REPORT OF THE
STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE ON

A Feasible Proposal to Establish a Small Business Risk-Sharing Pool with Insurance Reforms to Improve Access and Moderate Rate Increases and an Evaluation of Options for Monitoring Costs and Rates of Health Insurance Carriers

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 9

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STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

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TO: The Honorable L. Douglas Wilder
Governor of Virginia
and
The General Assembly of Virginia

I am pleased to transmit this report containing the response of the State Corporation Commission's Bureau of Insurance to Senate Joint Resolution No. 181 of the 1991 Session of the General Assembly of Virginia. Pursuant to the resolution, the report is also being submitted to the Commission on Health Care for All Virginians.

This report contains a feasible proposal for the establishment of a small business risk-sharing pool. Insurance reforms that moderate rate increases and improve access to health insurance for small employer groups are also proposed along with a small employer group health reinsurance association.

The Bureau of Insurance also evaluated options for monitoring the costs and rates of health insurance carriers.

The Bureau of Insurance confined its study to the areas addressed in Senate Joint Resolution No. 181. These recommendations represent the first step in making health insurance more affordable for small employer groups. The Bureau of Insurance recognizes that there are factors affecting the availability and affordability of health insurance for small employer groups that are not addressed by the proposals in this report.

Respectfully submitted,

Steven T. Foster
Commissioner of Insurance

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Executive Summary

Senate Joint Resolution 181, adopted by the 1991 General Assembly, requested the State Corporation Commission's Bureau of Insurance (Bureau) to develop a feasible proposal to establish a small business risk-sharing pool with insurance reforms that would improve access to health care coverage and serve to moderate rate increases The Bureau was also requested to evaluate options for monitoring the costs and rates of health insurance carriers

Nearly 13% of all Virginians under age 65 do not have health insurance Approximately 60% of these individuals are in families where the head of the household is employed In Virginia, nearly 36% of all businesses do not offer health insurance to their employees Approximately 41% of the small businesses with less than 26 employees do not offer health insurance The majority of all businesses in Virginia (87%) have less than 20 employees

Many of the problems in the small employer group market are caused by current market practices of insurers Many carriers either do not accept small employers or charge premiums that small employers cannot afford to pay

In accordance with Senate Joint Resolution 181, the State Corporation Commission's Bureau of Insurance, makes the following recommendations

(1) The adoption of small group health insurance market reforms designed to increase access and improve affordability of health insurance for small employer groups,

(2) The establishment of a small employer group health insurance risk-sharing program, and

(3) The establishment of a small employer group health reinsurance association

This report defines a small employer group to be an employer with at least two but less than 50 employees The National Association of Insurance Commissioners (NAIC) considers a small group to be one with less than 26 employees as defined in a recent draft model act on small employer group health reform. Some carriers believe that it is the coverage for groups with less than 26 employees that is most in need of market reform The Bureau recognizes that the market for groups with less than 26 employees may be more in need of reform than the market for larger groups However, there are groups employing between 26 and 50 persons that also experience difficulty obtaining and maintaining health coverage. It is because of those difficulties that this report defines a small group as one with at least two but less than 50 employees.

Proposed Features to Reform the Small Group Market

To promote greater access to health care coverage, rate stability, and continuity of coverage, the Bureau proposes several market reforms for the Virginia small business health insurance market Many of the proposed market reforms are consistent with the NAIC Model Act entitled "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups "

Under the Bureau's recommended market reforms, all small employer group carriers would be required to offer and issue a "standard" health policy and a basic "mandates exempt" health policy to small employer groups A small employer group carrier would also be prohibited from engaging in the following practices

- o offering coverage only to certain persons in a group,
- o imposing new waiting periods or pre-existing condition requirements when a group changes carriers or when insured employees change employers, and
- o non-renewing a small employer group's coverage after unfavorable claims experience

In order to moderate small employer group rate increases over time, all carriers in the small employer group market would be required to limit rate variations for small employer groups within similar geographic regions which possess similar demographic composition and health policy benefits. To ensure compliance with the proposed rate reform measures, each small employer group carrier would be required to file with the State Corporation Commission (SCC) annually an actuarial certification.

