

NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

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Section 1. Title

This regulation shall be known and may be cited as the Nondiscrimination in Health Insurance Coverage in the Group Market Model Regulation.

Section 2. Purpose

The purpose of this regulation is to incorporate the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and federal regulations that prohibit carriers providing health insurance coverage under a health benefit plan in the group market from discriminating against individual participants or beneficiaries in these plans with respect to plan eligibility and in setting premium and contribution rates based on any health factor of the participants or beneficiaries.

Section 3. Definitions

As used in this regulation:

- A. "Affiliation period" means a period of time that must expire before health insurance coverage provided by a carrier becomes effective, and during which the carrier is not required to provide benefits.
- B. "Beneficiary" has the meaning stated in Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA).
- C. "Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. For the purposes of this regulation, carrier includes a sickness and accident insurance company, a nonprofit hospital and health service corporation, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Drafting Note: HIPAA uses the term "health insurance issuer" instead of "carrier." The definition of "health insurance issuer" contained in HIPAA is consistent with the term "carrier," as defined in Subsection C of this section.

- D. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Where the word “commissioner” appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. Where jurisdiction of managed care organizations lies with some other state agency, or dual regulation occurs, a state should add additional language referencing that agency to ensure the appropriate coordination of responsibilities.

- E. (1) “Creditable coverage” means, with respect to an individual, health benefits or coverage provided under any of the following:
- (a) A group health plan;
 - (b) A health benefit plan;
 - (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines);
 - (e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents). For purposes of Chapter 55 of Title 10, U.S.C., “uniformed services” means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service);
 - (f) A medical care program of the Indian Health Service or of a tribal organization;
 - (g) A state health benefits risk pool;
 - (h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Program (FEHBP));
 - (i) A public health plan, which for purposes of this regulation, means a plan established or maintained by a state, county, or other political subdivision of a state that provides health insurance coverage to individuals enrolled in the plan; or
 - (j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).
- (2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

Drafting Note: States may wish to grant the commissioner rulemaking authority to further define the coverage that falls within the definition above. However, the commissioner’s authority is limited by the requirements of HIPAA with respect to creditable coverage. The definition of “creditable coverage” is governed by HIPAA’s preemption rule relating to state provisions addressing preexisting conditions, which is more stringent than the general preemption test under HIPAA. State provisions relating to preexisting conditions are preempted if they differ from the requirements of HIPAA, unless the state provision falls into one of seven explicit exceptions. However, one of these seven exceptions is broad and permits a state requirement to stand if the requirement “prohibits the imposition of any preexisting condition exclusion in cases not described in Section 2701(d) or expands the exceptions described in such section.” PHSA Section 2723(b)(2)(v). The language of this section permits states to continue to prohibit preexisting condition exclusions in a number of situations not specifically addressed by HIPAA.

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

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

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

Drafting Note: If using the suggested definition above, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child above is not intended to be limited to natural children of the participant.

- G. “Enrollment date” means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever is earlier.
- H. (1) “Genetic information” means information about genes, gene products and inherited characteristics that may derive from the individual or a family member.
- (2) “Genetic information” includes information regarding an individual’s carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.
- I. (1) “Group health plan” means an employee welfare benefit plan, as defined in Section 3(1) of ERISA, to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
- (2) For purposes of this regulation:
- (a) Any plan, fund or program that would not be, but for PHSA Section 2721(e), as added by Pub. L. No. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to Subparagraph (b) of this paragraph, as an employee welfare benefit plan that is a group health plan;
- (b) In the case of a group health plan, the term “employer” also includes the partnership in relation to any partner; and
- (c) In the case of a group health plan, the term “participant,” as defined in Subsection P, also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual’s beneficiary who is, or may become, eligible to receive a benefit under the plan, if:
- (i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership; or

- (ii) In connection with a group health plan maintained by a self-employed individual, under which, one or more employees are participants, the individual is the self-employed individual.

Drafting Note: Paragraph (1) of the definition of “group health plan” tracks the federal definition of “group health plan” found in PHSA Section 2791(a)(1), as amended by HIPAA. However, the federal law’s definition of “group health plan” also defines “medical care” as part of the definition of “group health plan.” In this model regulation, the definition of “medical care” is separate from the definition of “group health plan” and is found in Subsection N of this section. The definition of “group health plan” in this model also differs from the federal definition in that it contains Paragraph (2), which tracks the language of PHSA Section 2721(e), as amended by HIPAA, addressing the treatment of partnerships.

- J.
 - (1) “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
 - (2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

Drafting Note: HIPAA uses the term “health insurance coverage.” “Health benefit plan,” as defined in this model regulation, is intended to be consistent with the definition of “health insurance coverage” contained in HIPAA. Paragraphs (3), (4), (5), and (6) below track the language of HIPAA that addresses “excepted benefits,” i.e., those benefits that are excepted from the requirements of HIPAA.

