

Introduction

This State Survey in nine parts:

- NAIC Model Laws and Regulations
- Recent Activity in State Mandated Benefits
- State-Mandates
- MEWA Regulation
- TPA Regulation
- Stop-Loss Regulation
- UR Regulation
- Miscellaneous

NAIC Model Laws or Regulations

Health Insurance Reserves Model Regulation

Requires insurers to establish minimum claim, premium and contractual reserves to meet statutory minimums.

Comprehensive Health Insurance and Health Cost Containment Model Law

This model law provides for the mandatory availability of comprehensive health insurance coverage and creates a state Health Care Commission to implement programs designed to provide health care cost and quality controls.

Standardized Health Claim Form Model Regulation

The purpose and intent of this regulation is to standardize the forms used in the billing and reimbursement of health care, reduce the number of forms utilized, increase efficiency in the reimbursement of health care through standardization and encourage the use of and prescribe a timetable for implementation of electronic data interchange of health care expenses and reimbursement.

Health Carrier Claim Audit Guidelines Model Law

The purpose of this law is to provide for the reasonable standardization of statewide claim audit guidelines of health care bills for health care services and their reimbursements by health carriers, preferred provider organizations, third party administrators, or any other health benefit plan to determine whether data in a health care record of an institutional provider is supported by services listed on the claim for payment of an insured or an institutional provider. It is further the purpose of this law to alleviate the potential conflict of the audit with medical uses of the health record and to reduce the cost of conducting a necessary audit.

Small Employer Health Insurance Availability Model Law

The purpose and intent of this law is to enhance the availability of health insurance coverage to small employers and individuals regardless of their health status or claims experience, to prevent abusive rating practices, to prevent segmentation of the health insurance market based upon health risk, to spread health insurance risk more broadly, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to limit the use of preexisting condition exclusions, to provide for development of *basic* and *standard* health benefit plans to be offered to all small employers and individuals, to provide for establishment of risk-spreading mechanisms, and to improve the overall fairness and efficiency of the small group and individual health insurance markets.

Model Regulation to Eliminate Unfair Sex Discrimination

The purpose of this regulation is to eliminate the act of denying benefits or coverage on the basis of sex or marital status in the terms and conditions of insurance contracts and in the underwriting criteria of insurance carriers.

Health Information Privacy Model Law

The purpose of this law is to set standards to protect health information from unauthorized collection, use and disclosure by requiring carriers to establish procedures for the treatment of all health information.

Preferred Provider Arrangements Model Law

The purpose of this law is to encourage health care cost containment while preserving quality of care by allowing health care insurers to enter into preferred provider arrangements and by establishing minimum standards for preferred provider arrangements and the health benefit plans associated with those arrangements.

Utilization Review Model Law

This law established standards and criteria for the structure and operation of utilization review processes designed to facilitate ongoing assessment and management of health care services.

Managed Care Plan Network Adequacy Model Law

The purpose and intent of this law are to establish standards for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility and quality of health care services offered under a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide services to covered persons.

Third Party Administrator Law

The purpose of this law is to regulate TPAs regardless of whether they administer fully insured or self-funded plans.

Stop-Loss Insurance Model Law

The purpose of this law is to establish criteria for the insurance of stop-loss insurance

policies. Nothing in this act shall be construed as imposing any requirement or duty on any person other than an insurer or as treating any stop-loss policy as a direct policy of health insurance.

Jurisdiction of Health Care Providers Model Law

The purpose of this law is to give the states jurisdiction over providers of health care benefits; to indicate how each provider of health care benefits may show under what jurisdiction it falls; to allow for examinations by the states if the provider of health care benefits is unable to show it is subject to another jurisdiction; to make such a provider of health care benefits subject to the laws of the state if it cannot show that it is subject to another jurisdiction; and to disclose to purchasers of such health care benefits whether or not the plans are fully insured.

Standard Group Health Model Law

This model law sets forth the definition of group health, what groups are eligible and what are the standard provisions to be included therein.

Group Health Insurance Mandatory Conversion Law

All group health coverage must have the right of conversion to individual coverage.

Group Coverage Discontinuance and Replacement Model Regulation

This is the state equivalent of COBRA.

Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups

The intent of this law is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

Group Coordination of Benefits Model Law

The purpose of this regulation is to:

- Permit, but not require, plans to include a COB provision unless prohibited by federal law
- Establish a uniform order of benefit determination under which plans pay claims
- Provide authority for the orderly transfer of necessary information and funds between plans
- Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first
- Reduce claims payment delays
- Require that COB provisions be consistent with this regulation.

Model Regulation for Certification of Health Plans

The purpose of this regulation is to promote wellness by establishing criteria and procedures for the state's designation of health insurance policies and subscriber contracts meeting or exceeding said criteria as certified health plans or policies.

Off-Label Drug Use Model Law

In order to prevent unfair discrimination among insured persons in this state and to prohibit unfair competition among health carriers that include coverage for drugs as part of health benefit plans, standards for payment or reimbursement of costs associated with prescription drugs are required. Some health benefit plans deny payment for drugs that have been approved by the federal Food and Drug Administration (FDA) when the drugs are used for indications other than those stated in the labeling approved by the FDA while other health benefit plans with similar drug coverage pay or reimburse for off-label use. Denial of payment or reimbursement for off-label use can interrupt or effectively deny access to necessary and appropriate treatment for persons being treated for life-threatening illnesses. In addition, drugs for off-label use may provide efficacious treatment at a lower cost.

Group Health Mandatory Drug/Alcohol Dependency Law

The purpose of this law is to encourage consumers to avail themselves of basic levels of benefits under group health insurance policies and other contracts for the care and the treatment of alcohol and other drug dependency, and to preserve the rights of the consumer to select coverage according to his or her medical and economic needs.

Model Newborn Children Law

All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly-born child of the insured or subscriber from the moment of birth.

Health Examination Benefits Availability Law

The purpose of this law is to require insurers providing group health insurance on an expense-incurred basis to make coverage for periodic physical examinations available at the option of the policyholder to facilitate early detection and prevention of sickness and disease.

Accident Sickness Insurance Minimum Standards Model Law

The purpose of this law is to standardize and simplify the terms and coverage's of individual accident and sickness insurance policies and group accident and sickness insurance policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage. This act is also intended to facilitate public understanding and comparison, to eliminate provisions contained in individual accident and sickness insurance policies and group supplemental health insurance that may be misleading or unreasonably confusing in connection either with the purchase of these coverage's or with the settlement of claims. This Act also provides for full disclosure in the sale of accident and sickness coverage's, group supplemental health insurance and dental and vision plans.

Agents and Brokers Licensing Model Law

This law governs the qualifications and procedures for the licensing of insurance agents,

insurance brokers, surplus line brokers, insurance consultants and limited insurance representatives. These provisions shall apply to any and all lines of insurance and types of insurers including but not limited to life, health, property, liability, credit, title, fire, or marine operating on a stock, mutual reciprocal, fraternal, hospital or medical service plan, as set forth in this law. For purposes of this law; all references to insurance shall include annuities unless the context otherwise requires. This law also requires reporting to the commissioner the termination of a producer by an insurer, whether with or without cause.

MEWA Licensing Model Regulation

The purpose of this regulation is to require licensed agents, brokers, third-party administrators and insurers to submit information to the Department prior to assisting in any way the transaction of insurance by certain types of multiple employer arrangements identified in this regulation. These reports will help the Department identify unauthorized insurance arrangements before the transactions occur. The reports also will help licensees identify unauthorized insurance arrangements so that they can protect themselves from potential liability for assisting in the transaction of unauthorized insurance.

Managing General Agents Law

This law provides that no person, firm, association or corporation shall act in the capacity of an Managing General Agent with respect to risks located in this state for an insurer licensed in this state unless such person is a licensed producer in this state. Further, no person, firm, association or corporation shall act in the capacity of a Managing General Agent representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as a producer in this state (such license may be a nonresident license) pursuant to the provisions of this law.

Health Maintenance Organization Model Law

The model law clearly authorizes the establishment and operation of HMOs. Restrictive provisions in other laws which are inappropriate to HMOs are rendered inapplicable. Appropriate grants of authority are established to enable the HMOs to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient and ethical operation of HMOs. As in the case with insurance and hospital and medical service corporations, HMOs are *affected with the public interest*. Regulatory safeguards dovetailed to the unique nature of HMOs are essential. Thus, the purpose of this model bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMOs of a wide variety including those based upon the medical care foundation or individual practice association concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of *modus operandi* is required. Instead the HMO concept can be refined and subjected to further experimentation. Second, the model law attempts to provide a regulatory monitoring system not only to prevent or remedy abuse, but also to assist in the future improvement and development of this alternative form of a health care delivery system.