The NAIC is considering adoption of a model regulation to monitor compliance with these rate reform measures

A small employer group carrier would also be required to make adequate disclosure, as part of its solicitation and sales materials, of its rating practices and renewability provisions

Proposed Features of the Small Employer Group Risk-Sharing Program

In order to aggregate the experience of small businesses and allow them to purchase health insurance on the same scale as larger employers, the Bureau proposes establishing a Small Employer Group Risk-Sharing Program (Program) Eligibility for this program would be limited to employers that have been in business for more than one year and employ at least two but less than 50 persons on a full-time basis.

The Bureau believes that the Commission on Health Care for All Virginians may wish to consider the approach undertaken by the Florida legislature as the best way to develop a risk-sharing program The Florida approach merits consideration because it has been successful in attracting and maintaining participants.

The Program would be administered by a private non-profit corporation The corporation would seek and procure coverage from insurers and health maintenance organizations (HMOs) The corporation would also arrange for reinsurance, determine business and employee eligibility, collect premiums, and perform market research and product development. The functions performed by the corporation would defray some of the costs that insurance carriers or health care plans normally incur and should be reflected in reduced premiums for participants in the Program

The Program would be funded primarily through employer and employee premium contributions and private donations Funds to cover the initial start-up costs and long-term subsidies for this program could come from the Virginia

Indigent Health Care Trust Fund If these funds are utilized, the Virginia General Assembly may need to enact a statute to govern the operation of this non-profit corporation and the use and accountability of these state funds

Proposed Features of the Small Employer Group Health Reinsurance Association

The Bureau has determined that it is feasible to establish a small employer group health reinsurance association The purpose of the proposed Small Employer Group Reinsurance Association (Association) is to provide a reinsurance mechanism for spreading risk among all small employer group carriers in the market The basis of competition would then be directed toward service, risk management, and product development, rather than risk selection As a condition of doing business in this Commonwealth, all carriers in the small employer group health insurance market would be members of the Association

The Bureau considered two reinsurance options - the prospective and the retrospective methods. Using the prospective method, carriers that participate in the reinsurance mechanism would identify high risk groups or individuals within a group at the time of application for coverage The carrier would pay a "premium" to cede the risk of covering the high risk group or individual to the Association The Association would reinsure up to the level of coverage provided in a basic or standard health care policy The carrier would be responsible for paying the first $5,000 in claims per calendar year and 10% of the next $50,000 in claims Claims against the Association would first be financed by premiums for ceded groups and individuals. If losses exceed premiums, participating small employer group carriers would be assessed an amount not to exceed 5% of their annual direct premiums from health benefit plans covering small employer groups

Using the retrospective method, a carrier would not be required to identify high risk cases at the time of application for coverage Instead, carriers would cede groups or individuals to the Association after a specified claims amount (stop-loss) had been exceeded. A list of conditions would be developed to determine which medical conditions qualify for reinsurance This method allows carriers with less sophisticated underwriting systems to compete favorably with other carriers

The Bureau also proposes the possibility of utilizing funds from the Virginia Indigent Health Care Trust Fund to help finance the Association and, in turn, reduce the ultimate premium level paid by employers and/or employees

Options for Monitoring the Costs and Rates of Health Insurance Carriers

The Bureau evaluated three options for monitoring the costs and rates of health insurance carriers in Virginia No state, including Virginia, has an existing comprehensive system in place that monitors all of the costs and rates associated with health insurance The options which were considered are as follows

- using information currently provided in the annual financial statement made by insurers to the SCC,
- requiring companies to report their claims and expense costs and their rates to the Bureau of Insurance, and
- reviewing rates by monitoring loss ratios

Each of these options would involve considerable time and expense on the part of the agency doing the monitoring, and the insurers being monitored. The Bureau believes that it would be more productive and cost effective to pursue the other initiatives in this report first and then consider the implementation of a system to monitor costs and rates in the future

Introduction

Senate Joint Resolution 181, adopted by the 1991 General Assembly, requested the State Corporation Commission's Bureau of Insurance (Bureau) to develop a feasible proposal to establish a small business risk-sharing pool with insurance reforms that would improve access to health care coverage and serve to moderate rate increases The Bureau was also requested to evaluate options for monitoring the costs and rates of health insurance carriers

