Annual limits applicable to grandfathered group health plans and group health insurance coverage; not applicable to grandfathered individual health insurance coverage.
§ 2712 of the PHSA—Prohibition on rescissions.	Applicable to grandfathered health plan coverage.
§ 2714 of the PHSA—Extension of dependent coverage until age 26.	Applicable to grandfathered health plan coverage. For a group health plan or group health insurance coverage that is a grandfathered health plan for plan years beginning before Jan. 1, 2014, §2714 of the PHSA is applicable in the case of an adult child only if the adult child is not eligible for other employer-based health plan coverage.
§ 2715 of the PHSA—Development and utilization of uniform explanation of coverage documents and standardized definitions.	Applicable to grandfathered health plan coverage.
§ 2718 of the PHSA—Bringing down the cost of health care coverage (for insured coverage).	Applicable to insured grandfathered health plan coverage.

Drafting Note: As noted in the drafting note above, some requirements of the PHSA, ERISA and IRC that were applicable prior to the enactment of the ACA continue to apply to grandfathered health plan coverage. As such, HIPAA portability and nondiscrimination requirements applicable to the individual market and GINA requirements applicable to the individual market prior to the effective date of the ACA continue to apply to grandfathered health plan coverage. States should be aware that this Act does not include many of these provisions, such as provisions related to crediting previous coverage for purposes of applying a preexisting condition exclusion period with respect to the small group market or provisions related to determining whether an individual can be treated as an “eligible individual” (or HIPAA-eligible) for purposes of qualifying for guaranteed issued coverage without the imposition of any preexisting condition exclusions with respect to the individual market. States will have to consider how they want to address this situation in retaining some provisions that continue to apply to grandfathered health plan coverage and enacting new provisions consistent with the requirements of the ACA that are applicable to health benefit plans beginning Jan. 1, 2014, in the individual and small group markets.

Section 5. Restrictions Relating to Premium Rates

- A.
 - (1) With respect to the premium rates charged by a health carrier offering a health benefit plan providing individual market health insurance coverage subject to this Act, the carrier shall develop its premium rates based on the following and vary the premium rates with respect to the particular plan or coverage only by:
 - (a) Whether the plan or coverage covers an individual or family;
 - (b) Geographic rating area, established in accordance with Section 2701(a)(2) of the PHSA;
 - (c) Age, except that the rate shall not vary by more than 3 to 1 for adults; and
 - (d) Tobacco use, except that the rate shall not vary by more than 1.5 to 1.
 - (2) A premium rate shall not vary with respect to any particular health benefit plan or individual market health insurance coverage by any other factor not described in Paragraph (1).
 - (3) With respect to family coverage under a health benefit plan providing individual market health insurance coverage, the rating variations permitted under Paragraph (1)(c) and (d) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan.
- B. The premium charged with respect to any particular health benefit plan or individual market health insurance coverage shall not be adjusted more frequently than annually except that the premium rates may be changed to reflect:
 - (1) Changes to the family composition of the policyholder;
 - (2) Changes in geographic rating area of the policyholder, as provided in Subsection A(1)(b);
 - (3) Changes in tobacco use, as provided in Subsection (A)(1)(d);
 - (4) Changes to the health benefit plan requested by the policyholder; or
 - (5) Other changes required by federal law or regulations or otherwise expressly permitted by state law.
- C. A health carrier shall consider all enrollees in all health benefit plans (other than grandfathered health plan coverage) offered by the carrier in the individual market, including those enrollees who do not enroll in such plans through an exchange, as established under Section 1311 of the Federal Act, to be members of a single risk pool.

Drafting Note: States should be aware that Section 1312(c)(3) of the Federal Act permits a state to merge its individual and small group health insurance markets. States should also be aware that Section 1312(c)(4) of the Federal Act prohibits states from requiring grandfathered health plan coverage to be included in the single risk pool for non-grandfathered health plan coverage.

Drafting Note: If the final ACA Health Insurance Market Reforms and Rate Review regulations determine to exempt student health insurance coverage from certain provisions of the federal regulations, States may wish to modify their requirements accordingly.

- D. The Commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by health carriers are consistent with the purposes of this Act.
- E. In connection with the offering for sale of individual market health insurance coverage under this Act, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:
 - (1) The provisions of the coverage concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates; and

Drafting Note: States should be aware that the requirement that health carriers disclose the information described in Paragraph (1) above is required under Section 2709 of the PHSA. However, States may not require that this information be provided in the summary of benefits and coverage (SBC) required under Section 2715 of the PHSA and the federal regulations implementing that section.