It is also possible that the statutes of a given state are presently broad enough to allow operation of at least certain types of HMOs and provide the commissioner with appropriate

authority to regulate them. In those states, a bill such as this may be desirable in order to consolidate and define more clearly the authority for and manner of regulation of an HMO. However, it may be possible to form HMOs under existing laws in some states before passage of this model regulation and it is anticipated that these programs can develop concurrently with any legislative activity.

Insurance Information and Privacy Protection Model Law

The purpose of this law is to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance support organizations to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision.

Unfair Trade Practices Law

The purpose of this law is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in Pub. L. No. 79-15(1945) by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. Nothing herein shall be construed to create or imply a private cause of action for a violation of this law.

Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment

The purpose of this regulation is to identify specific acts or practices in life and health insurance which are prohibited by Section 4G(1) and (2) of the Model NAIC Unfair Trade Practices Law.

Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Total or Partial Blindness

The purpose of this regulation is to identify specific acts or practices that are prohibited by Section 4G of the Unfair Trade Practices Law.

Unfair Discrimination Against Subjects of Domestic Abuse in Health Benefit Plans Model Law

The purpose of this law is to prohibit unfair discrimination by health carriers and insurance professionals on the basis of abuse status. Nothing in this law shall be construed to create or imply a private cause of action for a violation of this law.

Unfair Claims Settlement Practices Law

The purpose of this law is to set forth standards for the investigation and disposition of claims arising under policies or certificates of health insurance. It is not intended to cover claims involving workers' compensation insurance. Nothing herein shall be construed to create or imply a private cause of action for violation of this law.

Improper Termination Practices Model Law

The purpose of this law is to protect policyholders from improper termination's of insurance coverage and to set forth standards for the regulation and disposition of terminations of policies or certificates of insurance. Nothing in this law shall be construed to create or imply a private cause of action for violation of this law except that a named insured may appeal the termination of the named insured's policy.

Employee Leasing Registration Model Act

A corporation, partnership, sole proprietorship, or other business entity that provides staff, personnel or employees to be employed in this state to other businesses pursuant to a lease arrangement shall, before becoming eligible to be issued a policy of workers' compensation insurance or becoming eligible to secure coverage on a multiple coordinated policies basis, register with the commissioner.

Private Employer Workers' Compensation Group Self-Insurance Model Law

The provisions of this law shall apply to workers' compensation self-insurance groups. Public employer workers' compensation self-insurance groups shall not be deemed to be insurers or insurance companies and shall not be subject to the provisions of the insurance laws and regulation except as otherwise provided herein.

Public Employer Workers' Compensation Group Self-Insurance Model Law

The provisions of this law shall apply to public employer workers' compensation self-insurance groups. Public employer workers' compensation self-insurance groups shall not be deemed to be insurers or insurance companies and shall not be subject to the provisions of the insurance laws and regulations except as otherwise provided herein.

Twenty-Four Hour Coverage Pilot Project Model Law

It is the intent of this state to determine whether the costs of the workers' compensation system and the health care delivery system can be more effectively managed than under the current system by combining the benefits required by workers' compensation with the benefits offered under a group health insurance policy or benefit plan. Therefore, this state authorizes the establishment of up to ten (10) pilot projects to be administered by Department of Insurance after consulting with the workers' compensation administrator. Each pilot project shall terminate five (5) years after the first date of operation of the project, unless extended by an Act of Legislature.

Recent Activity In State-Mandated Benefits

Recent activity in state-mandated benefits:

1. Liability Law

Eight states now have laws allowing covered persons to sue their health care plan:

- AZ GA ME TX
- CA LA OK WA

2. External Grievance

Forty states now have laws allowing covered persons to appeal grievances to an external review body.

3. Mental Health Laws

Twenty-nine states now have laws mandating mental health parties.

4. Contraception Benefits

Twelve states now have laws mandating contraception benefits.

5. Clinical Trial Coverage

Ten states now have laws mandated that plan cover clinical trial expenses.

6. Physician Antitrust Waivers

Only one state (TX) permits physicians to collectively bargain with insurers with antitrust immunity. Many states have attempted, unsuccessfully, to enact such law.