The request came, in part, as a result of recommendations by the Technical Advisory Panel (TAP) to the Virginia Indigent Health Care Trust Fund (Trust Fund) in its 1990 study regarding the technical and operational considerations of requiring employers to contribute to the Trust Fund The TAP study concluded that nearly 13% of all Virginians under age 65 do not have health insurance The majority (approximately 60%) of these individuals are in families where the head of the household is employed The TAP study also estimates that nearly 36% of all businesses in Virginia do not offer health insurance to their employees, and 41% of the small businesses in Virginia with less than 26 employees do not offer health insurance

This report presents an overview of the problems in the small employer group health insurance market Proposals to reform the small employer group health insurance market, establish a small employer group risk-sharing program, and establish a small employer group health reinsurance association are included in this report. The report also examines options for monitoring the costs and rates of health insurance carriers

Methodology

To develop a feasible plan for establishing a small business risk-sharing program for health care coverage in Virginia, the Bureau reviewed numerous articles and related studies A nationwide survey was conducted to ascertain how many states had adopted some type of small group health insurance risk-sharing program. Telephone interviews were conducted and ongoing discussions have been held with those states that have established or are considering establishing some type of small employer group risk-sharing program The Bureau's research included an analysis of programs in Connecticut, Kansas, Minnesota, Georgia, Oregon, North Carolina, Vermont, Florida, and a large pool operated by the Cleveland Council of Small Enterprises (COSE) in Ohio The Bureau also reviewed several other projects funded by the Robert Wood Johnson Foundation

Another survey was conducted to determine how many states monitored the costs and rates of health insurers Follow-up telephone interviews were conducted with insurance regulators from states with some form of prior approval of health insurance rates None of those states monitor the costs and rates of group health insurance

The work of the National Association of Insurance Commissioners (NAIC) was also reviewed To address some of the problems in the small group market the NAIC adopted a Model Act in December, 1990 entitled "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups."

The NAIC also has developed two "exposure" drafts of Model Acts that address the problems of availability and affordability of small group health

coverage. The first version of the Small Group Health Reform Model Act is referred to as the "Prospective Reinsurance With or Without an Opt-Out " The NAIC Health Care Working Group recommended to the NAIC's Accident and Health Insurance Committee that this draft be exposed for comment This option establishes a reinsurance program and provides for the development of a basic "no frills" health policy and a "standard" health policy

The second version of the Small Group Health Reform Model Act, referred to as the "Allocation Model", was exposed as an alternative It is designed to improve availability of coverage by requiring carriers either to provide coverage on a guaranteed issue basis or accept their fair share of high risk groups through allocation Many of the provisions of the allocation option are the same as or similar to provisions in the reinsurance option

Many of the provisions from the December, 1990 NAIC Model Act and the two exposure drafts are incorporated in the recommendations contained in this report In addition, information about present market conditions was obtained from insurers actively writing accident and sickness (health) coverage in Virginia Information regarding employer practices and health benefits was also reviewed

Background

Many of the problems in the small employer group market are caused by the current market practices of insurers Many of the market practices that are common today were not utilized in the past These practices have evolved as a result of a combination of the growth and competitive nature of the industry, as well as the relative absence of regulatory market restrictions that apply to this market

During the late 1940's and early 1950's, Blue Cross and Blue Shield organizations provided most of the private group health insurance available Premium rates were set by charging every subscriber in a given area the same price for coverage. This practice is known as "community rating " Healthy groups subsidized some of the cost of the less healthy groups, and most individuals paid similar premiums regardless of their health status

During the mid-1950's, commercial insurers began to compete with the Blue Cross and Blue Shield organizations The commercial insurers developed the "experience rating" approach. Under this approach, a group's claims experience influenced what was charged to that particular group Commercial insurers were then able to offer healthier groups lower rates based on each group's own claims experience. As healthier groups withdrew from the community rated system to pursue the lower prices offered by commercial insurers, the remaining community pool became saturated with less healthy individuals As a result of having fewer healthy groups to subsidize the cost of the less healthy groups, community rated premiums increased substantially

