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 Enrollment Opportunities

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.

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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)

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Section4.

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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 adopte-4 (f)-2.h4 (i(t)0.7)0.7 (i)-1.6 (n)2-0.(4)5-4Tc 0 Tw 19.33

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(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 las6 (er)]TJ0 Tc0.7 (38 0 Td[Tw -20 l)-6.9 (f0 Td( )TjEMC /P <</MCID 01BDC 1-2.323

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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 [Drafting note: See 45 C.F.R. 147.106(e)(1)(i) and 45 C.F.R. 156.111(a)(3)(i).]

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(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.

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(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. Silapp-

(2) (a) This paragraph applies only within a group of individuals who are treated as similarly situated individuals.

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(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:

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(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.

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(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;

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(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;

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(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;

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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 pla (gr)-1.66 -595 (t)-4oe rupavtht.7 (h(h)-0.7 o)-4.1 (p)-0.6 eltgiblpethtge

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(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

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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 s1e2 (0 Td)D2617.5 Tw1.7 (o)-4 (en5.6g)-2.5-1.8 (a)-2. (e(ui)-1.6.5-1.8 (a)-2.

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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

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(c)

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(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:

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(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 001 T97ate

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- 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 1.4 (s)-2.4

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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

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(k) For carriers that use a formulary in providing prescription drug coverage, an

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Section19. Rules Related to Fair Marketing

A. A health carrier offering health benefit plans providing small group market health insurance

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(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 insur(r)-1.8 (o)-4 (d)-0

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(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

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