

SMALL GROUP MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION

Section 1.	Statement of Purpose
Section 2.	Definitions
Section 3.	Applicability and Scope
Section 4.	Restrictions Relating to Premium Rates
Section 5.	Single Risk Pool
Section 6.	Guaranteed Availability of Small Group Market Health Insurance Coverage; Enrollment Periods
Section 7.	Guaranteed Renewability of Small Group Market Health Insurance Coverage
Section 8.	Prohibition on Waiting Periods Exceeding Ninety (90) Days
Section 9.	Prohibition on Preexisting Condition Exclusions
Section 10.	Prohibition on Discrimination Based on Health Factors
Section 11.	Essential Health Benefits Package
Section 12.	Parity in Mental Health and Substance Use Disorder Benefits
Section 13.	Prescription Drug Benefits
Section 14.	Prohibition on Discrimination in Providing Essential Health Benefits
Section 15.	Cost-Sharing Requirements
Section 16.	Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage
Section 17.	Provision of Summary of Benefits and Coverage; Uniform Glossary
Section 18.	Certification and Disclosure of Prior Creditable Coverage
Section 19.	Rules Related to Fair Marketing
Section 20.	Rules Related to Quality of Care Reporting Requirements
Section 21.	Severability
Section 22.	Effective Date

Section 1. Statement of Purpose

This regulation is intended to implement the provisions of the Small Group Market Health Insurance Coverage Model Act (“Act”). The purposes of the Act and this regulation are to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the small group market and provide for the establishment of coverage and other benefit requirements in the small group market.

Section 2. Definitions

As used in this regulation:

- A. “Actuarial Value” or “AV” means the percentage paid by a health benefit plan of the total allowed costs of benefits.
- B. “Annual open enrollment period” means the period each year during which a small employer, eligible employee or covered person may enroll or change coverage in a health benefit plan.
- C. “CMS” means the federal Centers for Medicare and Medicaid Services.
- D. (1) “Cost-sharing” means any expenditure required by or on behalf of a covered person with respect to essential health benefits.
(2) “Cost-sharing” includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers and spending for non-covered services.

- E. “EHB-benchmark plan” means the standardized set of essential health benefits (EHB) that a health carrier must provide as required by the commissioner or Secretary.
- F. “Enrollment date” means the first day of coverage or, if there is a waiting period, the first day of the waiting period.
- G. “HHS” means the U.S. Department of Health and Human Services.
- H. (1) “Health factor” means, in relation to any individual, any of the following health status-related factors:
 - (a) Health status;
 - (b) Medical condition, including both physical and mental illnesses;
 - (c) Claims experience;
 - (d) Receipt of health care services;
 - (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 small group market health insurance coverage, including the time chosen to enroll, such as under special enrollment or later enrollment.
- I. “Late enrollee” means an individual whose enrollment in a health benefit plan is a late enrollment.
- J. “Late enrollment” means enrollment of an individual in a health benefit plan providing small group market health insurance coverage other than the earliest date on which coverage can be effective for the individual under the terms of the plan other than through a special enrollment period.
- K. “Minimum essential coverage” has the meaning stated in Section 5000A(f) of the Internal Revenue Code (Code).

- L. “Percentage of the total allowed costs of benefits” means the anticipated covered medical spending for EHB coverage, as defined in Section 3L of the Act, paid by a health benefit plan for a standard population, computed in accordance with the plan’s cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.
- M. “Plan” means, with respect to a health carrier and a product, the pairing of health insurance coverage benefits under the product with a metal tier level, as described in Section 1302(d) and (e) of the Federal Act, and service area. The product comprises all plans offered within the product, and the combination of all plans offered within a product constitutes the total service area of the product.
- N. “Plan year” means the year that is designated as the plan year in the plan document of a health benefit plan providing small group market health insurance coverage, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:
 - (1) The deductible or limit year used under the plan;
 - (2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;
 - (3) If the plan does not impose deductibles or limits on a yearly basis, and the policy is not renewed on a yearly basis, the plan year is the employer’s taxable year; or
 - (4) In any other case, the plan year is the calendar year.
- O. “Product” means a discrete package of health insurance coverage benefits that a health carrier offers using a particular product network type (e.g. HMO, PPO, EPO, POS or indemnity) within a geographic service area.
- P. “Special enrollment period” means a period during which an eligible employee or covered person who experiences certain qualified events may enroll in or change enrollment in a health benefit plan outside of the annual open enrollment periods.
- Q. “Wellness program” means a program of health promotion or disease prevention.

Section 3. Applicability and Scope

Subject to the provisions in Section 4 of the Act and specific provisions in this regulation, this regulation is applicable to health carriers offering health benefit plans providing small group market health insurance coverage in this State.

Section 4. Restrictions Relating to Premium Rates

- A. The premium rate charged by a health carrier offering a health benefit plan providing small group market health insurance coverage, in accordance with Section 5 of this regulation, may vary only, with respect to the particular coverage involved, on the basis of the following:

- (1) Whether the plan covers an individual or family:
 - (a) For family coverage, the total premium for family coverage must be determined by summing the premiums for each individual family member, except that if there are more than three (3) covered children under the age of twenty-one (21), the total family premium shall include only the premiums for all covered family members over the age of twenty-one (21) and the three (3) oldest covered children under the age of twenty-one (21);
 - (b) For family coverage, any rating premium variation on the basis of age or tobacco use must be applied separately to the portion of the premium attributable to each covered family member;

Drafting Note: As specified in 45 CFR §147.102(c)(2), a state has the option to establish uniform family tiers and uniform rating multipliers for those tiers in lieu of the family rating methodology specified in Subparagraphs (a) and (b) of this paragraph, but only if the state does not permit any rating variation for age and tobacco use as described in Paragraphs (3) and (4). If the state does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology in this section under Subparagraphs (a) and (b) of this paragraph will apply in that state.

- (c) The total premium charged to the small group is determined by summing the premiums of covered persons in accordance with Subparagraphs (a) and (b) of this paragraph, or for a state that does not permit any rating variation for the factors described in Paragraphs (3) and (4), the methodology established by the state for calculating total premium; and

Drafting Note: States should be aware that the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule (79 FR 13743) published in the *Federal Register* March 11, 2014, provides in 45 CFR §147.102(c)(3) that a state may require a health carrier to offer, or a health carrier may voluntarily offer, to a small employer group premiums that are based on the average covered amounts provided the total small employer group premium is the same total amount derived in accordance with Subparagraphs (a) and (b) of this paragraph or determined using the methodology to calculate premium established by a state that does not permit any rating variation for the factors described in Paragraphs (3) and (4). If a state requires a health carrier to offer, or a health carrier decides to voluntarily offer, small employer group premiums that are based on the average covered person amounts or a health carrier voluntarily offers such premiums, then effective for plan years beginning on or after Jan. 1, 2015, the health carrier must comply with the additional requirements found in 45 CFR §147.102(c)(3)(iii).

- (2)
 - (a)
 - (i) Geographic rating area, as established by HHS in accordance with 45 CFR §147.102(b), unless the commissioner establishes alternative geographic rating areas pursuant to Item (ii) of this subparagraph; and
 - (ii) The commissioner may adopt regulations establishing uniform geographic rating area subject to the provisions of 45 CFR §147.102(b); and

Drafting Note: States choosing to limit the permissible variation based on geographic rating areas, or to establish uniform geographic area multipliers, should consider incorporating those provisions in an additional provision under this paragraph, such as Item (iii).

Drafting Note: States should be aware that 45 CFR §147.102(b) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish one or more geographic rating areas within that state. If a state does not establish geographic rating areas, or the federal Centers for Medicare and Medicaid Services (CMS) determines that the state's geographic rating areas are not adequate, the default will be one geographic rating area for each metropolitan statistical area in the state and one geographic rating comprising all non-metropolitan statistical areas in the state, as defined by the Office of Management and Budget (OMB).