The dismantling of the community rating system was the first in a multi-step process used by insurers Commercial insurers began to look for new ways to further segregate risks They became more diligent in examining health conditions It soon became common for an insurer to make an additional charge for certain health conditions, and to exclude certain conditions from coverage. Individuals with a history of an illness such as diabetes could be denied coverage altogether. Using aggregate experience along with claims histories, insurers began to refuse coverage to entire industry and occupational

classifications The segments of business hardest hit by the transformation of industry practices in the health insurance market were small groups, groups with chronically ill employees, and groups in higher risk occupations

The socioeconomic significance of the small group market cannot be overemphasized Nationally, the United States Department of Labor, Bureau of Labor Statistics estimates that 87% of the U S firms have fewer than 20 employees The Virginia Employment Commission also estimates that 87% of all Virginia firms have less than 20 employees It is within these groups that most of the uninsured workers and their dependents are found

There are a variety of reasons why small employers do not offer health insurance Some small employers, especially those requiring unskilled labor, may be indifferent to offering health insurance to their employees Other small employers may want to provide health insurance benefits, but may not be able to generate enough revenue to pay a portion of, or all of, the premiums

Small employers that do offer coverage also face obstacles in maintaining coverage for their employees Some small firms attempting to purchase health insurance for their employees may be offered coverage at an attractively low one year premium that excludes coverage for pre-existing conditions At the time of renewal, they often face substantial premium increases regardless of their claims experience This practice is commonly referred to as "price baiting " Small groups often switch from one carrier to the next in search of lower rates and in an effort to stay one step ahead of price increases As a result of this constant movement by small employer groups, continuity of coverage is not maintained Some employees who have chronic illnesses are without necessary coverage because each new carrier may exclude pre-existing conditions from coverage

Proposal to Establish a Small Business Risk-Sharing Program with Insurance Reforms that Improve Access and Moderate Rate Increases

In accordance with Senate Joint Resolution 181, the State Corporation Commission's Bureau of Insurance makes the following recommendations

(1) The adoption of small group health insurance market reforms designed to increase access and affordability, place limits on premiums that can be charged, limit the use of pre-existing condition restrictions, and require disclosure of specified rating practices and provisions regarding renewability of coverage,

(2) The establishment of a small employer group health insurance risk-sharing program to aggregate the experience of small businesses in order to purchase health insurance more economically, and

(3) The establishment of a small employer group health reinsurance association to spread the cost of high-risk groups among all insurers in the small employer group market

These recommendations are not designed to solve all of the problems in the small employer group market The recommendations do represent, however, a first step in addressing some of the problems confronting small employer groups in the health insurance market In taking this step it should be recognized that other related issues, problems, and remedies may need to be addressed in the future

Proposed Market Reforms for the Virginia Small Business Health Insurance Market

The Bureau of Insurance proposes the following market reforms to promote access, rate stability and continuity of coverage for small group employers, their employees and dependents The proposed market reform measures are specifically designed to affect the entire small group environment Proposals for establishing a small employer group risk-sharing program and a small employer group reinsurance association were developed to operate in conjunction with the market reforms outlined below

Guaranteed Availability

To ensure the availability of coverage, all licensed carriers in the small group market would be required to offer and market a "standard" health care policy and a basic "no frills" health care policy to all small employer groups All small employer group carriers would be required to issue a policy to each small employer group that elects to be covered under either one of these policies and who agrees to make the required premium payments and to satisfy the other reasonable provisions of the policy

All small employer group carriers would be required to file with the State Corporation Commission (SCC), in a format and manner prescribed by the SCC, a "basic" health care policy and a "standard" health care policy to be issued by the carrier In some states, the benefit level and other components of the policies are determined by a committee appointed by the Commissioner of Insurance The committee is composed of representatives of carriers, small group employers, employees, health care providers, and agents In Virginia, it may not be necessary to form a new committee Consideration should be given to utilizing either the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) or the Commission on Health Care for All Virginians to develop the policies

