product, and the combination of all plans offered within a product constitutes the total service area of the product.

L. "Policy year" means, with respect to:

(1) Grandfathered health plan coverage providing individual market health insurance coverage and student health insurance coverage, the 12-month period that is designated as the policy year in the policy documents of the health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year; or

(2) Non-grandfathered health plan coverage providing individual market health insurance coverage, or a market in which the State has merged has merged the individual and small group market risk pools for coverage issued or renewed beginning Jan. 1, 2014, a

Drafting Note: States should be aware that 45 CFR §147.102(e) (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 peg cec

(b) The index rate must be adjusted on a market-wide basis for the state based on

B. A health carrier may restrict enrollment in health insurance coverage to open or special enrollment periods.

C. (1) A health carrier must allow an individual to purchase health insurance coverage during an annual open enrollment period established by HHS unless i10w (p)-0.(a)-3.3 6l establishes abroader open enrollment periodi10w (a)-3.2 (n)-0.8 ( )-10.7 (t)-5.9 (h)-0 deslribed inParagraph(2).

(2) The health carrier must ensure coverage is effectiveafor individu or as estab

D. Forindividui10w (a limited open enrollment periodci145 (t3)-5.c-6.3 (e)-6.4 (uir)-3.1 (n(e)-3 (n)

(c) The product continues to cover at least a majority of the same service categories;

(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's 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 non-grandfathered individual market health insurance coverage as described in Subsection A, or uniformly modifying non-grandfathered individual market health insurance coverage as described in Subsection C, the health carrier must provide to each individual written notice of the renewal before the date of the first day of the next open enrollment period in a form and manner specified by the Secretary.

E. (1) Nothing in this section should be construed to require a health carrier to renew or continue in force individual market health insurance coverage for which continued eligibility would otherwise be prohibited under applicable federal law.

(2) Medicare eligibility or entitlement to such benefits is not a basis for non-renewal or termination of an individual's health insurance coverage in the individual market.

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 renewability provisions under Section 2742 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 of Preexisting Condition Exclusions

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

B. As described in Section 4 of the Act, grandfathered health plan coverage that is individual health insurance coverage is not required to comply with this section.

Section 9. Prohibition on Discrimination Based on Health Factors

Drafting Note: For purposes of this *Individual Market Health Insurance Coverage Model Regulation* (#TBD), states should be aware that Section 2705 of the PHSA extends the HIPAA nondiscrimination prohibitions 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. In addition, states should be aware that in the Incentives for Nondiscriminatory Wellness Programs in Group Health Plans; Final Rule (78 F 33158) published in the *Federal Register* June 3, 2013, the preamble of that final rule (78 Fed. Reg. 33167) states that "[c]ommenters requested that the wellness provisions be extended to the individual market or that states be (l)-(h)1 (a)aai(a)-5 (rr)-1.710.3 ()-2.6 (

(c) Prescription drug benefits that meet the requirements of Section 12 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

(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 coursean en1r
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C. Nothing in this section shall be construed to prevent a health carrier from appropriately utilizing reasonable medical management techniques.

Section 14. Cost-Sharing Requirements

A. (1) For a policy 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 policy 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 policy 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)

(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 of 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 (b), 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.8 u3 (i)-3.3 (gh)-0

E. (1) A carriermust provide an SBC in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

Drafting Note: States should refer to the Drafting Note at the beginning of this section regarding the circumstances in which a SBC may be provided electronically consistent with the safe harbor provided by the federal agencies.

(2) A carrier satisfies the requirements of this subsection if the carrier:

(a) Hand-delivers a printed copy of the SBC to the individual or dependent;

(b) Mails a printed copy of the SBC to the mailing address provided to the carrier by the individual or dependent;

(c) Provides the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosures by email;

(d) Posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with subparagraphs (a) through (c) of this paragraph, that the SBC is available on the Internet and includes the applicable Internet address; or

(e) Provides the SBC by any other method that can reasonably be expected to provide actual notice.

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G. (1) If a health carrier offering a health benefit plan providing individual market health insurance coverage subject to the Act makes any material modification, as defined under Section 102 of ERISA, in any terms of the 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 renewal or reissuance of coverage, the health carrier must provide notice of the modification to an individual covered under a health benefit plan not later than sixty (60) days prior to the date on which the modification will become effective.

(2) The health carrier must provide the notice of modification in a form that is consistt (r)11.1

(a) The number of individuals that were issued or received renewals of individual market health benefit plans in the previous calendar year (separated as to newly issued plans and renewals);

(b) The number of individual 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 new metropolitan statistical area geographic divisions

(c) The number of individual market health benefit plans that were voluntarily not renewed by individuals in the previous calendar year; and

(d) The number of individual 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.

F. A health carrier may not create financial incentives or disincentives for producers to sell or to not sell any of its individual 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 individual market health benefit plans are created by the structure.

G. 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.

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

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.

Section22. Effective Date

Thisregulationshall be effective on [insert date].