- (b) For purposes of this paragraph, geographic rating area is to be determined in the small group market using the small employer's principal business address;
- (3) Age:
 - (a) The rate may not vary based on age by more than 3:1 for like individuals of different age who are twenty-one (21) and older, and the variation in rate must be actuarially justified for individuals under age twenty-one (21);
 - (b) The rate for each covered person must be based on the covered person's age as of the date of plan issuance, renewal or addition to the plan;
 - (c) Variations in rates based on age must be consistent with the uniform age rating curve established by HHS under 45 CFR §147.102(e), unless the commissioner establishes an alternative age rating curve pursuant to Subparagraph (d) of this paragraph; and
 - (d) The commissioner may adopt regulations establishing a uniform age rating curve, subject to the restrictions imposed by 45 CFR §147.102(e). Any uniform age rating curve must be based on the following uniform age bands:
 - (i) A single age band for individuals age 0 through 20;
 - (ii) One-year age bands for individuals age 21 through 63; and
 - (iii) A single age band for individuals age 64 and older; and

Drafting Note: States should be aware that 45 CFR §147.102(e) of the final rule published in the *Federal Register* Feb. 27, 2013, permits a state to establish a uniform age rating curve in the individual or small group market, or both markets. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with 45 CFR §147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

- (4) Subject to Section 2705 of the Public Health Service Act (PHSA) and its implementing regulations (related to prohibiting discrimination based on health status and programs of health promotion or disease prevention), tobacco use:
 - (a) The rate may not vary by more than 1.5:1 on the basis of tobacco use;
 - (b) A rating surcharge for tobacco use may only be applied to individuals who may legally use tobacco under federal and state law;
 - (c) A rating charge for "tobacco use" may only be applied to individuals who have used tobacco on average four (4) or more times per week within the most recent six-month period; and

- (d) The health carrier may consider the use of any tobacco product for rating purposes, but may not consider religious or ceremonial use of tobacco. Further, the health carrier must consider “tobacco use” in terms of when a tobacco product was last used.

Drafting Note: The reference to Section 2705 of the PHSA in the introductory language for this paragraph is meant to reflect the requirement that a health carrier can only impose a rating surcharge for tobacco use if the carrier has a wellness program that offers a tobacco cessation program in which covered persons may participate.

Drafting Note: States may prohibit tobacco use as a rating factor or may impose stronger restrictions on tobacco use rating than the restrictions in this regulation as provided in Paragraph (4) above.

- B. A premium rate may not vary with respect to a particular coverage by any other factor not described in Subsection A.
- C. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 5. Single Risk Pool

- A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must consider the claims experience of all covered persons in all health benefit plans (other than grandfathered health plan coverage) subject to Section 5 of the Act and offered by the carrier in the small group market in a state, including covered persons who do not enroll in such plans through the exchange, to be members of a single risk pool.

Drafting Note: As specified in 45 CFR §156.80, a state may require the individual and small group health insurance markets within the state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in 45 CFR §147.103.

- B.
 - (1)
 - (a) A health carrier must establish an index rate that is effective January 1 of each calendar year for the small group market, described in Subsection A or, if applicable, a merged market, if the state has required such merger, based on the total combined claims cost for providing essential health benefits within the single risk pool of that state market.
 - (b) The index rate must be adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and exchange user fees (expected to be remitted under 45 CFR §156.50(b) or §156.50(c) and (d), as applicable, plus the dollar amount under 45 §156.50(d)(3)(i) and (ii) expected to be credited against user fees payable in that state market).
 - (c) The premium rate for all of the health carrier’s plans in the relevant state market must use the applicable market-wide adjusted index rate, subject only to plan-level adjustments permitted in Paragraph (2).
 - (2) For plan years beginning on or after January 1, 2014, a health carrier may vary premium rates for a particular health benefit plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

- (a) The actuarial value and cost-sharing design of the plan;
 - (b) The plan's provider network, delivery system characteristics and utilization management practices;
 - (c) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits; and
 - (d) Administrative costs, excluding exchange user fees.
- (3) (a) A health carrier may not establish an index rate and make the market-wide adjustments pursuant to Paragraph (1), or make the plan-level adjustments pursuant to Paragraph (2), more or less frequently than annually, except as provided in Subparagraph (b) of this paragraph.
- (b) Beginning the quarter after HHS issues notification that the federally-facilitated Small Business Health Options Program (SHOP), as that term is defined in 45 CFR §155.20, can process quarterly rate updates, a health carrier in the small group market (not including a merged market) may establish index rates and make the market-wide adjustments pursuant to Paragraph (1), and make the plan-level adjustments pursuant to Paragraph (2), no more frequently than quarterly, provided that any changes to rates must have effective dates of January 1, April 1, July 1 or October 1.
- C. This section does not apply to grandfathered health plan coverage in accordance with 45 CFR §147.140.

Section 6. Guaranteed Availability of Small Group Market Health Insurance Coverage; Enrollment Periods

- A. Subject to Subsections B through D and Section 6 of the Act, a health carrier offering a health benefit plan providing small group market health insurance coverage must offer to any small employer in the state all products that are approved for sale in the small group market and must accept any small employer that applies for coverage under any of those products.

Drafting Note: States should be aware that additional exceptions (*i.e.* exceptions for network plans, limited financial capacity, etc.) to guaranteed availability of coverage can be found in Section 6 of the *Small Group Market Health Insurance Coverage Model Act* (#106). Those provisions were not included in this section in order to avoid unnecessary duplication. However, states may choose to include those provisions in this section if they want to do so.

- B. A health carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.
- C. (1) Subject to Paragraph (2), a health carrier must allow a small employer to purchase health insurance coverage at any point during the year.

- (2) A health carrier may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules as provided in Section 6D of the Act and Section 7B(3) of this regulation, and pursuant to applicable state law.
- D.
 - (1) A health carrier must establish special enrollment periods for qualifying events consistent with the requirements of Section 9 of the Act and as defined under section 603 of ERISA. These special enrollment periods are in addition to any other special enrollment periods required under state or federal law.
 - (2) In addition to the provisions of Paragraph (1), a health carrier must permit an individual within a group, who is otherwise eligible to enroll, to enroll in a health benefit plan when:
 - (a) The individual is enrolled in a health benefit plan that is a network plan that does not provide benefits to individuals who no longer reside, live or work in the service area and the individual loses coverage under the plan because the individual no longer resides, lives or works in the service area; and
 - (b) The individual is enrolled in a health benefit plan that no longer offers any benefits to the class of similarly situated individuals, as described in Section 10C of this regulation that includes the individual.

Drafting Note: States should be aware that federal preemption standards allow states to impose stronger consumer protections in state law such as, for example, additional special enrollment periods or open enrollment periods that allow individuals to purchase coverage more frequently than the federal minimum requirements.

- E.
 - (1) A health carrier must provide covered persons thirty (30) days after the date of the qualifying event described in Subsection D to elect coverage.
 - (2)
 - (a) The health carrier must offer to special enrollees all of the benefit packages available to similarly situated individuals who enroll when first eligible for coverage and may not require a special enrollee to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible for coverage.
 - (b) Any difference in benefits or cost-sharing requirements for different individuals is a different benefit package.
 - (3) The coverage must become effective consistent with the following based on when the health carrier receives the election:
 - (a) Between the first and fifteenth day of any month, the health carrier must ensure a coverage effective date of the first day of the following month; and
 - (b) Between the sixteenth and the last day of any month, the health carrier must ensure a coverage effective date of the first day of the second following month.

- F. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed availability provisions under section 2711 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of the Federal Act.

Section 7. Guaranteed Renewability of Small Group Market Health Insurance Coverage

- A. As provided in Section 7 of the Act and this section, subject to Subsection B, a health carrier offering a health benefit plan providing small employer market health insurance coverage subject to the Act must renew or continue in force the coverage at the option of the small employer.

Drafting Note: States should be aware that additional exceptions (*i.e.* exceptions for product discontinuation, market exit, loss of association membership, etc.) to guaranteed renewability of coverage can be found in Section 7 of the *Small Group Market Health Insurance Coverage Model Act* (#106). Those provisions were not included in this section in order to avoid unnecessary duplication. However, states may choose to include those provisions in this section if they want to do so.

- B. A health carrier may nonrenew or discontinue health insurance coverage based only on one or more of the following:
 - (1) The plan sponsor has failed to pay premiums in accordance with the terms of the health insurance coverage, including any timeliness requirements;
 - (2) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage;
 - (3) The plan sponsor has failed to comply with a material provision related to employer contribution or group participation requirements, pursuant to applicable state law. For purposes of this paragraph the following apply:
 - (a) The term “employer contribution requirement” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and employee dependents; and
 - (b) The term “group participation requirement” means a requirement relating to the minimum number of employees or employee dependents that must be enrolled in relation to a specified percentage or number of eligible employees of a small employer;
 - (4) The carrier is ceasing to offer coverage in the market in accordance with section 7D (discontinuing a particular product) or section 7E (discontinuing all coverage) of the Act and applicable state law; or
 - (5) For network plans, there is no longer any employee who lives, resides or works in the service area of the carrier (or the area for which the carrier is authorized to do business) using the same criteria under which the carrier would deny enrollment in the plan under Section 6E of the Act.