Both of these existing commissions are comprised of legislators, insurers, providers, and consumers They would determine benefit levels, cost-sharing factors, exclusions, and limitations for the "basic" health care policy and the "standard" health care policy Insurers and health services plans would be required to offer a "basic" health care policy and a "standard" health care policy designed by the Advisory Commission or the Commission on Health Care for All Virginians Health maintenance organizations would be required to offer a "basic" health care policy and a "standard" health care policy designed with benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit levels of HMOs, including any restrictions imposed by federal law. The policy and certificate forms implementing such plans would be subject to the approval of the SCC

Whole Group Coverage

Currently, carriers are permitted to adopt underwriting rules and procedures that exclude certain individuals from group coverage and thereby avoid assuming the risk for the entire group This practice should be prohibited If a small employer group carrier offers coverage to a small employer group, it should be required to offer coverage to all of the small employer group's full-time employees and their dependents

Health maintenance organizations would be exempt from offering coverage under the "basic" or "standard" health care plans in the following cases

(a) to a small employer group, where the employer is not physically located in the HMO's approved service area,

(b) to an employee of a small employer group, when the employee does not work or reside within the HMO's approved service area, or

(c) within a geographic area where the HMO demonstrates to the satisfaction of the SCC that it would not have the capacity within the area of its network of providers to deliver services adequately because of its obligation to existing group contract holders and enrollees

A health maintenance organization that claims exemption from the requirement to offer coverage pursuant to subparagraph (c) above would not be permitted to offer coverage in the applicable area to employer groups with 50 or more eligible employees or small employer groups for 180 days following each such refusal or the date on which the HMO notifies the SCC that it has regained capacity to deliver services to small employer groups, whichever is later

A small employer group carrier would be exempt from offering coverage if the SCC found that the acceptance of an application or applications would place the small employer group carrier in a financially hazardous condition

Continuity of Coverage

Small employer group members should not be subject to lapses in coverage because of their health status High premium increases often force many small employers to switch from one carrier to another in search of lower prices Because of this constant movement, continuity of coverage is not maintained Individuals with chronic illnesses are often without necessary coverage because pre-existing condition restrictions are imposed by each new carrier To prevent this type of activity, the Bureau proposes prohibiting the imposition of new pre-existing condition limitations After a covered employee has satisfied an initial policy's pre-existing condition requirements, all carriers in the small group market would be prohibited from assessing new waiting periods or other pre-existing condition requirements when a group changes carriers or when insured employees change employers.

Pre-existing condition provisions would not be permitted to exclude coverage for a period beyond 12 months following the individual's effective date of coverage These provisions would apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage Individuals who apply for coverage after the regular enrollment period (late enrollees) could be excluded from coverage for a period not to exceed 18 months

Any requirements used by a small employer group carrier in determining whether or not to provide coverage to a small employer group would be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small employer group carrier Uniformity would also be required for minimum participation and minimum employer contribution levels A small employer group carrier should vary

application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group

Renewability of Coverage

The requirement for whole group coverage will not be effective unless renewability of the coverage is guaranteed Often in today's market, coverage for some small groups, or individuals within those groups, is non-renewed after unfavorable claims experience accumulates To prevent this practice, all carriers in the small employer health insurance market would be required to renew all eligible employees and dependents at the option of the small group employer except for the following reasons

(1) Non-payment of the required premiums

(2) Fraud or misrepresentation by the employer or, with respect to coverage of individual insureds, the insureds or their representatives

(3) Non-compliance with the carrier's minimum participation requirements

(4) Non-compliance with the carrier's employer contribution requirements

(5) Repeated misuse of a provider network provision

(6) The small employer group carrier elects to non-renew all of its health benefit policies issued to small employers in this Commonwealth In such a case, the carrier would be required to

(a) Provide advance notice to the SCC of its decision not to renew coverage, and

(b) Provide notice of the decision not to renew coverage to all affected small employer groups and their employees Notice to the SCC would be required to be provided at least ten working days prior to the carrier giving notice to the affected small employer groups and their employees Non-renewals would not be permitted to take effect for at least 30 days after notifying affected employers and employees