- (2) A listing of and descriptive information, including benefits and premiums, about all health benefit plans offered by the carrier that provide individual market health insurance coverage and the availability of the plans for which the individual is qualified.
- F.
 - (1) Each health carrier shall maintain at its principal place of business a complete and detailed description of its rating 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 health 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 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 carrier at its principal place of business.
 - (3)
 - (a) A health carrier shall make the information and documentation described in Paragraph (1) available to the Commissioner upon request.
 - (b) 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 of Insurance except as agreed to by the health carrier or as ordered by a court of competent jurisdiction.

Drafting Note: States should be aware that, with respect to the information and documentation described in Paragraph (1), certain provisions of the Federal Act or federal regulations or other federal law or state law or regulations may require the Department of Insurance to make public or share with other entities, such as health insurance exchanges or federal agencies.

Section 6. Guaranteed Availability of Individual Market Health Insurance Coverage

- A. Subject to Subsections B-E, each health carrier that offers a health benefit plan providing individual market health insurance coverage in this state shall issue any applicable health benefit plan to any eligible individual who 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.

- B. (1) A health carrier described under Subsection A may restrict enrollment in coverage described in Subsection A to open or special enrollment periods.
- (2) A health carrier described under Subsection A shall, in accordance with regulations established by the Secretary, establish special enrollment periods for qualifying events and as provided in Section 9B of this Act.
- C. (1) Subject to Paragraph (3), a health carrier with respect to coverage offered through a network plan shall not be required to offer coverage under that plan or accept applications for that plan pursuant to Subsection A in the case of the following:
 - (a) To an individual, when the individual does not live or reside within the carrier's established geographic service area for such network plan; or

Drafting Note: States should be aware that Section 2702 of the PHSA does not expressly provide, for network plans, an exception for guaranteed issue in the individual market for individuals who do not live or reside within the carrier's established geographic service area.

- (b) Within the geographic service area for such network plan where the 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 any additional individuals because of its obligations to existing enrollees.
- (2) A health carrier that cannot offer coverage pursuant to Paragraph (1)(b) may not offer coverage in the individual market in the applicable geographic service area to new individuals or to any enrollees 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.
- (3) A health carrier shall apply the provisions of this subsection uniformly to all individuals without regard to the claims experience of those individuals and their dependents or any health status-related factor relating to such individuals and their dependents.
- D. (1) A health carrier described under Subsection A shall not be required to provide coverage if:
 - (a) For any period of time the carrier demonstrates, and the Commissioner determines, the carrier does not have the financial reserves necessary to underwrite additional coverage; and
 - (b) The 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 the claims experience of an individual and their dependents or any health status-related factor relating to such individual and their dependents.
- (2) A health carrier that denies coverage in accordance with Paragraph (1) may not offer coverage in the individual market in this state for the later of:

- (a) A period of 180 days after the date the coverage is denied; or
- (b) Until the carrier has demonstrated to the Commissioner that it has sufficient financial reserves to underwrite additional coverage.

Drafting Note: States may apply the provisions of Paragraph (2) on a service-area-specific basis.

- E.
 - (1) This section shall not be construed to require a health carrier offering health benefit plans only in connection with group health plans to offer coverage in the individual market.
 - (2) This section shall not be construed to require that a health carrier offering health benefits plans only through one or more bona fide associations offer coverage in the individual market. However, if the health carrier offers health benefit plan bona fide association coverage in the individual market, the health carrier shall offer such coverage to eligible individuals in the individual market as required under Subsection A and consistent with the provisions of Section 3A of this Act.

Drafting Note: With respect to Paragraph (2), states should be aware that Section 2742(e)(1) of the PHSA, as enacted by HIPAA, provided an exception to guaranteed issue in the individual market for bona fide associations with respect to “eligible individuals” (as that term is defined in Section 2741(b) of the PHSA). With the enactment of the Federal Act and its guaranteed issue requirements under Section 2702 of the PHSA for the individual market, this exception for bona fide associations in Section 2742(e)(1) of the PHSA was effectively eliminated such that, beginning Jan. 1, 2014, bona fide associations that choose to participate in the individual market are subject to the guaranteed issue requirements of Section 2702 of the PHSA.

Drafting Note: States should be aware that, the proposed regulations issued by the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register*, Nov. 26, 2012, and as further described below in the drafting note, state that Section 2702 of the PHSA, as enacted by the ACA, does not include an explicit guaranteed availability exception allowing health carriers to limit the offering of certain plans to members of bona fide associations. As such, it appears, that, under the proposed rules, health carriers must offer plans to all individuals regardless of membership in the bona fide association. Therefore, given this provision in the proposed regulations, states may want to consider not addressing this issue in statute and consider, instead, addressing it by regulation after final regulations are issued on the subject. In addition, those states that may have existing laws on this issue related to bona fide associations may wish to review that language and consider repealing it until final regulations are issued.