- C.
- (1) At the time of coverage renewal only, a health carrier may modify the health insurance coverage for a product offered in the small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with federal or state law and is effective uniformly among small group market health insurance plans with that product.
 - (2) For purposes of Paragraph (1), a modification made uniformly and solely pursuant to applicable federal or state requirements is considered a uniform modification of coverage if:
 - (a) The modification is made within a reasonable time period after the imposition or modification of the federal or state requirement; and
 - (b) The modification is directly related to the imposition or modification of the federal or state requirement.
 - (3) Other types of modifications made uniformly are considered a uniform modification of coverage if the small group market health insurance coverage for the product meets all of the following criteria:
 - (a) The product is offered by the same health carrier, as that term is defined in section 3B of the Act;
 - (b) The product is offered as the same product network type;
 - (c) The product continues to cover at least a majority of the same service area;
 - (d) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of health care services, or to maintain the same metal tier level described in section 1302(d) and (e) of the Federal Act; and
 - (e) The product provides the same covered benefits, except any changes in benefits that cumulatively impact the plan-adjusted index rate, as described in Section 5B of this regulation, for any plan within the product within an allowable variation of +/- two (2) percentage points, not including changes pursuant to applicable federal or state requirements.

Drafting Note: States should be aware that 45 CFR §147.106(e)(4) permits a state to broaden the standards described in Paragraph (3)(c) and (d) above.

- D. If a health carrier is renewing small group market health insurance coverage as described in Subsection A, or uniformly modifying coverage as described in Subsection C, the health carrier must provide to each plan sponsor written notice of the renewal at least sixty (60) calendar days before the date of the coverage will be renewed in a form and manner specified by the Secretary.

- E. In the case of group health insurance coverage that is made available by a health carrier in the small group market to small employers only through one or more associations, the reference to “plan sponsor” is deemed, with respect to coverage provided to a small employer member of the association, to include a reference to the small employer.
- F. Nothing in this section should be construed to require a health carrier to renew or continue in force small group market health insurance coverage for which continued eligibility would otherwise be prohibited under applicable federal law.
- G. This section applies to grandfathered health plan coverage in accordance with 45 CFR §147.140 to the extent the grandfathered health plan coverage was required to comply with the guaranteed renewability provisions under section 2712 of the PHSA in effect pursuant to Pub. L. No. 104-191 (HIPAA) prior to the effective date of the Federal Act.

Section 8. Prohibition on Waiting Periods Exceeding Ninety (90) Days

- A.
 - (1) A health carrier offering a health benefit plan providing small group market health insurance coverage may not apply any waiting period longer than ninety (90) days.
 - (2)
 - (a) A health carrier may not consider the period before an individual’s late or special enrollment date a waiting period.
 - (b)
 - (i) If an individual loses eligibility for coverage under the health benefit plan and subsequently becomes eligible for coverage, a health carrier may only consider the individual’s most recent period of eligibility in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage.
 - (ii) Similarly, a health carrier must apply the provisions of Item (i) to an individual who becomes eligible for coverage under the health benefit plan after a suspension of coverage that applied generally under the plan.
- B.
 - (1)
 - (a) Except as provided in Paragraphs (2) and (3), an individual is otherwise eligible to enroll under the terms of a health benefit plan if the individual has met the plan’s substantive eligibility conditions, such as being in an eligible job classification, achieving job-related licensure requirements specified in the plan’s terms or satisfying a reasonable bona fide employment-based orientation period.
 - (b) A plan sponsor is not required to offer small group market health insurance coverage to any particular individual or class of individuals despite the individual being otherwise eligible to enroll under the plan, but individuals otherwise eligible for coverage under the plan may not be required to wait more than ninety (90) days before coverage is effective.
 - (2) Conditions of eligibility to enroll for coverage under the terms of a health benefit plan may be based solely on the lapse of a time period, but only for a time period of no more than ninety (90) days.

- (3)
 - (a) Other conditions of eligibility to enroll for coverage under the terms of a health benefit plan are permitted unless the condition is designed to avoid compliance with this section as determined in accordance with the following provisions:
 - (i) Subject to Subparagraph (b) of this paragraph, if eligibility is based on an employee having a specified number of hours of service per pay period, or working full-time, and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period, or work full-time, the terms of the health benefit plan may allow a reasonable period of time, not to exceed twelve (12) months and beginning on any date between the employee's employment start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plan's eligibility condition; or
 - (ii) If eligibility is based on an employee's having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours.
 - (b) Except for cases in which the health benefit plan imposes a waiting period exceeding a 90-day period in addition to a measurement period, as described in Subparagraph (a)(i) of this paragraph, the time period for determining whether the employee meets the plan's eligibility requirements will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no more than thirteen (13) months after the employee's employment start date plus the time remaining until the first day of the next calendar month if the employee's employment start date is not the first day of a calendar month.
 - (c)
 - (i) To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month.
 - (ii) For purposes of Item (i), one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position otherwise eligible for small group market health insurance coverage under the health benefit plan.
- C. The health carrier may treat an employee whose employment has terminated and then rehired as newly eligible to enroll for coverage upon rehire and, therefore, required to meet the health benefit plan's eligibility requirements and waiting period anew, if reasonable under the circumstances and the termination and rehiring is not used or designed as a subterfuge to avoid compliance with the 90-day waiting period limitation.
- D.
 - (1) Under this section, all calendar days are counted beginning on the enrollment date, including weekends and holidays.

- (2) For administrative convenience, a health carrier that imposes a 90-day waiting period may choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.
- E. A health carrier satisfies the requirements of this section if, under the terms of the health benefit plan, an individual employee can elect coverage that begins on a date before the end of a 90-day waiting period and may not be considered in violation of this section if an individual employee takes, or is permitted to take, additional time beyond any 90-day waiting period to elect coverage.
- F. A health carrier that relies on the eligibility information reported to it by the small employer will not be considered to violate the requirements of this section with respect to the carrier's administration of any waiting period if the following is satisfied:
 - (1) The carrier requires the small employer to make a representation and update this representation with any changes regarding the terms of any eligibility conditions or waiting periods imposed before an individual is eligible for coverage under the health benefit plan; and
 - (2) The carrier has no specific knowledge of a waiting period imposed that exceeds the permitted 90-day period.

Section 9. Prohibition of Preexisting Condition Exclusions

A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not impose any preexisting condition exclusions as provided in Section 9A of the Act.

Section 10. Prohibition on Discrimination Based on Health Factors

Drafting Note: The Departments of Labor, Health and Human Services (HHS) and the Treasury (collectively, the Departments) published joint final regulations implementing the HIPAA nondiscrimination and wellness provisions Dec. 13, 2006, at 71 FR 75014 (the 2006 regulations). These regulations implemented the provisions of Section 2702 of the Public Health Service Act (PHSA), as enacted by HIPAA, which generally prohibited group health plans and group health insurance issuers from discriminating against individual employees and their dependents in eligibility, benefits or premiums based on a health factor. These regulations, however, permitted group health plans and group health insurance issuers to establish certain rules which, under the ACA, are no longer permitted. One example of such rules is a provision in the 2006 regulations permitting group health plans and group health insurance issuers to impose preexisting condition exclusions (with some limitations) for the group market. Because such provisions from the 2006 regulations are no longer permitted due to the ACA, they have not been included in this section. However, states should be aware that they may want to somehow retain these provisions for purposes of continued enforcement related to grandfathered health plan coverage and some group health benefit plan coverage with plans years that extend into 2014 (and possibly additional years, as permitted). States also should be aware that the ACA retained provisions from Section 2702 of the PHSA, now Section 2705 of the PHSA, as enacted by Section 1201 the ACA. For the group market only, this section provides for a general exception to the prohibition on discrimination based on a health factor to allow premium discounts or rebates and modification to otherwise applicable cost sharing, including copayments, deductibles or coinsurance, in return for adherence to certain programs of health promotion and disease prevention. States also should be aware that Section 2705 of the PHSA also extends the HIPAA nondiscrimination protections to the individual market. However, Section 2705 of the PHSA does not extend the wellness program exception to the prohibition on discrimination to coverage in the individual market.