(7) The SCC finds that the continuation of the coverage would

(a) Not be in the best interests of the policyholders or certificate holders; or

(b) Impair the carrier's ability to meet its contractual obligations

In such cases the SCC would assist affected small employer groups in finding replacement coverage

A small group employer carrier that elected to non-renew its health benefit policies would be prohibited from writing new business in the small employer group market in Virginia for a period of five years from the date of notice to the SCC

Premium Rate Restrictions

Rating factors having an impact on small employer group premiums can be divided into two categories. The first category is claims experience, which includes such things as actual claims history, current health status, and duration of coverage since issue. The second category includes factors such as age, sex, dependent status, geography, and benefit design. The premium rate restrictions discussed below serve to restrict the degree to which the first category, claims experience, may influence the size of periodic premium increases. The proposed restrictions will not affect the second category of rating factors used by insurers.

Claims Experience

The use of claims experience for setting insurance rates is a generally accepted practice in the insurance industry known as experience rating It has enabled some small employers with healthy employees to purchase health insurance at a lower premium than they may otherwise have paid under the concept of community rating Experience rating also gives small employers an incentive to promote health conscious lifestyles among their employees However, some carriers use claims experience to raise premiums or terminate coverage in ways that appear to be inequitable. In view of this, there is a need to restrict some rating practices currently used by some insurers In order to address the problem noted above, the Bureau recommends that all carriers in the small employer group market be required to limit rate variations based on claims experience for small employer groups that are within similar geographic regions and have similar demographic composition and benefit design These proposed rate restrictions would be consistent with those contained in the NAIC Model Act adopted in December, 1990 entitled, "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups." More specifically, as prescribed in the NAIC Model Act, premium rates for health insurance sold to small employer groups would be subject to the following restrictions·

(1) The average rate for any class of business could not be more than 20% above or below the average rate for any other class of business

(2) No employer group within a class of business could have a rate which is more than 25% above or below the average rate for that same class of business. The average rate would be the mid-point between the highest rate and the lowest

(3) No employer group within a class of business could receive an annual rate increase in excess of the increase in the new business rate (which is the lowest rate for a new applicant in a class of business) plus 15% In the case where a carrier is not issuing any new policies, but only renewing policies, the carrier could use the percentage increase applied to the lowest rate plus 15%

To illustrate how these three proposed rate restrictions would be applied, assume a carrier has two distinct occupational classes of small group health business

	Low Rate	Average Rate	High Rate
Class A Clerical Workers	$75	$100	$125
Class B Coal Miners	$90	$120	$150

1st restriction.

Since the Class B average rate is 20% above Class A, it is in compliance with this restriction The carrier could have other distinct classes, but all average rates would have to be in the range of $100-$120

2nd restriction.

In each class, the low rate is 75% of the average rate, and the high rate is 125% of the average rate. In view of this, both classes comply with the maximum range set forth in the second restriction since they are within 25% above or below the average rate Since this example utilizes the maximum differences within and between classes of business, it further illustrates the maximum overall spread of rates. The highest rate of $150 is 200% of the lowest rate which is $75

3rd restriction:

If, after one year, the rates in Class A change to a low of $90, an average of $125 and a high of $156, each rate will have increased 25%. The maximum rate increase, due to claims experience or duration of coverage since issue for any employer in Class A would be 25% plus a 15% adjustment

Other Factors

In this proposal, the rating limits do not restrict the use of rating factors for items such as demographics or benefit design Additionally, they do not restrict the aggregate annual increase resulting from medical care inflation In view of this, the proposed rating restrictions apply only to a portion of a carrier's rate structure It would be virtually impossible to determine the expected overall rate limits for any particular small employer group As an example, using claims experience factors can result in the highest rate being 200% of the lowest rate judging by the restrictions noted above However, factors in the other factors category can be used in addition to this rating procedure As an example, using age as a rating factor, groups with older employees having bad claims experience can result in rates that are greater than 200% of the rates for a younger group that has good claims experience This would be achieved by taking into account the claims experience used to obtain a rate of 200% of the lowest rate and adding to this a factor for older ages which would then increase the 200% to a higher percentage

