INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL ACT

Editor's Note: Provided for your convenience are references to the corresponding sections of the federal Public Health Service Act (PHSA). A key to the PHSA section titles f]

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(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10,

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(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care services;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities;

(8) Disability; or

(9) Any other health status-related factor determined appropriate by the Secretary.

BB. (1) "Individual market health insurance coverage" means health insurance coverage, other than a converted policy, offered to individuals in the individual market, but does not include short-term limited duration insurance.

(2) For purposes of this Act, "student health insurance coverage," as defined in Subsection MM of this Act, shall be considered a type of individual health insurance coverage.

CC. "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

DD. "Network plan" means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

EE. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

FF. (1) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date of the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(2) Genetic information shall not be treated as a condition under Paragraph (1) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

GG. "Policyholder" means an individual who has paid premium for himself or herself and his or her dependents, if any, who are also covered under a health benefit plan providing individual health insurance coverage, and is responsible for continued premium payments under the terms of the health benefit plan.

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(1) Rules for, or determination of, eligibility including enrollment and continued eligibility for benefits under the health benefit plan;

(2) The computation of premium or contribution amounts under the health benefit plan; and

(3) Other activities related to the creation, renewal or replacement of a contract of individual health insurance coverage.

OO. "Waiting period" means

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

D. The Commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by health carriers are consistent with the purposes of this Act.

E. In connection with the offering for sale of individual market health insurance coverage under this Act, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions of the coverage concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates; and

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

(2) A listing of and descriptive information, including benefits and premiums, about all health benefit plans offered by the carrier that provide individual market health insurance coverage and the availability of the plans for which the individual is qualified.

F. (1) Each health carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each health carrier shall file with the Commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this Act and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the carrier at its principal place of business.

(3) (a) A health carrier shall make the information and documentation described in Paragraph (1) available to the Commissioner upon request.

(b) Except in cases of violations of this Act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department of Insurance except as agreed to by the health carrier or as ordered by a court of competent jurisdiction.

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

Section 6.

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(1) The policyholder has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the carrier has not received timely premium payments;

(2) The policyholder or the

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(a) The carrier provides advance notice of its decision under this paragraph to the Commissioner in each state in which it is licensed; and

(b) Provides notice of the decision not to renew coverage at least 180 days prior to the nonrenewal of any health benefit plans to:

(i) All affected policyholders

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of age or older.

Drafting Note: For purposes of this section, there is no definition of "dependent". Section 152(f)(1) of the Internal Revenue Code defines

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

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

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

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

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

(4) Notwithstanding Paragraph (1), the health carrier may request, but not require, that an individual or a family member of the individual undergo a genetic test if each of the following conditions is met:

(a) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations or equivalent federal regulations and any applicable state or local law or regulations for the protection of human subjects in research;

(b) The carrier clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(i) Compliance with the request is voluntary; and

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

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

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

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

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(ii) Silver level. A health benefit plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan;

(iii) Gold level. A health benefit plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan; and

(iv) Platinum level. A health benefit plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.

B. If a health carrier offers health insurance coverage in any level of coverage specified under Section 1302(d) of the Federal Act, as described in Subsection A(2)(c) above, the carrier shall also offer such coverage in that level as a health benefit plan in which the only enrollees are individuals who, as of the beginning of a policy year, have not attained the age of 21 years.

C. A health benefit plan not providing a bronze, silver, gold or platinum level of coverage, as described in Subsection A(2)(c) above, shall be treated as meeting the requirements of Section 1302(d) of the Federal Act with respect to any policy year if it provides a catastrophic plan that meets the requirements of Section 1302(e) of the Federal Act.

D. This section shall not apply to a dental plan described in Section 1311(d)(2)(B)(ii) of the Federal Act.

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(a) Conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);

(b) Exempt from obtaining an investigational new drug application; or

(c) Approved or funded by:

(i) The National Institutes of Health, the Centers for Disease Control and Prevention; the Agency for Health Care Research and Qu n u0ncyny2 (tr)14

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(ii) For a child, designate any participating physician who specializes in pediatrics as the child's primary care health care professional and is available to accept the child.

(b) The provisions of Subparagraph (a)(ii) shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

(2) (a) If a health carrier provides coverage for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier:

(i) Shall not require any covered person's, including a primary care health care professional's authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional .217 Td[(R2e)7.9 (p)29(o)-6.7

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

Section 17. Provision of Summary of Benefits and Coverage Explanation

A. Health carriers offering health benefit plans providing individual market health insurance coverage shall provide a summary of benefits and coverage explanation pursuant to the standards adopted by the Secretary under Section 2715(a) of the PHSA to:

(1) An applicant at the time of application;

(2) An enrollee prior to the time of enrollment or reenrollment, as applicable; and

(3) A policyholder at the time of issuance of the policy.

B. A health carrier described in Subsection A shall be deemed to have complied with Subsection A if the summary of benefits and coverage described in Section 2715(a) of the PHSA is provided in paper or electronic form, in accordance with the standards adopted by the Secretary under Section 2715(d) of the PHSA.

C. Except in connection with a policy renewal or reissuance, if a health carrier makes any material modifications in any of the terms of the coverage, as defined for purposes of Section 102 of ERISA, that is not reflected in the most recently provided summary of benefits and coverage, the carrier shall provide notice of the modification to covered persons not later than sixty (60) days prior to the date on which the modification will become effective.

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

Drafting Note: The language of this section reflects the provisions of Section 2715 of the PHSA. Regulations issued by the Secretary related to Section 2715 of the PHSA

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(1) The period of creditable coverage of the individual under the health benefit plan; and

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

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

Section 19.

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Section 24. Effective Date

This Act shall be effective on [insert date].

Public Health Service Act sections:

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

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

2013 Proc. 1st Quarter 107-110, 121, 127, 182-214, 258, 590 (adopted).

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