- A. (1) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not establish a rule for eligibility, including continued eligibility, of an employee to enroll for benefits under the plan that discriminates based on any health factor that relates to the employee or dependent of the employee.

- (2) For purposes of this section, a rule of eligibility includes a rule relating to:
 - (a) Enrollment;
 - (b) The effective date of coverage;
 - (c) Waiting or affiliation periods;
 - (d) Late and special enrollment;
 - (e) Eligibility for benefit packages, including rules for individuals to change their selection among benefit packages;
 - (f) Benefits, including a rule relating to covered benefits, benefit restrictions, and cost-sharing mechanisms, such as coinsurance, copayments and deductibles, as described in Subsection C(1) and (2);
 - (g) Continued eligibility; and
 - (h) Terminating coverage, including disenrollment, of an individual under the plan.
 - (3) Nothing in this section prohibits a health carrier from establishing more favorable rules of eligibility for individuals with an adverse health factor, such as a disability, than for individuals without the adverse health factor.
- B.
- (1)
 - (a) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not require an employee, 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 employee or a dependent of the employee.
 - (b) In determining an individual employee's premium or contribution rate, discounts, rebates, payments-in-kind and any other premium differential mechanisms shall be taken into account.
 - (2)
 - (a) Subject to Subparagraph (b) of this paragraph, nothing in this subsection restricts the aggregate amount that a health carrier may charge a small employer for coverage under a plan.
 - (b) A health carrier may not quote or charge a small employer or an individual employee or dependent of an employee a different premium than that quoted or charged an individual employee in a group of similarly situated individuals based on a health factor unless permitted under Paragraph (3) or under Section 4 of this regulation.

- (3) Notwithstanding Paragraphs (1) and (2), a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may establish a premium or contribution differential based on whether an individual has complied with the requirements of a wellness program that satisfies the requirements of Subsection E.

- C. (1) (a) Subject to federal or state law or regulations and Subparagraph (b) of this paragraph, Subsection A does not require a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act to provide coverage for any particular benefit to any group of similarly situated individuals.

- (b) (i) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act shall make the benefits provided under a plan available uniformly to all similarly situated individuals, as those groups are determined under Paragraph (2).

- (ii) For any restriction on a benefit or benefits provided under a plan, the health carrier:
 - (I) Shall apply the restriction uniformly to all similarly situated individuals; and
 - (II) May not direct the restriction, as determined based on all of the relevant facts and circumstances, at individual employees or dependents of employees based on any health factor of the individual employee or a dependent of the individual employee.

- (iii) The health carrier may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the cost-sharing requirement:
 - (I) Applies uniformly to all similarly situated individuals;
 - (II) Is not directed at individual employees or dependents of individual employees based on any health factor of the individual employee or dependent of an individual employee; and
 - (III) Does not apply to preventive services specified in Section 2713 of the Public Health Service Act (PHSA).

- (iv) 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 employee or dependent of an individual employee.

- (c) If the health carrier generally provides benefits for a type of injury, the health carrier may not deny an individual employee or dependent of an employee 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. This provision applies to an injury resulting from a medical condition even if the medical condition is not diagnosed before the injury
 - (d) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act with a cost-sharing mechanism, such as a deductible, copayment or coinsurance, that requires a higher payment from an individual employee, based on a health factor of that individual employee or dependent of the individual employee, 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 wellness program that satisfies the requirements of Subsection E.
- (2) (a) This paragraph applies only within a group of individuals who are treated as similarly situated individuals.
- (b) (i) Subject to Subparagraph (d) of this paragraph, Subsection A does not prohibit a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act from treating dependents of employees as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among groups of dependents is based on a bona fide employment-based classification that is consistent with the small employer's usual business practice.
 - (ii) Whether an employment-based classification is bona fide shall be determined based on all of the relevant facts and circumstances.
 - (iii) For purposes of Item (ii), relevant facts and circumstances include whether the small employer uses the classification for purposes independent of qualification for health insurance 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.

- (iv) A classification based on a health factor may not be determined to be a bona fide employment-based classification for purposes of this subsection unless the requirements of Subsection A(3) and Subsection B(3) are satisfied.
 - (c)
 - (i) Subject to Subparagraph (d) of this paragraph, Subsection A does not prohibit a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act from treating dependents of individual employees as two (2) or more distinct groups of similarly situated individuals if the distinction made between or among the groups is based on any of the following factors:
 - (I) A bona fide employment-based classification of the individual employee through whom the dependent is receiving coverage;
 - (II) Relationship to the individual employee (e.g., as a spouse or as a dependent child);
 - (III) Marital status;
 - (IV) With respect to a dependent child of the individual employee, age or student status to the extent that such treatment does not conflict with the requirements of section 2714 of the PHSA; or
 - (V) Any other factor, if the factor is not a health factor.
 - (ii) Item (i) may not be construed to prevent the health carrier from providing more favorable treatment of individuals under the plan with adverse health factors in accordance with Subsection A(3) and Subsection B(3).
 - (d) Notwithstanding Subparagraphs (b) and (c) of this paragraph, unless permitted under Subsection A(3) or Subsection B(4), if the creation or modification of an employment or coverage classification is directed at individual employees or dependents of individual employees based on a health factor of an individual employee or a dependent of an individual employee, the classification is not permitted under this subsection.
- D.
 - (1) Except to the extent permitted under Paragraph (2)(b) or Paragraph (3), in accordance with Subsections A and B, a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may not establish a rule of eligibility or set an individual employee's premium or contribution rate based on:
 - (a) Whether the individual employee is confined in a hospital or other health care institution; or
 - (b) The individual employee's ability to engage in normal life activities.

- (2) (a) In accordance with Subsections A and B, a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act may 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 the 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.
 - (b) Notwithstanding Subparagraph (a) of this paragraph, the health carrier may establish a rule for eligibility that requires an individual to begin work for the small employer sponsoring the plan before coverage under the plan becomes effective if the rule for eligibility applies regardless of the reasons for the absence.
 - (3) Notwithstanding Paragraphs (1) and (2), a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act 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 Subsection C(2).
- E. (1) For purposes of this subsection, the following terms have the meanings indicated:
- (a) (i) "Activity-only wellness program" means a health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward, but does not require the individual to attain or maintain a specific health outcome.
 - (ii) Examples of an "activity-only wellness program" include walking, diet or exercise programs, which some individuals may be unable to participate or complete (or have difficulty participating or completing) due to a health factor, such as severe asthma, pregnancy or a recent surgery.
 - (b) (i) "Health-contingent wellness program" means a wellness program that requires an individual to:
 - (I) Satisfy a standard related to a health factor to obtain a reward;
or
 - (II) Undertake more than a similarly situated individual based on a health factor in order to obtain the same reward.
 - (ii) "Health-contingent wellness program" includes a wellness program that is an activity-only wellness program or an outcome-based wellness program.
 - (c) (i) "Outcome-based wellness program" means a health-contingent wellness program that requires an individual to attain or maintain a specific health outcome, such as not smoking or attaining certain results on biometric screenings, in order to obtain a reward.