(4) In the case of previously issued health benefit policies, a premium rate for a rating period, adjusted pro rata for a rating period of less than one year, could conceivably exceed the ranges set forth in subparagraphs (1) and (2) for a period of three years In such case, the percentage increase in the premium rate charged to a small employer group in such a class of business for a new rating period should not exceed the sum of the following

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case where a small employer group carrier is not issuing any new policies, but only renewing policies, the small employer group carrier should use the percentage change in the low premium rate, and

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer group as determined from the carrier's rate manual for the class of business

(5) Small employer group carriers should apply rating factors, including case characteristics, consistently with respect to all small employer groups in a class of business.

A small employer group carrier should not be allowed to transfer a small employer group involuntarily into or out of a class of business (a distinct grouping of employers as shown on the records of the small employer group carrier) A small employer group carrier should not offer to transfer a small employer group into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage since issue.

The SCC would be authorized to suspend the application of paragraphs (1) and (2) above as to the premium rates applicable to one or more small employer groups included within a class of business of a small employer group carrier If, after reviewing a filing by the small employer group carrier, the SCC finds that the suspension is reasonable in light of the financial condition of the small employer group carrier, or that the suspension would enhance the efficiency and fairness of the marketplace for small employer group health insurance, a suspension may be granted for one or more rating periods.

Compliance with Small Employer Group Rate Reform

To ensure compliance with the proposed rate reform measures, each small employer group carrier would be required to maintain, at its principal place of business, a complete and detailed description of its rating practices and renewal underwriting practices. This detailed information and documentation should demonstrate that its rating methods and practices are based upon sound actuarial principles

Each small employer group carrier would be required to file with the SCC annually on or before March 15, an actuarial opinion certifying that the carrier is in compliance with the proposed premium rate restrictions and that the rating methods of the small employer group carrier are actuarially sound A copy of the certification would be retained by the small employer group carrier at its principal place of business.

Small employer group carriers would be required to make the above information and documentation available to the SCC upon request

Disclosure of Rating Practices and Renewability Provisions

Small employer groups generally do not employ benefit administrators or other insurance experts to procure coverage for the group It is imperative, however, that consumers in the small employer group market understand the coverage prior to purchase. In connection with the offering for sale of any health benefit policy to a small employer group, a small employer group carrier should be required to make an adequate disclosure to the employer and individual employees as part of its solicitation and sales materials, of all of the following

(1) The extent to which premium rates for a specified small employer group are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of such small employer group;

(2) The provisions concerning such small employer group carrier's right to change premium rates and the factors other than claim experience which affect changes in premium rates,

(3) The provisions relating to renewability of policies and contracts; and

(4) The provisions relating to any pre-existing condition limitation

Proposal to Establish a Small Employer Group Risk-Sharing Program

Purpose

Unlike large employers, small employer groups do not have the benefit of spreading costs among a large number of employees The purpose of this proposed small employer group health care risk-sharing program would be to aggregate the experience of small businesses, thereby allowing them to purchase health insurance on the same scale as larger employers

Eligibility

The Program would be available to businesses with the following characteristics

(1) The employer has been in business for more than one year, and

(2) The employer has at least two but less than 50 persons working on a full-time basis (30 or more hours per week).

Currently, there is no generally accepted definition of what constitutes a small employer group Traditionally, and for the purpose of this proposal, a small employer group is defined as having less than 50 full-time employees This definition of a small employer group may be questioned. A number of states and the draft NAIC Small Group Health Reform Model Act define a small employer group as having less than 26 employees. Carriers also vary in their definition and treatment of small employer groups A telephone survey of the top 25 writers of health insurance in Virginia by premium volume was conducted The responses of companies revealed that small groups are considered to range from 9 to 200 full-time employees. The majority of the companies contacted consider a small employer group to be one with less than 50 full-time employees.

Additionally, the 1990 Trust Fund survey on health coverage of employees by firm size revealed that employers with more than 25 employees do experience some difficulty in providing health insurance coverage for their employees. The 1990 legislation that allows the issuance of a limited mandated benefit product (§38.2-3425 of the Code of Virginia) allows the product to be sold to groups of less than 50 employees.