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

- (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (5) “Health benefit plan” shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under a 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 a group health plan maintained by the same plan sponsor:
 - (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (6) “Health benefit plan” shall not include the following if offered as a separate policy, certificate or contract of insurance:
 - (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- K. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a medical condition, illness, injury or disease.
- L. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.
- M. (1) “Health factor” means, in relation to an individual, any of the following health status-related factors:
 - (a) Health status;
 - (b) Medical condition, including both physical and mental illnesses, as defined in Subsection O;
 - (c) Claims experience;
 - (d) Receipt of health care;
 - (e) Medical history;
 - (f) Genetic information;

- (g) Evidence of insurability, including:
 - (i) Conditions arising out of acts of domestic violence; or
 - (ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or
 - (h) Disability.
- (2) For purposes of this subsection, “health factor” does not include the decision whether to elect health insurance coverage, including the time chosen to enroll, such as under special enrollment or late enrollment.

Drafting Note: This definition tracks the language contained in PHSA Section 2702(a), as amended by HIPAA, and federal final interim regulations.

- N. “Medical care” means amounts paid for:
- (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and
 - (3) Insurance covering medical care referred to in Paragraphs (1) and (2).
- O. (1) “Medical condition” means any condition, whether physical or mental, including any condition resulting from illness, injury, accident, pregnancy or congenital malformation.
- (2) For purposes of Paragraph (1), genetic information is not a condition.
- P. “Participant” has the meaning stated in Section 3(7) of ERISA.
- Q. (1) “Preexisting condition” means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage.
- (2) “Preexisting condition” shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the health benefit plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.
- (3) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.
- R. “Significant break in coverage” means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

- S. “Waiting period” means, with respect to a health benefit plan and an individual, who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to Subsection E(2), a waiting period shall not be considered a gap in coverage.

Section 4. Applicability and Scope

This regulation shall apply to any carrier that provides coverage under a health benefit plan in the group market.

Section 5. Prohibited Discrimination in Rules for Eligibility

- A. A carrier subject to this regulation shall not establish a rule for eligibility, including continued eligibility, of an individual to enroll for benefits under the plan that discriminates based on any health factor that relates to the individual or dependent of the individual.
- B. For purposes of this section, rules of eligibility include rules relating to:
 - (1) Enrollment;
 - (2) The effective date of coverage;
 - (3) Waiting or affiliation periods;
 - (4) Late and special enrollment;
 - (5) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;
 - (6) Benefits, including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Section 7A and B of this regulation;
 - (7) Continued eligibility; and
 - (8) Terminating coverage, including disenrollment, of an individual under the plan.
- C. Nothing in this section prohibits a carrier subject to this regulation from:
 - (1) Establishing more favorable rules of eligibility for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor; or
 - (2) Subject to state law, charging a higher premium or contribution with respect to an individual with an adverse health factor if the individual would not be eligible for coverage, but for the adverse health factor.

Section 6. Prohibited Discrimination in Premium and Contribution Rates

- A. (1) A carrier subject to this regulation shall not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution rate that is greater than the premium or contribution rate for a similarly situated individual enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.
- (2) In determining an individual's premium or contribution rate, discounts, rebates, payments-in-kind and any other premium differential mechanisms shall be taken into account.
- B. (1) Subject to Paragraph (2), nothing in this section restricts the aggregate amount that a carrier subject to this regulation may charge an employer for coverage under a plan.
- (2) A carrier subject to this regulation shall not quote or charge an employer or an individual participant or beneficiary a different premium than that quoted or charged an individual in a group of similarly situated individuals based on a health factor unless permitted under Section 5C(2) of this regulation or Subsection D of this section.
- C. Notwithstanding Subsections A and B, a carrier subject to this regulation may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.
- D. Nothing in this section prohibits a carrier subject to this regulation from charging an individual a premium or contribution rate that is less than the premium or contribution rate for similarly situated individuals if the lower charge is based on an adverse health factor of the individual, such as a disability.

Section 7. Application of Section 5 to Plan Benefits; Preexisting Condition Exclusions; Similarly Situated Individuals

- A. (1) Subject to Paragraph (2), Section 5 of this regulation does not require a carrier subject to this regulation to provide coverage for any particular benefit to any group of similarly situated individuals.
- (2) (a) A carrier subject to this regulation shall make the benefits provided under a plan available uniformly to all similarly situated individuals, as those groups are determined under Subsection C.
- (b) For any restriction on a benefit or benefits provided under a plan, a carrier subject to this regulation:
 - (i) Shall apply the restriction uniformly to all similarly situated individuals; and
 - (ii) Shall not direct the restriction, as determined based on all of the relevant facts and circumstances, at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

