# NONDISCRIMINATION IN HEALTH INSURANCE COVERAGE IN THE GROUP MARKET MODEL REGULATION

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

E. (1) "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

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

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

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

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

G. "Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period, whichever is earlier.

H. (1) "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member.

(2) "Genetic information" includes information regarding an individual's carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

I. (1) "Group health plan" means an employee welfare benefit plan, as defined in Section 3(1)

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

**Drafting Note:** Paragraph (1) of the definition of "group health plan" tracks the federal definition of "group health plan" found in PHSA Section 2791(a)(1), as amended by HIPAA. However, the federal law's definition of "group health plan" also defines "medical care" as part of the definition of "group health plan." In th 1(l)-2.6 w oc) p 47 (S)0.7gdual is'. Intinn of "round ii(o)-11.3(l)-2.7 (t)-16.6 (h def)-(i)-2.6 .p(a)-19.3 (w)-14 a

(g) Evidence of insurability, including:

(i) Conditions arising out of acts of domestic violence; or

(ii) Participation in activities, such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities; or

(h) Disability.

(2) For purposes of this subsection, "health factor" does not include the decision whether to elect health insurance coverage, including the time chosen to enroll, such as under special enrollment or late enrollment.

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

N. "Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in Paragraph (1); and

(3) Insurance covering medical care referred to in Paragraphs (1) and (2).

O. (1) "Medical condition" means any condition, whether physical or mental, including any condition resulting from illness, injury, accident, pregnancy or congenital malformation.

(2) For purposes of Paragraph (1), genetic information is not a condition.

P. "Participant" has the meaning stated in Section 3(7) of ERISA.

Q. (1) "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the enrollment date of the coverage.

(2) "Preexisting condition" shall not mean a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the health benefit plan, provided that the prior creditable coverage was continuous to a date not more than ninety (90) days prior to the enrollment date of the new coverage.

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

R. "Significant break in coverage" means a period of ninety (90) consecutive days during all of which the individual does not have any creditable coverage, excœu

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

**Section 4. Applicability and Scope**

(c) A carrier subject to this regulation may impose annual, lifetime or other limits on benefits and may require a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit under the plan if the limit or cost-sharing requirement:

(i) Applies uniformly to all similarly situated individuals; and

(ii) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(d) For purposes of this paragraph, a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(3) If a carrier subject to this regulation generally provides benefits for a type of injury, the plan or carrier shall not deny an individual participant or beneficiary benefits otherwise provided under the plan for treatment of the injury if the injury results from an act of domestic violence or a medical condition.

(4) A carrier subject to this regulation with a cost-sharing mechanism, such as a deductible, copayment or coinsurance, that requires a higher payment from an individual, based on a health factor of that individual or dependent of that individual, than for a similarly

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