7. Fertility Coverage

State laws dealing with fertility benefits are of types

a. Type 1 - Requiring Fertility Coverage

- MD AR RI
- HA MA IL

b. Type 2 - Fertility Coverage Must Be Offered

- TX CT CA

c. Type 3 - Only HMOs Must Provide Coverage

- MT OH WV

d. Type 4 - New York Model

Insurers may not deny coverage of medical conditions solely because of infidelity.

8. Pharmacy Access and Pricing

States have enacted a variety of programs to improve access to prescription drugs for targeted populations. Such pharmacy assistance program for low-income residents might include moderate-income aged and disabled persons.

New state regulations are placing on HMO drug formularies. HMOs will be allowed to continue variable pricing practices such as tiered co-pays, which provide a lower level of benefits for non-formulary prescription drugs.

9. Prompt Payment

Prompt payment legislation continued to be a priority in the states.

10. Assignment of Benefits

New state legislation is emerging requires health plans to honor assignment of benefits by subscribers to nonparticipating providers. While passage of such legislation represents a windfall for providers, it has consequences for consumers: (1) higher out-of-pocket expenses due to balance billing; (2) reduced choice because providers will have little incentive to join networks; and (3) reduced access to care.

State-Mandates

Benefits Which Must Be Covered

Benefits that are required to be covered must automatically be included in the health care plan.

Benefits That Must Be Offered

Benefits that are required to be offered must be made available as an optional addition to the plan, but employers are not required to purchase them for employees.

Persons Who Must Be Covered

Some states have enacted laws requiring health plans to cover specific groups of people, especially children, to ensure that they are not excluded from coverage.

Providers Who May Be Covered

Unless specific state laws were enacted, many providers (psychologists, nurses e.g.) would not be deemed medical providers (or physician) and, as a consequence, excluded from being covered.

Coordination of Benefits

Birthday Rule

- Yes means that if a child is a dependent of parents, both of whom are covered by a different plan, the parent whose birthdate falls first in the calendar year is primary.
- No means that the plan covering the father is primary; this is the so-called gender rule.

Divorced/Separated Rule

- Yes means the parent with custody is primary; in the instance of such parent's remarriage, the plan of the spouse with custody is primary.
- There are not any *no* responses to this category.

Joint Custody (Divorced/Separated) Rule

- Yes means that where the divorced or separated parents have joint custody they should be treated for plan priority purposes as being married; i.e., the birthday rule or the gender rule

should apply.

- No means that, for purposes of determining which plan is primary, the joint custody order may be ignored and other facts and circumstances shall be used.

Active v. Inactive Rule

- Yes means that in the following situation:

<u>Plan</u>	<u>Employee</u>	<u>Status</u>	<u>Dependent SPMs</u>	<u>Status</u>
A	John	Active	Mary	Retire
B	Mary	Retired	N/A	N/A

Plan A will be primary to Mary; Plan B will be secondary to Mary.

- There are not any no responses to this category.

Longer v. Shorter

- Yes means that if the usual rules, for whatever reasons fail to declare a plan clearly as *primary* the plan having the participant covered for the longer period is primary.
- There are not any *no* responses to this category.

Managed Care Rule

This category deals with the case of Bill who incurs a legal liability to pay his medical procedure through his employer's plan A using Provider X of say, \$1,000. The same procedure using provider x with the plan of Bill's wife, of which he is a dependent spouse's pay, \$600. The question becomes for plan B in determining its secondary payment, does it replace Bill's \$1,000 legal liability from A with his legal liability with B or \$600.

- Yes - the \$1,000 is replaced.
- No - the \$600 is not replaced.

COBRA Rule

This category deals with the person who is an active employee with Plan M at the same time being a COBRA with Plan N, such person's prior employer.

- Yes means that Plan N is primary to Plan M.
- No means that Plan M is primary to Plan N.

Preservation of Deductibles and Copayments Rule

This is referred to as the preservation of deductibles and copayment rule. It works as follows:

1. Primary plan pays \$500 where the submitted charges were \$1,000.
 2. Secondary plan, with such \$1,000 submitted charges would also pay \$500 but \$400 of which was for the copayment and deductible.
- Yes means that the secondary plan would by only \$100 (\$1,000 - 500 - 400).
 - No means that the secondary plan would pay \$500.

Continuation and Conversion

Many states have enacted their own continuation of coverage mandates. Some are similar to COBRA, a few are more liberal but most are less liberal.

Further more than a few states have conversion of benefits mandates which are not substitutes for continuation.