- (c) A carrier subject to this regulation may impose annual, lifetime or other limits on benefits and may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the limit or cost-sharing requirement:
 - (i) Applies uniformly to all similarly situated individuals; and
 - (ii) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.
 - (d) For purposes of this paragraph, a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.
 - (3) If a carrier subject to this regulation generally provides benefits for a type of injury, the plan or carrier shall not deny an individual participant or beneficiary benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition.
 - (4) A carrier subject to this regulation with a cost-sharing mechanism, such as a deductible, copayment or coinsurance, that requires a higher payment from an individual, based on a health factor of that individual or dependent of that individual, than for a similarly situated individual under the plan, does not violate this subsection if the payment differential is based on whether the individual has complied with the requirements of a bona fide wellness program.
- B.
 - (1) Section 5 of this regulation does not prohibit a carrier subject to this regulation from imposing a preexisting condition exclusion period if the preexisting exclusion period:
 - (a) Complies with the requirements for imposing a preexisting condition exclusion period established by federal regulation;
 - (b) Is applied uniformly to all similarly situated individuals, as those groups are determined under Subsection C; and
 - (c) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.
 - (2) For purposes of this subsection, a plan amendment relating to a preexisting condition exclusion that is applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.
- C.
 - (1) This subsection applies only within a group of individuals who are treated as similarly situated individuals.

- (2) (a) Subject to Paragraph (4) of this subsection, Section 5 of this regulation does not prohibit a carrier subject to this regulation from treating participants as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among groups of participants is based on a bona fide employment-based classification that is consistent with the employer's usual business practice.
 - (b)
 - (i) Whether an employment-based classification is bona fide shall be determined based on all of the relevant facts and circumstances.
 - (ii) For purposes of Item (i), relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage, such classifications may include:
 - (I) Full-time versus part-time status;
 - (II) Geographic location;
 - (III) Membership in a collective bargaining unit;
 - (IV) Date of hire;
 - (V) Length of service;
 - (VI) Current employee versus former employee status; and
 - (VII) Occupation.
 - (iii) A classification based on a health factor shall not be determined to be a bona fide employment-based classification for purposes of this subsection unless the requirements of Section 5C and Section 6D of this regulation are satisfied.
- (3) (a) Subject to Paragraph (4), Section 5 of this regulation does not prohibit a carrier subject to this regulation from treating beneficiaries as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among the groups of beneficiaries is based on any of the following factors:
 - (i) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;
 - (ii) Relationship to the participant (e.g., as a spouse or as a dependent child);
 - (iii) Marital status;
 - (iv) With respect to a child of the participant, age or student status; or

- (v) Any other factor, if the factor is not a health factor.
- (b) Subparagraph (a) of this paragraph shall not be construed to prevent a carrier subject to this regulation from providing more favorable treatment of individuals under the plan with adverse health factors in accordance with Section 5C and Section 6D of this regulation.
- (4) Notwithstanding Paragraphs (2) and (3), unless permitted under Section 5C or Section 6D of this regulation, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on a health factor of the participants or beneficiaries, the classification is not permitted under this subsection.

Section 8. Application of Sections 5 and 6 to Nonconfinement and Actively-at-Work Provisions

- A. Except to the extent permitted under Subsection B(2) or Subsection C, in accordance with Sections 5 and 6 of this regulation, a carrier subject to this regulation shall not establish a rule of eligibility or set an individual's premium or contribution rate based on:
 - (1) Whether the individual is confined in a hospital or other health care institution; or
 - (2) The individual's ability to engage in normal life activities.
- B.
 - (1) In accordance with Sections 5 and 6 of this regulation, a carrier subject to this regulation shall not establish a rule for eligibility or set an individual's premium or contribution rate based on whether the individual is actively-at-work, including whether an individual is continuously employed, unless absence from work due to any health factor is treated, for purposes of the plan, as being actively-at-work.
 - (2) Notwithstanding Paragraph (1), a carrier subject to this regulation may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before coverage under the plan becomes effective if the rule for eligibility applies regardless of the reasons for the absence.
- C. Notwithstanding Subsections A and B, a carrier subject to this regulation may establish a rule of eligibility or set an individual's premium or contribution rate with respect to similarly situated individuals, as those groups are determined under Section 7C of this regulation.

Section 9. Enforcement

- A. The commissioner shall conduct a reasonable investigation based on a complaint [add any means by which the commissioner receives complaints] received by the commissioner and issue a prompt determination as to whether a violation of this regulation may have occurred.
- B. If the commissioner finds from the investigation that a violation of this regulation may have occurred, the commissioner shall promptly begin an adjudicatory proceeding.
- C. The commissioner may address a violation of this regulation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive

relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these.

- D. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

Drafting Note: States may wish to delete this section if the substance of it already exists in state law.

Section 10. Effective Date

This regulation shall be effective on [insert date].

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

2002 Proc.1st Quarter 13, 14, 177, 184, 211-218 (adopted).