- (ii) To comply with this subsection, an “outcome-based wellness program” typically has two tiers:
 - (I) For individuals who do not attain or maintain the specific health outcome, compliance with an educational program or an activity may be offered as an alternative to achieve the same reward. This alternative pathway, however, does not mean that the overall program, which has an outcome-based component, is not an outcome-based wellness program; and
 - (II) If a measurement, test or program screening is used as part of an initial standard and individuals who meet the standard are granted the reward, the program is considered an outcome-based wellness program. For example, if a wellness program tests individuals for specified conditions or risk factors, including biometric screening such as testing for high cholesterol, high blood pressure, abnormal body mass index or high glucose level, and provides a reward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range or at risk to take additional steps, such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, complying with a walking or exercise program or complying with a health care provider’s plan of care, to obtain the same reward, the program is an outcome-based wellness program and is subject to the requirements of Paragraph (5) for health-contingent wellness programs that are outcome-based wellness programs.
- (d) (i) “Participatory wellness program” means a wellness program that:
 - (I) Does not base any condition for obtaining an award on an individual satisfying a standard that is related to a health factor; or
 - (II) Does not provide a reward.
- (ii) Examples of “participatory wellness program” include:
 - (I) A program that reimburses employees for all or part of the cost for membership in a fitness program;
 - (II) A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes;

- (III) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a health benefit plan for the costs of, for example, prenatal care or well-baby visits;
 - (IV) A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking;
 - (V) A program that provides a reward to employees for attending a monthly, no-cost health education seminar; and
 - (VI) A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action, educational or otherwise, required by the employee with regard to the health issues identified as part of the assessment.
- (e)
 - (i) Except where expressly provided otherwise, references in this section to an individual obtaining a “reward” include both obtaining a reward, such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit or any financial or other incentive and avoiding a penalty, such as the absence of a premium surcharge or other financial or nonfinancial disincentive.
 - (ii) Except where expressly provided otherwise, references in this section to a health benefit plan providing a “reward” include both providing a reward, such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit or any financial or other incentive and imposing a penalty, such as a premium surcharge or other financial or nonfinancial disincentive.
- (2) Subsection B(3) and Subsection C(2)(c) provide exceptions to the general prohibition against discrimination based on a health factor for a health benefit plan that varies benefits, including cost-sharing mechanisms, or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this subsection.
- (3) A participatory wellness program, as defined in Paragraph (1)(d), does not violate the provisions of this section only if participation in the program is made available to all similarly situated individuals, regardless of health status.
- (4) A health-contingent wellness program that is an activity-only wellness program, as defined in Paragraph (1)(a), does not violate the provisions of this section only if all of the following requirements are satisfied:
 - (a) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year;

- (b) (i) The reward for the activity-only wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage provided in Paragraph (6) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents, such as spouses or spouses and dependent children, may participate in the wellness program, the reward may not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled.
 - (ii) For purposes of this subparagraph, the cost of coverage is determined based on the total amount of employer and employee contributions toward the cost of coverage for the benefit package under which the employee is, or the employee and any dependents are, receiving coverage;
- (c) (i) The program must be reasonably designed to promote health or prevent disease.
 - (ii) A program satisfies Item (i) if, based on all of the relevant facts and circumstances:
 - (I) It has a reasonable chance of improving the health of, or preventing disease in, participating individuals; and
 - (II) It is not overly burdensome, is not a subterfuge for discriminating based on a health factor and is not highly suspect in the method chosen to promote health or prevent disease;
- (d) (i) The full reward under the activity-only wellness program must be available to all similarly situated individuals.
 - (ii) Under this subparagraph, a reward under an activity-only wellness program is not available to all similarly situated individuals for a period unless the program meets both of the following requirements:
 - (I) The program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and
 - (II) The program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

- (iii) While a carrier is not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in either Item (ii)(I) or (II), a reasonable alternative standard must be furnished by the carrier upon the individual's request or the condition for obtaining the reward must be waived;
- (iv) All of the facts and circumstances are taken into account in determining whether a carrier has furnished a reasonable alternative standard, including but not limited to the following:
 - (I) If the reasonable alternative standard is completion of an educational program, the carrier must make the educational program available or, instead of requiring the employee to find such a program unassisted, assist the employee in finding such a program, and may not require an individual to pay for the cost of the program;
 - (II) The time commitment required must be reasonable;
 - (III) If the reasonable alternative standard is a diet program, the carrier is not required to pay for the cost of food, but must pay any membership or participation fee; and
 - (IV) If an individual's personal physician states that a plan standard, including, if applicable, the recommendations of the plan's medical professional, is not medically appropriate for that individual, the carrier must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Carriers may impose standard cost-sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations;
- (v)
 - (I) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply with the requirements of this paragraph in the same manner as if it were an initial program standard.
 - (II) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements of Paragraph (5), including Paragraph (5)(d)(iv);
- (vi) If reasonable under the circumstances, a carrier may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program.

Carriers may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request; and

- (e) The carrier must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward and, if applicable, the possibility of waiver of the otherwise applicable standard, including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in Paragraph (7) of this subsection.
- (5) A health-contingent wellness program that is an outcome-based wellness program, as defined in Paragraph (1)(c), does not violate the provisions of this subsection only if all of the following are satisfied:
- (a) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year;
 - (b)
 - (i) The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage, as defined in Paragraph (6) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents, such as spouses or spouses and dependent children, may participate in the wellness program, the reward may not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents of the employee are enrolled;
 - (ii) For purposes of this subparagraph, the cost of coverage is determined based on the total amount of small employer and employee contributions toward the cost of coverage for the benefit package under which the employee is, or the employee and any dependents are, receiving coverage;
 - (c)
 - (i) The program must be reasonably designed to promote health or prevent disease;
 - (ii) A program satisfies Item (i) if, based on all of the relevant facts and circumstances:
 - (I) It has a reasonable chance of improving the health of, or preventing disease in, participating individuals; and
 - (II) It is not overly burdensome, is not a subterfuge for discriminating based on a health factor and is not highly suspect in the method chosen to promote health or prevent disease;

- (iii) To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test or screening that is related to a health factor, as explained in Subparagraph (d) of this paragraph;
- (d)
 - (i) The full reward under the outcome-based wellness program must be available to all similarly situated individuals;
 - (ii) Under this subparagraph, a reward under an outcome-based wellness program is not available to all similarly situated individuals for a period unless the program allows a reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test or screening, as described in this subparagraph;
 - (iii) While health carriers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in Item (ii), a reasonable alternative standard must be furnished by the carrier upon the individual's request or the condition for obtaining the reward must be waived;
 - (iv) All of the facts and circumstances are taken into account in determining whether a health carrier has furnished a reasonable alternative standard, including but not limited to the following:
 - (I) If the reasonable alternative standard is the completion of an educational program, the health carrier must make the educational program available or, instead of requiring an employee to find an educational program unassisted, assist the employee in finding such a program and may not require the employee to pay for the cost of the program;
 - (II) The time commitment required must be reasonable;
 - (III) If the reasonable alternative standard is a diet program, the health carrier is not required to pay for the cost of food, but must pay any membership or participation fee; and
 - (IV) If an individual's personal physician states that a plan standard, including, if applicable, the recommendations of the plan's medical professional, is not medically appropriate for that individual, the health carrier must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Health carriers may impose standard cost-sharing under the plan or coverage for medical items and services furnished pursuant to the physician's

recommendations;

- (v) To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements of Paragraph (4) in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, another outcome-based wellness program, it must comply with the requirements of this paragraph, subject to the following special rules:
 - (I) The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances; and
 - (II) An individual must be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the carrier, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness;
- (vi)
 - (I) It is not reasonable to seek verification, such as a statement from an individual's personal physician, under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard;
 - (II) However, if a health carrier provides an alternative standard to otherwise applicable measurement, test or screening that involves an activity that is related to a health factor, then the rules of Paragraph (4) for activity-only wellness programs apply to that component of the wellness program and the health carrier may, if reasonable under the circumstances, seek verification that it is unreasonably difficult due to a medical condition for an individual to perform or complete the activity or it is medically inadvisable to attempt to perform or complete the activity; and
- (e) The health carrier must disclose in all plan materials describing the terms of an outcome-based wellness program the availability of a reasonable alternative standard to qualify for the reward and, in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward and, if applicable, the possibility

of waiver of the otherwise applicable standard, including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in Paragraph (7).

- (6) (a) For purposes of this subsection, the applicable percentage is thirty (30) percent, except that the applicable percentage is increased by an additional twenty (20) percentage points to fifty (50) percent to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.
- (b) The rules of this paragraph are illustrated in examples found in 45 CFR 146.121(f)(5).
- (7) The following language, or substantially similar language, can be used to satisfy the notice requirement of Paragraphs (4) and (5):

"Your health benefit plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

Section 11. Essential Health Benefits Package

- A. To meet the requirements of Section 13 of the Act, provision of essential health benefits means that a health benefit plan provides health benefits that:
 - (1) Are substantially equal to the EHB-benchmark plan including:
 - (a) Covered benefits;
 - (b) Limitations on coverage including coverage of benefit amount, duration and scope; and
 - (c) Prescription drug benefits that meet the requirements of Section 10 of this regulation;
 - (2) With the exception of the essential health benefits category of coverage for pediatric services, do not exclude an enrollee from coverage in an essential health benefits category;
 - (3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, comply with the requirements of 45 CFR §146.136 related to parity in mental health and substance use disorder benefits;

- (4) Include preventive health services, as provided in Section 14 of the Act;
- (5) If the EHB-benchmark plan does not include coverage for habilitative services, include habilitative services in a manner that meets one of the following:
 - (a) Provides parity by covering habilitative services benefits that are similar in scope, amount and duration to benefits covered for rehabilitative services;
 - (b) Is determined by the health carrier and reported to HHS; or
 - (c) As determined by the state as provided in 45 CFR §156.110(f).
- B. A health carrier offering a health benefit plan in the small group market providing essential health benefits may substitute benefits if the carrier meets the following conditions:

Drafting Note: States should be aware that they may adopt more restrictive requirements related to health carriers substituting benefits, including not permitting the practice.