- F. This section shall not be construed to require that a health carrier offering only student health insurance coverage to otherwise offer coverage in the individual market so long as the carrier is offering student health insurance coverage consistent with the provisions of Section 3MM of this Act.
- G. At the time of renewal, a health carrier may modify coverage under a health benefit plan offering individual market health insurance coverage so long as such modification is consistent with state law and effective on a uniform basis among all individuals with the health benefit plan.

Section 7. Guaranteed Renewability of Individual Market Health Insurance Coverage

- A. Except as provided in this section, a health carrier offering health benefit plans providing individual market health insurance coverage in this state subject to this Act shall renew or continue in force the coverage, at the option of the policyholder.
- B. A health carrier may not renew or discontinue coverage under a health benefit plan subject to this Act if:

- (1) The policyholder 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 policyholder or the policyholder'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) The carrier elects to cease offering individual market health insurance coverage in this state in accordance with Subsection D and other applicable state law;
- (4) In the case of a health carrier that offers coverage through a network plan, the policyholder no longer lives or resides within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to Section 6C(1)(b) of this Act;
- (5) The Commissioner:
 - (a) Finds that the continuation of the coverage would not be in the best interests of the covered persons or would impair the carrier's ability to meet its contractual obligations; and
 - (b) Assists affected covered persons in finding replacement coverage;
- (6) In the case of health benefit plans that are made available in the individual market only through one or more bona fide associations, the membership of a policyholder 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 covered person;
- (7) In the case of health benefit plans that are made available in the individual market as student health insurance coverage, the student policyholder covered under the coverage ceases to be a student at the institution of higher education through which the student health insurance coverage is offered, provided the coverage is terminated under this paragraph uniformly without regard to any health status-related factor related to any covered person; or
- (8) 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 this state's individual 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 policyholders; and

- (ii) The Commissioner in each state in which an affected policyholder 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 policyholders;
 - (c) Provides notice to each enrollee issued that particular type of health benefit plan (obsolete product form) that the policyholder has the option to purchase all other health benefit plans currently being offered by the carrier in the individual market in this 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) of this paragraph acts uniformly without regard to the claims experience of those covered persons or any other health status-related factor relating to any covered person who may become eligible for coverage.
- C. In any case in which a health carrier decides to discontinue offering a particular type of health benefit plan of individual market health insurance coverage, the health carrier may discontinue coverage in accordance with applicable state law only if the carrier:
 - (1) Provides advance notice of its decision under this subsection to the Commissioner in each state in which it is licensed;
 - (2) Provides notice of the decision not to renew coverage at least 90 days prior to the nonrenewal of the health benefit plan to:
 - (a) All affected policyholders; and
 - (b) The Commissioner in each state in which an affected policyholder is known to reside, 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 policyholders;
 - (3) Provides notice to each enrollee issued that particular type of health benefit plan that the policyholder has the option to purchase all other health benefit plans providing individual market health insurance coverage currently being offered by the carrier in this state; and
 - (4) In exercising this option to discontinue that particular type of health benefit plan and in offering the option of coverage pursuant to Paragraph (3) acts uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any policyholder or dependent of a policyholder or new policyholders and their dependents who may become eligible for coverage.
- D. (1) In any case in which a health carrier elects to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, in this state, the carrier may discontinue such coverage only in accordance with applicable state law and if:

- (a) The carrier 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 not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:
 - (i) All affected policyholders; and
 - (ii) The Commissioner in each state in which an affected policyholder 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 policyholders.
 - (2) In the case of a discontinuance under Paragraph (1), the health carrier shall be prohibited from writing new business in the market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.
 - (3) In the case of a discontinuance under Paragraph (1), the health carrier, as determined by the Commissioner, may renew its existing business in the market in this state or may be required to nonrenew all of its existing business in the market in this state.
- E. In the case of a health carrier doing business in one established geographic service area of the state, the provisions of this section shall apply only to the carrier's operations in that service area.

Section 8. Extension of Dependent Coverage

- A. A health carrier offering a health benefit plan providing individual market health insurance coverage that makes available dependent coverage of children shall make that coverage available for children until attainment of twenty-six (26) years of age.
- B.
 - (1) With respect to a child who has not attained twenty-six (26) years of age, a health carrier shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the policyholder.
 - (2)
 - (a) A health carrier shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on a factor, such as the presence or absence of the child's financial dependency upon the policyholder or any other person, residency with the policyholder or with any other person, marital status, student status, employment or any combination of those factors.
 - (b) In addition to Subparagraph (a) of this paragraph, a health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage.
- C. Nothing in this section shall be construed to require a health carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.
- D. The terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years

of age or older.