Both the states' continuation and conversion of coverage laws are preempted by ERISA for self-funded plans.

Patient's Bill of Rights Legislation

ERISA allows participants to sue health plans that deny coverage of treatment, but only to get that medical care covered or to recoup the cost of participant-paid treatment and not for damages. However, some states have superseded ERISA by enacting laws allowing patients to sue their HMO for damages.

High Risk Health Pool

High-risk health insurance pools are established and maintained by a state to provide health insurance for residents who, because of the existence or history of a medical condition, are unable to buy coverage on the open market and do not have other private insurance or access to an employer-sponsored group health plan. They are called "high risk" pools because the consumers in them are considered at high risk of incurring high medical expenses. In addition, most states that offer a high-risk pool impose a cap on health insurance premiums bought through the pool. The cap is a fixed percentage above the standard premium charged for individual health coverage on the open market in the state.

External Grievance System

External grievance systems allow the participant to take a dispute with the health plan to a doctor or review board unaffiliated with the health plan. Thus, both the participant and health plan receive an impartial ruling on its decision to deny coverage of services or treatment. Additionally, such participant may file a complaint against the health insurer with the state's department of insurance.

Prompt Pay Health Claim Requirement

Prompt-pay laws require health plans to pay health claims within a specified time period, or face fines, added interest payments, and other penalties. Note that prompt-pay laws apply only to *clean claims* (meaning claims without defect and with full information provided).

MEWA Regulations

The 1983 Amendments to ERISA (so-called Erlenborn Amendment) established the following MEWA governance:

1. If unrelated entities (employers, plans, etc.) share a plan as a joint venture it is a MEWA so long as the participant and the entities have an employee-employer relationship. With a MEWA, the states and Federal authorities have joint jurisdiction over the MEWA (which is not an insurer).

2. Where the joint venture fails the test in (1) above, it is not a MEWA but rather an unauthorized insurer. Over such unauthorized insurer, the states have total control.

3. States that refuse to adopt legislation exercising their right to jointly regulate such MEWAs with the Federal authorities must recognize such joint venture as an ERISA plan free of

any state regulation.

4. Thus states have these options with unrelated entity jointly-ventured self-funded healthcare plans:

- If they fail to gain MEWA status (i.e., are funding vehicles for ERISA welfare plans), states have total jurisdiction over such plans as unauthorized insurance.
- If they do gain MEWA status, the states may (a) enact legislation and co-regulate with the DOL or (b) permit such plans to be totally regulated by the DOL (as a self-funded plan).

5. Many states have chosen to declare summarily (by regulation or rulings typically) that MEWAs are unauthorized insurance. Such position of the states, if challenged in Federal Court would most likely have to be reviewed and changed.

TPA Regulations

Because of ERISA preemption issues, some (not all) do not regulate TPAs to the extent that a self-funded health care plan is directly affected. States are free to regulate short of such affectation, however; an example would be state-required registration.

The difficulty faced by the TPA who declines registration because of the ERISA preemption would need to show that its entire block of self-funded plans consisted of ERISA plans only; i.e., there were no church government; or fully insured plans; or MEWAs.

Nearly all of the states have some type of TPA law; such law is typically the NAIC model law. The new model TPA law of the NAIC gives TPA *breathing room* in two particular ways:

- A *de minimis* rule excusing licensure in a state where only a small number of the affected participants reside.
- A *reciprocity* rule whereby two states would agree that any TPA would need to license in only one of the two states.

Stop-Loss Regulation

There are several ways by which a state may regulate stop-loss coverage.

- Require the policy form to be submitted to the state for approval
- Influence the terms of stop-loss (minimum specific, e.g.)
- Regulate premiums (actuarial assumptions to be filed and approved, e.g.).

UR Regulations

Of the states which have enacted UR Regulations, the most common version is the NAIC Model. There are four significant issues with such law which should be noted:

- What agency is responsible for its enforcement?
- What are the registration and certification requirements?

- What types of coverage may be excluded (workers' compensation, e.g.).
- What type of UR firms are granted an exemption (other state-regulated as with URAC-Accredited firms, e.g.).

Miscellaneous

This is a *catch-all* for the many state rulings, etc. which affect self-funding and which do not conveniently fit in any of the other discussion areas. Examples include medical savings account, balance-billing requirements, premium taxes, assignment of commissions, special managed care mandates, etc.