 - (1) Substitutes a benefit that:
 - (a) Is actuarially equivalent to the benefit that is being replaced as determined in Paragraph (2);
 - (b) Is made only within the same essential health benefit category; and
 - (c) Is not a prescription drug benefit; and
 - (2) Submits evidence of actuarial equivalence that is:
 - (a) Certified by a member of the American Academy of Actuaries;
 - (b) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
 - (c) Based on a standardized plan population; and
 - (d) Determined regardless of cost-sharing.
- C. A health benefit plan does not fail to provide essential health benefits solely because it does not offer the services described in 45 CFR §156.280(d).
- D. A health carrier offering a health benefit plan in the small group market providing essential health benefits may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits or non-medically necessary orthodontia as essential health benefits.
- E. A health carrier offering health benefit plan in the small group market providing essential health benefits may not impose annual and lifetime dollar limits on essential health benefits in accordance with 45 CFR §147.126.

Section 12. Parity in Mental Health and Substance Use Disorder Benefits

- A. The provisions of 45 CFR §146.136 apply to a health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act, as the term “small employer” is defined in Section 2791 of the PHSA as provided in Section 11 of this regulation.

Drafting Note: Section 1304 of the Federal Act gives states the option, prior to Jan. 1, 2016, to define a “small employer” as an employer that employed an average of at least one (1), but not more than fifty (50) employees on business days during the preceding calendar year and that employs at least one (1) employee on the first day of the plan year. On or after Jan. 1, 2016, a “small employer” must be defined as an employer that employed an average of at least one (1) but not more than one hundred (100) employees on business days during the preceding calendar year and who employs at least one (1) employee on the first day of the plan year. As such, the small employer exemption provided in Section 2726 of the PHSA and implementing regulations will continue to apply to employers with fifty-one (51) or more employees in 2016 when the upper limit of the small employer size increases in accordance with Section 1304 of the Federal Act. For more information, states can refer to page 68248 of the final rules published in the *Federal Register* (78 FR 68240), Nov. 13, 2013.

- B. This section applies to non-grandfathered health plan coverage and grandfathered health plan coverage.

Section 13. Prescription Drug Benefits

- A. A health benefit plan does not provide essential health benefits unless it:
 - (1) Except as provided in Subsection B, covers at least the greater of:
 - (a) One drug in every United States Pharmacopeia (USP) category and class; or
 - (b) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and
 - (2) Submits its drug list to the state.
- B. A health benefit plan does not fail to provide essential health benefits prescription drug benefits solely because it does not offer drugs approved by the U.S. Food and Drug Administration as a service described in 45 CFR §156.280(d).
- C.
 - (1) A health benefit plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health benefit plan.
 - (2)
 - (a) The procedures must include a process for an enrollee, the enrollee’s designee or the enrollee’s prescribing physician or other prescriber to request an expedited review based on exigent circumstances.
 - (b) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

- (c) A health benefit plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician or other prescriber, as appropriate, of its coverage determination no later than twenty-four (24) hours after it receives the request.
- (d) A health benefit plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

Drafting Note: The provisions of Subsection C above reference health benefit plans having procedures, including an expedited review process as part of those procedures, in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health benefit plan. In considering what procedures, if any, states may want to require health carriers to have in place for their health benefit plans to carry out the provisions of Subsection C, states may want to review procedures in the NAIC models concerning internal and external review. In addition, states may want to review the provisions of the NAIC *Health Carrier Prescription Drug Benefit Management Model Act* (#22), particularly Section 7—Medical Exceptions Approval Process Requirements and Procedures.

Section 14. Prohibition on Discrimination in Providing Essential Health Benefits

- A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life or other health conditions.
- B. A health carrier must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Drafting Note: States should review their laws and regulations for consistency with the provisions of Subsection B above and, if necessary, revise the language in Subsection B.

- C. Nothing in this section shall be construed to prevent a health carrier from appropriately utilizing reasonable medical management techniques.

Section 15. Cost-Sharing Requirements

- A. (1) For a plan year beginning in calendar year 2014, cost-sharing may not exceed the following:
 - (a) For self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986, as amended; or
 - (b) For non-self-only coverage that is in effect for 2014, the annual dollar limit as described in Section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986, as amended.
- (2) For a plan year beginning in a calendar year after 2014, cost-sharing may not exceed the following:

- (a) For self-only coverage, the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in Subsection E; or
 - (b) For non-self-only coverage, twice the dollar limit for self-only coverage described in Subparagraph (a) of this paragraph.
- B. In the case of a plan using a network of providers, the annual limitation on cost-sharing, as defined in Subsection A does not apply to benefits provided out-of-network, other than benefits provided on an appeal or exceptions basis because medically necessary services were not reasonably accessible within the network.

Drafting Note: Subject to state or federal law or regulations, nothing in this section would prohibit a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in Subsection A or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network. Federal law does not prevent a state from establishing lower cost-sharing limits, or establishing limits that apply to out-of-network benefits.

- C. For a plan year beginning in a calendar year after 2014, any increase in the annual dollar limits described in Subsection A that does not result in a multiple of 50 dollars will be rounded down, to the next lowest multiple of 50 dollars.
- D. The premium adjustment percentage is the percentage, if any, by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance coverage for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.
- E. Nothing in this section is in derogation of the requirements of Section 14 of the Act.
- F. Emergency department services must be provided as follows:
 - (1) Without imposing any requirement under the health benefit plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and
 - (2) If such services are provided out of network, cost-sharing must be limited as provided in [insert reference to state law or regulation equivalent to Section 11C of the *Utilization Review and Benefit Determination Model Act*].

Section 16. Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage

- A. Subject to Subsection B, a health carrier must use the AV Calculator developed and made available by HHS to calculate the AV of a health benefit plan.
- B. If a health benefit plan's design is not compatible with the AV Calculator, the health carrier must meet the following:
 - (1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in Subparagraphs (a) and (b) of this paragraph:

- (a) Calculate the plan's AV by:
 - (i) Estimating the fit of its plan design into the parameters of the AV calculator; and
 - (ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or
 - (b) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries, calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator; and
 - (2) The calculation methods described in Paragraph (1)(a) and (b) may include in-network cost-sharing, including multi-tier networks.
- C. For health benefit plans offered in the small group market that, at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:
- (1) Counted towards the total anticipated medical spending of the standard population that is paid by the health benefit plan; and
 - (2) Adjusted to reflect the expected spending for health care costs in a benefit year so that:
 - (a) Any current year HSA contributions are accounted for; and
 - (b) The amounts newly made available under such integrated HRAs for the current year are accounted for.
- D.
- (1) Beginning in 2015, if submitted by the state and approved by HHS, a state-specific data set, in a format specified by HHS that can support the use of the AV Calculator as described in Subsection A, will be used as the standard population to calculate AV in accordance with Subsection A.
 - (2) The AV will be calculated using the default standard population described in Paragraph (3), unless a data set in a format specified by HHS that can support the use of the AV Calculator, as described in Subsection A, is submitted by a state and approved by HHS consistent with the requirements of 45 CFR §156.135(d) by a state specified by HHS.
 - (3) The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in Subsection A.

- E. (1) The AV, calculated as described in Subsections A through D, and within a de minimis variation as defined in Paragraph (3), determines whether a health benefit plan offers a bronze, silver, gold or platinum level of coverage.
- (2) The levels of coverage are:
- (a) A bronze plan is a health benefit plan that has an AV of 60%.
 - (b) A silver plan is a health benefit plan that has an AV of 70%.
 - (c) A gold plan is a health benefit plan that has an AV of 80%.
 - (d) A platinum plan is a health benefit plan that has an AV of 90%.
- (3) The allowable variation in the AV of a health benefit plan that does not result in a material difference in the true dollar value of the health benefit plan is +/-2 percentage points.
- F. Any health benefit plan offered in the small group market that meets any of the levels of coverage described in Subsection E satisfies minimum value.