Drafting Note: For purposes of this section, there is no definition of “dependent”. Section 152(f)(1) of the Internal Revenue Code defines “child” as including only sons, daughters, stepchildren, adopted children, including children placed for adoption and foster children. Some states have defined “dependent” similarly, while others have not. In defining “dependent,” states should keep in mind that the intent of the ACA is to require the availability of dependent coverage of children until the child reaches age 26 and that coverage cannot be conditioned based on certain dependency factors, such support, residency, student status or marital status.

Section 9. Prohibition of Preexisting Condition Exclusions; Special Enrollment Periods

- A. Health carriers offering health benefit plans providing individual market health insurance coverage shall not impose any preexisting condition exclusion with respect to such coverage.
- B.
 - (1) A health carrier described in Subsection A that makes coverage available under a health benefit plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in Paragraph (2) during which the dependent in the case of the birth or adoption (or placement for adoption) of a child or the spouse of the individual, if the spouse is otherwise eligible for coverage, may be enrolled as a dependent of the individual.
 - (2) The special enrollment period for individuals that meet the provisions of Paragraph (1) shall be a period of not less than thirty (30) days and begins on the later of:
 - (a) The date dependent coverage is made available; or
 - (b) The date of the marriage, birth or adoption or placement for adoption described in Paragraph (1).
 - (3) If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under Paragraph (2), the coverage of the dependent shall be effective:
 - (a) 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;
 - (b) In the case of a dependent’s birth, as of the date of birth; and
 - (c) In the case of a dependent’s adoption or placement for adoption, the date of the adoption or placement for adoption.

Drafting Note: States should be aware that, in some cases, individuals having prior group health plan coverage may be eligible for special enrollment in a health benefit plan if the individual was under a COBRA continuation provision and the coverage under such provision was exhausted or the individual was not under a COBRA continuation provision, but the coverage was terminated as a result of a COBRA qualifying event resulting in the loss of eligibility of coverage, including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or employer contributions toward such coverage were terminated.

Section 10. Prohibition on Discrimination Based on Health Status; Genetic Testing

Drafting Note: This section is based, in part, on Section 2753 of the PHSA. Section 2753 of PHSA prohibits health discrimination on the basis of genetic information in the individual health insurance market, as provided in GINA. GINA was enacted prior to the ACA and the provisions of Section 2753 were not specifically supplanted by the ACA. GINA included certain provisions, however, that because of ACA provisions related to premium rating restrictions, as reflected in Section 5 of this Act and a prohibition on preexisting condition exclusion periods, as reflected in Section 9 of this Act, are no longer permitted beginning Jan. 1, 2014. Given this, those provisions permitting the use of health status as a rating factor and the imposition of preexisting condition exclusion periods, are not included in this section. In addition, the definition of “underwriting purposes” in Section 3LL of this Act is broad enough to include the application of any preexisting condition exclusion, when those exclusions are permitted. As noted in Section 4 of this Act, states should be aware that those provisions could continue to apply to grandfathered health plan coverage.

- A. A health carrier offering health benefit plans providing individual market health insurance coverage in this state shall not establish rules for eligibility, including continuing eligibility, of any individual to enroll under the terms of coverage based on any health status-related factor in relation to the individual or dependent of the individual.
- B.
 - (1) A health carrier described in Subsection A shall not require any individual as a condition of enrollment or continued enrollment under a health benefit plan to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the bases of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.
 - (2) Nothing in Paragraph (1) may be construed to restrict the amount that an individual may be charged for individual market health insurance coverage.

Drafting Note: Section 2705(1) of the PHSA authorizes the Secretary to establish a 10-state demonstration project under which participating states shall apply the provisions of Section 2705(j) of the PHSA to programs of health promotion offered by a health carrier that offers health insurance coverage in the individual market in such state. If a state chooses to participate in the demonstration project, then it should revise Paragraph (2) above as follows:

- (2) Nothing in Paragraph (1) may be construed to:
 - (a) Restrict the amount that an individual may be charged for coverage under the plan; or
 - (b) Prevent the health carrier from establishing premium discounts or rebates or modifying otherwise applicable copayment amounts or deductibles in return for adherence to programs of health promotion and disease prevention, as provided in Section 2705(l) of the PHSA.
- C. A health carrier offering health benefit plans providing individual market health insurance coverage in this state shall not establish rules for the eligibility, including continued eligibility, of any individual to enroll for coverage under an individual health benefit plan based on genetic information.
- D. A health carrier offering health benefit plans providing individual market health insurance coverage shall not adjust premium or contribution amounts for an individual on the basis of genetic information concerning the individual or a family member of the individual.

- E. A health carrier offering health benefit plans providing individual market health insurance coverage shall not on the basis of genetic information impose any preexisting condition exclusion with respect to coverage under the plan.

