PROJECT HISTORY - 2014

INDIVIDUAL MARKET HEALTH INSURANCE COVERAGE MODEL REGULATION (#26)

1. Description of the Project, Issues Addressed, etc.

At the 2013 Spring National Meeting, the Regulatory Framework (B) Task Force began its review of an initial outline for developing the Individual Market Health Insurance Coverage Model Regulation as a companion regulation to the *Individual Market Health Insurance Coverage Model Act* (#36). The Task Force began discussing an initial draft of the model regulation at the 2013 Summer National Meeting. The draft model regulation incorporates the provisions of various federal regulations implementing the 2014 market reform provisions and other relevant provisions of the federal Affordable Care Act (ACA). The Task Force adopted the Individual Market Health Insurance Coverage Model Regulation Nov. 16 at the 2014 Fall National Meeting and presented it to the Health Insurance and Managed Care (B) Committee for its consideration. As part of the Task Force's report, the Committee adopted the Individual Market Health Insurance Coverage Model Regulation Nov. 17.

Major provisions in the model regulation include:

- Restrictions Relating to Premium Rates (Section 4)
- Single Risk Pool (Section 5)
- Guaranteed Availability of Individual Market Health Insurance Coverage; Enrollment Periods (Section 6)
- Guaranteed Renewability of Individual Market Health Insurance Coverage (Section 7)
- Prohibition on Preexisting Condition Exclusions (Section 8)
- Essential Health Benefits Package (Section 10)
- Prescription Drug Benefits (Section 12)
- Cost-Sharing Requirements (Section 14)
- Actuarial Value Calculation for Determining Level of Coverage; Levels of Coverage (Section 15)
- Enrollment in Catastrophic Plans (Section 16)
- Provision of Summary of Benefits and Coverage (Section 17)
- Certification and Disclosure of Prior Creditable Coverage (Section 18)

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force drafted the model regulation. The members of the Task Force at the time of adoption were: Wisconsin, Chair; Utah, Vice Chair; Arizona; California; Colorado; Connecticut; Delaware; Florida; Idaho; Illinois; Indiana; Kansas; Kentucky; Maine; Minnesota; Missouri; Montana; Nebraska; Nevada; New Jersey; N. Marina Islands; Ohio; Oklahoma; Oregon; Pennsylvania; Puerto Rico; South Dakota; Tennessee; Virginia; and West Virginia.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework (B) Task Force has a general charge to: coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation and regulations. The Task Force also has a specific charge to consider the development of new NAIC model laws and regulations, as well as the revision of existing NAIC model laws and regulations affected by federal legislation and final federal regulations promulgated pursuant to such legislation.

After the enactment of the ACA in March 2010, consistent with its charges, the Health Insurance and Managed Care (B) Committee directed the Task Force to review and revise existing NAIC models affected by the ACA or, as necessary, develop new NAIC models to assist the states in implementing the ACA. This proposed new NAIC model regulation is consistent with that directive.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The model regulation was drafted by the Regulatory Framework (B) Task Force. The Task Force held in-person meetings at each of the 2013 and 2014 National Meetings and several open conference calls, during which the drafts and comments received on the drafts were discussed. All drafts and comments were posted on the Task Force's page on the NAIC website. During these in-person meetings and open conference calls, representatives from various stakeholder groups participated,

including consumer representatives, such as the Georgetown University Health Policy Institute, the Center on Budget and Policy Priorities (CBPP), the Consumers Union and Families USA, and the Alzheimer's Foundation of America; industry representatives, such as the America's Health Insurance Plans (AHIP), the BlueCross and BlueShield Association (BCBSA), and the Pharmaceutical Research and Manufacturers of America (PhRMA); and individual consumers.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

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6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

There was only one significant issue discussed at the end of the drafting process. During the last public comment period, more than 40 comment letters were received concerning an issue related to network plans found in Section 14B. The issue related to a provision in the final federal regulations concerning the application of non-network cost-sharing to the annual limitation on cost-sharing. As provided in 45 CFR §156.130, in the case of a plan using a network of providers, the annual limitation on cost-sharing, as defined in 45 CFR §156.130(a), does not apply to benefits provided out-of-network. Section 14B of the model regulation reflected the federal provision, but included a drafting note alerting state insurance regulators that subject to state or federal law or regulations, nothing prohibits a health carrier from establishing contractual limits on cost-sharing that are lower than the limits provided in the federal regulations or establishing contractual limits on cost-sharing that apply to benefits provided both in-network and out-of-network. A majority of the comment letters received on this issue urged the Regulatory Framework (B) Task Force to consider revising the model regulation, at a minimum, to provide that the out-of-network cost-sharing that results from an exceptions or appeal process permitting a covered person to obtain covered benefits from an out-of-network provider should apply to the annual cost-sharing limitation.

During its meeting at the 2014 Fall National Meeting, the Task Force discussed the comment letters received on this issue and the suggested revisions to address it. The Task Force voted unanimously to revise Section 14B to permit benefits provided on an appeal or exceptions basis because medically necessary services were not reasonably available within the network to be applied to the annual cost-sharing limitation. The Task Force also voted unanimously to add a sentence to the drafting note specifically alerting the states that federal law does not prevent a state from establishing lower cost-sharing limits or establishing limits that apply to out-of-network benefits.

7. Any Other Important Information (e.g., amending an accreditation standard)

None

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