Section 17. Provision of Summary of Benefits and Coverage; Uniform Glossary

Drafting Note: States should be aware that in addition to the provisions of 45 CFR §147.200, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments), the federal agencies charged with implementing the ACA, have issued extensive sub-regulatory guidance in the form of frequently asked questions (FAQs) and enforcement safe harbors for issuers subject to Section 2715 of the PHSA and the implementing federal regulations. The drafting note below details this sub-regulatory guidance and issuer enforcement safe harbors.

Drafting Note: The Departments have maintained their intent to continue the safe harbors and other enforcement relief provided to issuers for the first year of applicability related to the requirement to provide a Summary of Benefits and Coverage (SBC) and a uniform glossary during subsequent years of applicability. The Departments confirmed their intent in the Affordable Care Act Implementation FAQs Part XIX, Q8 issued May 2, 2014, “in recognition of and to ensure a smooth transition to new market changes in 2014,” to extend the following previously-issued enforcement and transition relief guidance until further guidance is issued:

- Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the federal agencies’ basic approach to implementation of the SBC requirements during the first year of applicability);
- Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);
- Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);
- Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator); and related information related to use of the coverage examples calculator;
- Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer’s obligation to provide an SBC with respect to benefits it does not insure);
- Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);
- Affordable Care Act Implementation FAQs Part XIV, Q2 (regarding providing information about MEC (minimum essential coverage) and MV (minimum value) without changing the SBC template);
- Affordable Care Act Implementation FAQs Part XIV, Q3 (removal of the row on the SBC template related to annual limits information);
- Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding carve-out arrangements);

- Affordable Care Act Implementation FAQs Part XIV, Q7 (regarding anti-duplication rule for student health insurance coverage);
- The Special Rule contained in the Instruction Guides for Group and Individual Coverage;
- Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage); and
- Affordable Care Act Implementation FAQs Part XIV, Q6 (an enforcement safe harbor related to closed blocks of business).

The May 2, 2014, guidance also noted that “[t]his guidance supersedes any previous sub-regulatory guidance, including FAQs, stating that certain enforcement relief for the SBC and uniform glossary requirements is limited to the first or second year of applicability.”

- A. A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must provide a summary of benefits and coverage (SBC) for each benefit package without charge to persons and individuals described in this section and in accordance with this section.

Drafting Note: States should be aware that, as enacted, the Federal Act retained, with amendment, what was Section 2713 of the PHSA, now Section 2709 of the PHSA (Disclosure of Information), which requires health carriers to disclose information to individuals concerning the carrier’s right to change premium rates and the factors that may affect changes in premium rates and the benefits and premiums available under all health insurance coverage for which the individual is qualified. The provisions of this section do not include these required disclosure requirements.

- B.
 - (1) A health carrier offering a health benefit plan providing small group health insurance coverage must provide the SBC to the plan sponsor upon application for coverage, as soon as practicable following receipt of the application, but in no event later than seven (7) business days following receipt of the application.
 - (2) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the individual no later than the first day of coverage.
 - (3) If a health carrier renews or reissues the certificate or contract of coverage, the health carrier must provide a new SBC as follows:
 - (a) If written application is required in either paper or electronic form for renewal or reissuance, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or
 - (b) If renewal or reissuance is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new plan year; however, if the certificate or contract of insurance has not been issued or renewed before such 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issuance of the new certificate or contract of insurance or the receipt of the written confirmation of intent to renew whichever is earlier.
 - (4) If a plan sponsor requests an SBC or summary information about a health insurance product from a health carrier, the health carrier must provide an SBC as soon as practicable, but in no event later than seven (7) business days following receipt of the request.

- C.
 - (1) A health carrier must provide an SBC to covered persons and, consistent with Subsection D, with respect to each benefit package offered by the carrier for which the covered person is eligible.
 - (2) A health carrier must provide an SBC as part of any written application materials that are distributed by the carrier for enrollment. If the carrier does not distribute written application materials for enrollment, the carrier must distribute the SBC no later than the first date on which the employee is eligible to enroll in coverage for the employee and any dependents of the employee.
 - (3) If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the carrier must update and provide a current SBC to the covered person no later than the first day of coverage.
 - (4) A health carrier must provide the SBC to special enrollees, as described in Section 6 of this regulation, no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA Section 104(b)(1)(A) and its implementing regulations, which is ninety (90) days from enrollment.
 - (5) If a health carrier requires covered persons to renew in order to maintain coverage, the carrier must provide a new SBC when the coverage is renewed as follows:
 - (a) If written application is required for renewal in either paper or electronic form, the carrier must provide the SBC no later than the date on which the written application materials are distributed; or
 - (b) If the renewal is automatic, the carrier must provide the SBC no later than thirty (30) days prior to the first day of the new plan year; however, if the certificate or contract of insurance has not been issued or renewed before the 30-day period, the carrier must provide the SBC as soon as practicable, but in no event later than seven (7) business days after issue of the new certificate or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.
 - (6) A health carrier must provide the SBC to covered persons upon request for an SBC or summary information about health coverage, as soon as practicable, but in no event no later than seven (7) business days following receipt of the request.
- D.
 - (1) A person required to provide an SBC under this section with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the requirements of this section. Therefore, for example, in the case of a health benefit plan providing small group market health insurance coverage, the person satisfies the requirement to provide an SBC with respect to an individual if the health carrier provides a timely and complete SBC to the individual.
 - (2) If a health carrier provides a single SBC to an employee and any dependents of the employee at the employee's last known address, then the requirement to provide the SBC to the employee and any dependents of the employee is generally satisfied. However, if an employee's dependent's last known address is different than the

employee's last known address, the health carrier must provide a separate SBC to the employee's dependent at the dependent's last known address.

- (3) With respect to a health benefit plan providing small group health insurance coverage that offers multiple benefit packages, the health carrier must provide a new SBC automatically upon renewal only with respect to the benefit package in which the covered person is enrolled. A health carrier is not required to provide SBCs automatically upon renewal with respect to benefit packages in which the covered person is not enrolled. However, if the covered person requests an SBC with respect to another benefit package or more than one other benefit package for which the covered person is eligible, the health carrier must provide the SBC, or in the case of a request for SBCs relating to more than one benefit package, upon request as soon as practicable, but in no event later than seven (7) business days following receipt of the request.
- E. (1) Subject to Paragraph (3), an SBC provided under this section must include the following:
- (a) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of, or exceptions to, their coverage, in accordance with guidance as specified by the Secretary;
 - (b) A description of the coverage, including cost-sharing, for each category of benefits identified by the Secretary in guidance;
 - (c) The exceptions, reductions and limitations of coverage;
 - (d) The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;
 - (e) The renewability and continuation of coverage provisions;
 - (f) Coverage examples in accordance with Paragraph (2);
 - (g) A statement about whether the coverage provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code of 1986, as amended and whether the coverage's share of the total allowed costs of benefits provided under the coverage meets applicable requirements;
 - (h) A statement that the SBC is only a summary and that the policy, certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;
 - (i) Contact information for questions and obtaining a copy of the insurance policy, certificate or contract of insurance, such as a telephone number for customer service and a publicly accessible Internet address where a copy of the plan document or the insurance policy, certificate or contract of insurance can be reviewed and obtained;
 - (j) For carriers that maintain one or more provider networks, an Internet address, or similar contact information, for obtaining a list of network providers;

- (k) For carriers that use a formulary in providing prescription drug coverage, an Internet address, or similar contact information, for obtaining information on prescription drug coverage; and
 - (l) An Internet address for obtaining the uniform glossary, as described in Subsection G, as well as a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.
- (2) (a) The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the coverage for common benefit scenarios, including pregnancy and serious or chronic medical conditions in accordance with this paragraph. The Secretary may identify up to six (6) coverage examples that may be required in an SBC.
- (b) For purposes of this paragraph, a benefit scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specified period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality.

Drafting Note: The HHS Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

- (c) (i) For purposes of this paragraph, to illustrate benefits provided under the coverage for a particular benefits scenario, a carrier simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the policy or benefit package.
 - (ii) The illustration of benefits provided will take into account any cost-sharing, excluded benefits and other limitations on coverage as specified by the Secretary in guidance.
- (3) (a) In lieu of summarizing coverage for items and services provided outside of the United States, a carrier may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States.