- F.
 - (1) A health carrier offering health benefit plans providing individual market health insurance coverage shall not request or require an individual or a family member of an individual to undergo a genetic test.

 - (2) Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test.

 - (3)
 - (a) Nothing in Paragraph (1) shall be construed to preclude the health carrier from obtaining and using the results of a genetic test in making a determination regarding payment (as that term is defined for purposes of applying the regulations promulgated by the Secretary under part C of title XI of the Social Security Act and Section 264 of HIPAA, as may be revised from time to time) consistent with Subsections C and E.

 - (b) For purposes of Subparagraph (a) of this paragraph, the health carrier may request only the minimum amount of information necessary to accomplish the intended purpose.

 - (4) Notwithstanding Paragraph (1), the health carrier may request, but not require, that an individual or a family member of the individual undergo a genetic test if each of the following conditions is met:
 - (a) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations or equivalent federal regulations and any applicable state or local law or regulations for the protection of human subjects in research;

 - (b) The carrier clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:
 - (i) Compliance with the request is voluntary; and

 - (ii) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

 - (c) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes;

 - (d) The carrier notifies the Secretary in writing that the carrier is conducting activities pursuant to the exception provided in this paragraph, including a description of the activities conducted; and

 - (e) The carrier complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

- G.
 - (1) A health carrier offering health benefit plans providing individual market health insurance coverage shall not request, require or purchase genetic information for underwriting purposes.
 - (2) A health carrier offering health benefit plans providing individual market health insurance coverage shall not request, require or purchase genetic information with respect to any individual prior to the individual's enrollment under the plan in connection with such enrollment.
 - (3) If the health carrier obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning any individual, such request, requirement or purchase shall not be considered a violation of Paragraph (2) if such request, requirement or purchase is not in violation of Paragraph (1).
- H. Any reference in this section to genetic information concerning an individual or family member of an individual shall:
 - (1) With respect to the individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by the pregnant woman; and
 - (2) With respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

Section 11. Prohibition on Lifetime and Annual Limits

- A.
 - (1) Except as provided in Subsection B, health carriers offering health benefit plans providing individual market health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any individual.
 - (2)
 - (a) Except as provided in Subparagraph (b) of this paragraph and Subsections B and C, a health carrier shall not establish any annual limit on the dollar amount of essential health benefits for any individual.
 - (b) A health flexible spending arrangement (FSA), as defined in Section 106(c)(2) of the Internal Revenue Code, a medical savings account (MSA), as defined in Section 220 of the Internal Revenue Code, and a health savings account (HSA), as defined in Section 223 of the Internal Revenue Code are not subject to the requirements of Subparagraph (a) of this paragraph.
- B. The provisions of Subsection A shall not prevent a health carrier from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.
- C. Nothing in this section prohibits a health carrier from excluding all benefits for a given condition, as otherwise permitted under federal or state law.

Section 12. Prohibition on Rescissions of Coverage

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

Drafting Note: States should be aware that Sections 9 and 10 of the NAIC Utilization Review and Benefit Determination Model Act include language describing what should be included in an advance notice of a rescission that is considered an adverse determination.

- C. The provisions of this section apply regardless of any applicable contestability period.

Section 13. Comprehensive Health Insurance Coverage Requirements

- A. (1) Health carriers offering health benefit plans providing individual market health insurance coverage shall ensure that such coverage includes the essential health benefits package required under Section 1302(a) of the Federal Act, as described in Paragraph (2) of this subsection.
- (2) For purposes of this subsection, “essential health benefits package” means coverage that:
 - (a) Provides for the essential health benefits, as defined in section 3K of this Act;
 - (b) Limits cost-sharing for such coverage in accordance with section 1302(c) of the Federal Act, as described in Subsection B; and
 - (c) Subject to Subsection C, provides bronze, silver, gold or platinum level of coverage described in Section 1302(d) of the Federal Act as follows:
 - (i) **Bronze level.** A health benefit plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan;

- (ii) Silver level. A health benefit plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan;
 - (iii) Gold level. A health benefit plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan; and
 - (iv) Platinum level. A health benefit plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.
- B. If a health carrier offers health insurance coverage in any level of coverage specified under Section 1302(d) of the Federal Act, as described in Subsection A(2)(c) above, the carrier shall also offer such coverage in that level as a health benefit plan in which the only enrollees are individuals who, as of the beginning of a policy year, have not attained the age of 21 years.
- C. A health benefit plan not providing a bronze, silver, gold or platinum level of coverage, as described in Subsection A(2)(c) above, shall be treated as meeting the requirements of Section 1302(d) of the Federal Act with respect to any policy year if it provides a catastrophic plan that meets the requirements of Section 1302(e) of the Federal Act.
- D. This section shall not apply to a dental plan described in Section 1311(d)(2)(B)(ii) of the Federal Act.

Section 14. Coverage of Preventive Health Services

- A. (1) A health carrier offering health benefit plans providing individual market health insurance coverage shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:
 - (a) Except as otherwise provided in Subsection B, evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

Drafting Note: The items and services referenced in subparagraph (a) above can be found at this link:

<http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>. States should be aware that these items and services could change over time.

- (b) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a

recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

Drafting Note: The recommended immunizations for children, adolescents and adults referenced in Subparagraph (b) above can be found at this link: <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>.

- (c) With respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

Drafting Note: The comprehensive guidelines referenced in Subparagraph (c) above can be found at this link: <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>.

- (d) With respect to women, to the extent not described in Paragraph (1), evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Drafting Note: The comprehensive guidelines referenced in Subparagraph (d) above can be found at this link: <http://www.hrsa.gov/womensguidelines>.

- (2)
 - (a)
 - (i) A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in Paragraph (1) after the recommendation or guideline is no longer described in Paragraph (1).
 - (ii) Other provisions of state or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including Section 2715(d)(4) of the Public Health Service Act, which requires a health carrier to give sixty (60) days advance notice to an enrollee before any material modification will become effective.
 - (b) For purposes of Paragraph (1) and for purpose of any other provision of law, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.
 - (c) A health carrier shall, for policy years that begin on or after the date that is one year after the recommendation or guideline is issued, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

Drafting Note: This website: <http://www.HealthCare.gov/center/regulations/prevention.html> is provided in the interim final regulations published in the *Federal Register* July 19, 2010, which health carriers can visit once a year to find information necessary to determine any additional items or services that must be covered without cost-sharing requirements or to determine any items or services that are no longer required to be covered.

- B.
 - (1) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is billed separately or is tracked as individual encounter data separately from the office visit.
 - (2) A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.
 - (3) A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in Subsection A is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.
 - (4) Notwithstanding the requirements of this section, student administrative health fees are not considered cost-sharing requirements with respect to specified recommended preventive services.
- C.
 - (1) Nothing in this section requires a health carrier that has a network of providers to provide benefits for items and services described in Subsection A that are delivered by an out-of-network provider.
 - (2) Nothing in Subsection A precludes a health carrier that has a network of providers from imposing cost-sharing requirements for items or services described in Subsection A that are delivered by an out-of-network provider.
- D. Nothing prevents a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in Subsection A to the extent not specified in the recommendation or guideline.
- E. Nothing in this section prohibits a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health carrier may impose cost-sharing requirements for a treatment not described in Subsection A even if the treatment results from an item or service described in Subsection A.

Drafting Note: States should be aware that, under Section 2713(c) of the PHSA, the Secretary is given the discretionary authority to develop guidelines that would permit health carriers offering health benefit plans providing individual market health insurance coverage to utilize value-based insurance designs. If the Secretary develops such guidelines, the language in this section may have to be revised.

Section 15. Coverage for Participation in Approved Clinical Trials

- A. As used in this section, the following definitions apply:
 - (1) “Approved clinical trial” means a phase I, a phase II, a phase III or a phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology and the trial must be:

- (a) Conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);
- (b) Exempt from obtaining an investigational new drug application; or
- (c) Approved or funded by:
 - (i) The National Institutes of Health, the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid Services or a cooperative group or center of any of the entities described in this item;
 - (ii) A cooperative group or center of the U.S. Department of Defense or the U.S. Department of Veterans Affairs;
 - (iii) A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - (iv) The U.S. Departments of Veterans Affairs, Defense or Energy if the trial has been reviewed or approved through a system of peer review determined by the Secretary to:
 - (I) Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
 - (II) Provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.
- (2) “Life-threatening condition” means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- (3) “Qualified individual” means an individual with individual market health insurance coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life threatening condition because:
 - (a) The referring health care professional is participating in the trial and has concluded that the individual’s participation in the trial would be appropriate; or
 - (b) The individual provides medical and scientific information establishing that the individual’s participation in the trial is appropriate because the individual meets the conditions described in the trial protocol.
- (4) (a) “Routine patient costs” include all items and services covered by the health benefit plan of individual market health insurance coverage when the items or services are typically covered for an enrollee who is not a qualified individual enrolled in an approved clinical trial.
- (b) “Routine patient costs” do not include:

- (i) An investigational item, device or service that is part of the trial;
 - (ii) An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or services is not used in the direct clinical management of the patient;
 - (iii) A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or
 - (iv) An item or service customarily provided and paid for by the sponsor of a trial.
- B. A health carrier that offers a health benefit plan providing individual market health insurance coverage in this state may not:
 - (1) Deny participation by a qualified individual in an approved clinical trial;
 - (2) Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or
 - (3) Discriminate against an individual on the basis of the individual's participation in an approved clinical trial.
- C. A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.
- D. This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted outside of this state.
- E. This section shall not be construed to require a health carrier offering individual market health insurance coverage through a network plan to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.
- F. Nothing in this section shall be construed to limit a health carrier's coverage with respect to clinical trials.