Drafting Note: In Frequently Asked Questions (FAQs), the federal agencies charged with implementing the ACA provide that expatriate coverage is not subject to the ACA requirements for plan years ending before Dec. 15, 2015, including the requirements to provide an SBC with respect to expatriate coverage during the first year of applicability. States should refer to the Drafting Note at the beginning of this section for additional information regarding this enforcement safe harbor.

- (b) In any case, the carrier must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the coverage within the United States.
- F. (1) A carrier must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in regulations and applicable guidance.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the safe harbor for plans and issuers provided in the Special Rule in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition) for completing the SBC. As stated in the final Instruction Guides for Group and Individual Coverage (February 2012 Edition), the Special Rule provides: “To the extent a plan’s terms that are required to be described in the SBC template cannot reasonably be described in a manner consistent with the template and instructions, the plan or issuer must accurately describe the relevant plan terms while using its best efforts to do so in a manner that is still as consistent with the instructions and template format as reasonably possible. Such situations may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program.”

- (2) The SBC must be provided in a uniform format, use terminology understandable by the average individual covered under the policy, not exceed four (4) double-sided pages in length and not include print smaller than 12-point font.
 - (3) The carrier must provide the SBC as a stand-alone document.
- G.
 - (1) A health carrier offering a health benefit plan providing small group market health insurance coverage may provide an SBC in paper form.
 - (2) In lieu of providing an SBC in paper form under Paragraph (1), a health carrier may provide an SBC electronically, such as by email or an Internet posting, if the following is satisfied:
 - (a) The form is readily accessible by the plan sponsor;
 - (b) The SBC is provide in paper form free of charge upon request; and
 - (c) If the electronic form is an Internet posting, the carrier timely advises the plan sponsor in paper form or email that the documents are available on the Internet and provides the Internet address.
 - (3) A health carrier offering a health benefit plan providing small group market health insurance coverage may provide an SBC to a covered person in paper form.
- H. A health carrier must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this section, a carrier is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR §147.136(e) are met as applied to the SBC.
- I. If a health carrier offering a health benefit plan providing small group market health insurance coverage makes any material modification, as defined under Section 102 of ERISA, in any terms of coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the health carrier must 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. The notice of modification must be provided in a form that is consistent with Subsection G.

- J.
- (1) A health carrier offering a health benefit plan providing small group market health insurance coverage subject to the Act must make available to covered persons, the uniform glossary described in Paragraph (2) of this subsection in accordance with the appearance and form and manner requirements of Paragraphs (3) and (4).
 - (2) The uniform glossary must provide uniform definitions, specified by the Secretary in guidance of the following health-coverage-related terms and medical terms:
 - (a) Allowed amount; appeal; balance billing; co-insurance; complications of pregnancy; co-payment; deductible; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitative services; health insurance; home health care; hospice services; hospitalization; hospital out-patient care; in-network co-insurance; in-network co-payment; medically necessary; network; non-preferred provider; out-of-network co-insurance; out-of-network co-payment; out-of-pocket limit; physician services; plan; preauthorization; preferred provider; premium; prescription drug coverage; prescription drugs; primary care physician; primary care provider; provider; reconstructive surgery; rehabilitation services; skilled nursing care; specialist; usual customary and reasonable (UCR); and urgent care;
 - (b) Such other terms as the Secretary determines are important to define so that individuals may compare and understand the terms of coverage and medical benefits, including any exceptions to those benefits, as specified in guidance.
 - (3) A health carrier must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable to the average individual covered under a health insurance policy.
 - (4) A health carrier must make the uniform glossary described in this subsection available upon request, in either paper or electronic form (as requested), within seven (7) business days after receipt of the request.

Section 18. Certification and Disclosure of Prior Creditable Coverage

Drafting Note: The federal agencies charged with implementing the provisions of the ACA published a final rule (79 FR 10295) in the *Federal Register* Feb. 24, 2014, finalizing their proposed rule to amend 45 CFR §146.115 to eliminate the requirement for the group market to provide certificates of credible coverage and to demonstrate creditable coverage. The language in this section is consistent with the language from the final rule.

- A. The federal rules for providing certificates of creditable coverage and demonstrating creditable coverage under 45 CFR §146.115 have been superseded by the prohibition on preexisting condition exclusions in accordance with Section 2704 of the Public Health Service Act.
- B. The provisions of this section apply beginning December 31, 2014.

Section 19. Rules Related to Fair Marketing

- A. A health carrier offering health benefit plans providing small group market health insurance coverage subject to the Act must actively market each of its health benefit plans to individuals in this state, except that for health benefit plans providing small group market health insurance coverage not subject to Section 6 of the Act, a health carrier must offer coverage upon request and is not required to actively market such coverage.
 - B.
 - (1)
 - (a) A health carrier offering health benefit plans providing small group market health insurance coverage must actively offer all health benefit plans it actively markets in this state to any small employer that applies for or makes an inquiry regarding small group market health insurance coverage from the carrier.
 - (b) The offer may be provided directly to the small employer or delivered through a producer.
 - (2) The offer must be in writing and must include at least the following information:
 - (a) A general description of the benefits contained in the health benefit plan being offered to the small employer, and
 - (b) Information describing how the small employer may enroll in the plans.
 - (3) The carrier must provide a price quote to a small employer directly or through an authorized producer within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. The carrier must notify a small employer directly or through an authorized producer within five (5) working days of receiving a request for a price quote of any additional information needed by the carrier to provide the quote.
 - (4) Subject to Section 6A of the Act, the carrier must issue any health benefit plan to any eligible small employer that applies for the plan.
 - (5) The carrier may not directly or indirectly use group size or any health status-related factor as criteria for establishing eligibility for a health benefit plan.
 - C. A health carrier must establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health benefit plans providing small group health insurance coverage in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.
- Drafting Note:** Some states with smaller populations may determine that this provision is not necessary to assure fair marketing of health benefit plans providing small group health insurance coverage in their state.
- D.
 - (1) The health carrier may not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the carrier or for the issuance of any health benefit plan offered by the carrier.

- (2) A health carrier may modify the terms of a policy issued to a small employer that is not a member of the association provided the modifications do not affect the policy's benefit design or other substantive terms of coverage.

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

- E. A health carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.
- F.
 - (1) Health carriers offering health benefit plans providing small group health insurance coverage in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this regulation.
 - (2) Health carriers must elicit the following information from applicants for such plans at the time of application:
 - (a) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and
 - (b) Whether or not the prospective policyholder, certificateholder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162 (other than Section 162(l)), Section 125 or Section 106 of the United States Internal Revenue Code.
 - (3) If a health carrier offering a health benefit plan providing small group health insurance coverage fails to comply with Paragraph (2), the carrier will be deemed to be on notice of any information that could reasonably have been attained if the carrier had complied with Paragraph (2).
- G.
 - (1) A health carrier must file annually the following information with the commissioner related to small group market health benefit plans issued by the carrier to individuals in this state:
 - (a) The number of small employer that were issued, or received renewals of, small group market health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);
 - (b) The number of small group market health benefit plans in force in the state as of December 31 of the previous calendar year;

Drafting Note: Instead of requesting information on the number of individual health benefit plans in force in the state, as provided in Subparagraph (b) above, a state may decide it is more appropriate to request such information by county, three-digit zip code or metropolitan statistical area and non-metropolitan statistical area geographic regions.

- (c) The number of small group market health benefit plans that were voluntarily not renewed by small employers in the previous calendar year; and

- (d) The number of small group market health benefit plans that were terminated or not renewed and reasons (other than nonpayment of premium) for the termination or nonrenewal by the carrier in the previous calendar year.
- (2) The information described in Paragraph (1) shall be filed no later than March 15 of each year.
- H. A health carrier may not create financial incentives or disincentives for producers to sell or to not sell any of its small group market health benefit plans. The commissioner shall have authority to review a carrier's commission structure to ensure no financial incentives or disincentives to sell or to not sell any of its small group market health benefit plans are created by the structure.
- I. A health carrier may not employ marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life or other health conditions.

Section 20. Rules Related to Quality of Care Reporting

To be completed at a later date.

Section 21. Severability

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

Section 22. Effective Date

This regulation shall be effective on [insert date].

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

2015 Proc. 1st Quarter I 3-10 (adopted).