Section 16. Choice of Health Care Professional; Access to Pediatric and Obstetrical and Gynecological Care Requirements

- A.
 - (1) (a) If a health carrier offering individual market health insurance coverage under a health benefit plan requires or provides for the designation by a covered person of a participating primary health care professional, the health carrier shall permit each covered person to:
 - (i) Designate any participating primary care health care professional who is available to accept the covered person; and

- (ii) For a child, designate any participating physician who specializes in pediatrics as the child's primary care health care professional and is available to accept the child.
 - (b) The provisions of Subparagraph (a)(ii) shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.
 - (2) (a) If a health carrier provides coverage for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier:
 - (i) Shall not require any covered person's, including a primary care health care professional's authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology; and
 - (ii) Shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to item (i), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.
 - (b) (i) The health carrier may require the health care professional to agree to otherwise adhere to the health carrier's policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier.
 - (ii) For purposes of item (i), a health care professional, who specializes in obstetrics or gynecology, means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care.
 - (c) The provisions of Subparagraph (b)(i) shall not be construed to:
 - (i) Waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care; or
 - (ii) Preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.
- B. (1) A health carrier shall provide notice to covered persons of the terms and conditions of the health benefit plan related to the designation of a participating health care professional provided in Subsection A and of a covered person's rights with respect to those provisions.

- (2) The notice described in Paragraph (1) shall be included whenever the health carrier provides a policyholder with a summary plan description or other similar description of benefits under the health benefit plan.

Section 17. Provision of Summary of Benefits and Coverage Explanation

- A. Health carriers offering health benefit plans providing individual market health insurance coverage shall provide a summary of benefits and coverage explanation pursuant to the standards adopted by the Secretary under Section 2715(a) of the PHSA to:
 - (1) An applicant at the time of application;
 - (2) An enrollee prior to the time of enrollment or reenrollment, as applicable; and
 - (3) A policyholder at the time of issuance of the policy.
- B. A health carrier described in Subsection A shall be deemed to have complied with Subsection A if the summary of benefits and coverage described in Section 2715(a) of the PHSA is provided in paper or electronic form, in accordance with the standards adopted by the Secretary under Section 2715(d) of the PHSA.
- C. Except in connection with a policy renewal or reissuance, if a health carrier makes any material modifications in any of the terms of the coverage, as defined for purposes of Section 102 of ERISA, that is not reflected in the most recently provided summary of benefits and coverage, the carrier shall provide notice of the modification to covered persons not later than sixty (60) days prior to the date on which the modification will become effective.

Drafting Note: Under Section 2715(f) of the PHSA, a health carrier that willfully fails to provide the information required under Section 2715 of the PHSA is subject to a federal civil penalty of not more than \$1,000 for each such failure. In addition, Section 2715(f) of the PHSA provides that such failure with respect to each covered person shall constitute a separate offense.

Drafting Note: The language of this section reflects the provisions of Section 2715 of the PHSA. Regulations issued by the Secretary related to Section 2715 of the PHSA provide more specific information and requirements not reflected in this section. The NAIC, through the work of the Regulatory Framework (B) Task Force, anticipates developing a model regulation as a companion to this Act, which will reflect the more specific information and requirements provided in the federal regulation.

Section 18. Certification of Creditable Coverage

- A. Health carriers offering health benefit plans providing individual market health insurance coverage 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; and
 - (2) 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 Subparagraph (a) or (b), whichever is later.
- C. The certification described in this subsection is a written certification of:

- (1) The period of creditable coverage of the individual under the health benefit plan; and
- (2) The waiting period, if any, and affiliation period, if applicable, imposed on the individual for any coverage under the health benefit plan.

Drafting Note: Federal regulations issued pursuant to Section 2704(e) of the PHSA include additional information that must be included in a certificate of creditable coverage. The NAIC, through the work of the Regulatory Framework (B) Task Force, anticipates developing a model regulation as a companion to this Act, which will reflect the more specific information and requirements provided in the federal regulation.

Section 19. Standards to Assure Fair Marketing

- A. Subject to Section 6A of this Act, each health carrier providing individual market health insurance coverage shall actively market all health benefit plans sold by the carrier to eligible individuals in this state.
- B.
 - (1) Except as provided in Paragraph (2), a health carrier or a producer shall not, directly or indirectly, engage in the following activities:
 - (a) Encourage or direct individuals to refrain from filing an application for coverage with the carrier because of any health status-related factor or because of the industry, occupation or geographic location of the individual;
 - (b) Encourage or direct individuals to seek coverage from another carrier because of any health status-related factor or because of the industry, occupation or geographic location of the individual.
 - (2) The provisions of Paragraph (1) shall not apply with respect to information provided by a health carrier or producer to an individual regarding the established geographic service area or a restricted network provision of a health carrier.
- C.
 - (1) Except as provided in Paragraph (2), a health carrier shall not, 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 individual or the individual's dependents.
 - (2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer that does not vary because of any health status-related factor, industry, occupation or geographic area of the individual or the individual's dependents.
- D. A health carrier shall not 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 any individual or the individual's dependents placed by the producer with the carrier.
- E. Denial by a health carrier of an application for coverage from an individual shall be in writing or electronically provided and shall state the reason or reasons for the denial. Nothing in this subsection allows any denial by a health carrier that is not in compliance with Sections 6 and 7 of this Act.

- F. The Commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans providing individual market health insurance coverage to individuals in this state.
- G.
 - (1) A violation of this section by a health 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 health 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 providing individual market health insurance coverage in this state, the third-party administrator shall be subject to this section as if it were a health carrier.

Drafting Note: States should be aware that the provisions of Section 19 of this Act are subject to change depending on whether federal regulations or guidance are issued on the topic.

Section 20. Quality of Care Reporting Requirements

- A.
 - (1) Health carriers offering health benefit plans providing individual market health insurance coverage in this state shall annually submit to the Secretary and the commissioner in each state the carrier is licensed and to policyholders under the coverage, a report on whether the benefits under the coverage satisfy the elements described in Subsection B.
 - (2) The report required under Paragraph (1) shall be made available to each policyholder under the coverage during each open enrollment period.
- B.
 - (1) For purposes of Subsection A, using the reporting requirements developed by the Secretary, a health carrier shall report on coverage benefits and health care provider reimbursement structures that:
 - (a) Improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model, as defined for purposes of Section 3602 of the Federal Act, for treatment or services under the coverage;
 - (b) Implement activities that prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement by an appropriate health care professional;
 - (c) Implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology under the coverage; and
 - (d) Implement wellness and health promotion activities.

- (2) For purposes of Paragraph (1)(d), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:
 - (a) Smoking cessation;
 - (b) Weight management;
 - (c) Stress management;
 - (d) Physical fitness;
 - (e) Nutrition;
 - (f) Heart disease prevention;
 - (g) Healthy lifestyle support; and
 - (h) Diabetes prevention.

Section 21. Risk Adjustment Mechanism

The Commissioner may establish an assessment and payment mechanism for health carriers providing individual market health insurance coverage to adjust for actuarial risk that is consistent with the criteria and methods developed by the Secretary in accordance with Section 1343(b) of the Federal Act.

Drafting Note: States should be aware that, in guidance issued by the U.S. Department of Health and Human Services (HHS), HHS indicated that it would operate the risk adjustment program in those states that do not establish a State-based Exchange (SBE).

Section 22. Regulations

The Commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 23. Severability

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 24. Effective Date

This Act shall be effective on [insert date].

Public Health Service Act sections:

- § 2701 PHSA—Fair health insurance premiums
 - § 2702 PHSA—Guaranteed availability of coverage
 - § 2703 PHSA—Guaranteed renewability of coverage
 - § 2704 PHSA—Prohibition on preexisting condition exclusions or other discrimination based on health status
 - § 2705 PHSA—Prohibiting discrimination against individual participants and beneficiaries based on health status
 - § 2706 PHSA—Non-discrimination in health care
 - § 2707 PHSA—Comprehensive health insurance coverage
 - § 2708 PHSA—Prohibition on excessive waiting periods
 - § 2709 PHSA—Coverage for individuals participating in approved clinical trials
 - § 2709 PHSA—Disclosure of Information
 - § 2711 PHSA—No lifetime or annual limits
 - § 2712 PHSA—Prohibition on rescissions
 - § 2713 PHSA—Coverage of preventive health services
 - § 2714 PHSA—Extension of dependent coverage
 - § 2715 PHSA—Development and utilization of uniform explanation of coverage documents and standardized definitions
 - § 2716 PHSA—Prohibition on discrimination in favor of highly compensated individuals
 - § 2717 PHSA—Ensuring the quality of care
 - § 2719A PHSA—Patient Protections
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Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

2013 Proc. 1st Quarter 107-110, 121, 127, 184-214, 258, 590 (adopted).