For all of the above stated reasons, this report defines a small employer group as one with at least two but less than 50 employees The Bureau believes that this proposal is as feasible if limited to groups of less than 26

Insuring the Program

A major consideration in establishing a small employer group health care risk-sharing program is the insurance arrangement utilized by the Program Two options for insuring the Program are "self-insurance" or the procurement of insurance through private carriers.

A "self-insured" risk-sharing program would assume all of the risk for health coverage under the program The primary benefit would be flexibility in benefit design and a reduction in administrative cost In the initial stages of the Program, however, the disadvantage of assuming all of the risk for the Program far outweighs any advantages One catastrophic illness for a small self-insured program could render it insolvent

The private carrier option would provide more coverage alternatives for the Program, including health plans such as Blue Cross and Blue Shield, commercial carriers and HMOs The primary advantage of using the private carrier option is that it allows the Program to transfer risk and take advantage of an insurance structure already in place

The Program could opt to utilize one carrier, one traditional carrier in conjunction with one or more HMOs, or multiple carriers Using one carrier to provide coverage for all of the members of the Program would enhance the Program's negotiating position when making arrangements for health care coverage, but it would also limit the choice of delivery systems available to members

The Program could also opt to utilize multiple carriers including HMOs, traditional carriers, and other types of delivery systems such as preferred provider organizations (PPOs) This option would broaden the choice of delivery systems for members, but would dilute the bargaining power inherent with a single carrier, especially in the formative stages of the Program when the number of enrolled members may be low Many large group employers often use one traditional carrier and a few PPOs or HMOs to broaden the choice of delivery systems for members

The Program should attempt to gain leverage in negotiating health care arrangements and at the same time offer members a choice of delivery systems These goals can best be achieved by utilizing a single traditional carrier and a limited number of HMOs The Program should gain leverage in negotiating premiums as enrollment increases and becomes a larger percentage of the carrier's business.

Administration

The Program would be administered by a private non-profit corporation To contain costs, the administration of the Program should be centralized The corporation would operate subject to the supervision of a Board of Directors. The Board of Directors would be composed of representatives of carriers, small employers, employees, and health care providers

The corporation would seek and procure coverage from insurers and HMOs, arrange for reinsurance, determine business and employee eligibility, collect premiums, and perform market research and product development functions The functions performed by the corporation would defray some of the costs that insurance carriers or health services plans normally incur and should be reflected in reduced premiums for participating employers

Financing the Program

As a result of the research done by the Bureau, including a survey of states with risk-sharing arrangements, the Bureau believes that the Commission on Health Care for All Virginians may wish to consider adopting the approach used by Florida The Florida approach merits consideration because of its success in attracting and maintaining participants

The Florida Health Access Corporation (FHAC) is a private non-profit corporation established by the Florida legislature in 1989 to aggregate small employers in order to purchase health insurance The project is operational in five areas comprised of 16 counties and has been successful in enrolling over 1,400 firms representing more than 7,000 individuals.

The FHAC has been able to negotiate a reduction in the premium charged by the contracting HMO by agreeing to screen applicants for eligibility and by providing all administrative and marketing services for the project, including underwriting, premium calculations, billing, collections, and selection and monitoring of agents The FHAC has also been able to negotiate additional reductions in the HMO's premium for Florida Health Access plans Through a special agreement, the corporation will limit the HMO's risk by paying the HMO a set percentage of enrollee medical expenses if yearly medical expenses are greater than the premiums paid by enrollees The FHAC also pays the HMO directly for the portion of the premium that is used to protect the HMO from hospital claims between $15,000 and $115,000 In addition, the project provides direct subsidies for family coverage which reduces premium cost by an additional 15%

In addition to employer and employee premium contributions, and private donations, the Florida legislature appropriates money to support the activity of the corporation Funds from Florida's hospital tax are appropriated to the Department of Health and Rehabilitation. The funds are channeled directly to the corporation through contracts with the Florida Department of Health and Rehabilitation. Initially, $1 7 million was appropriated for start-up costs and subsidies. The Florida legislature has appropriated an additional $5.4 million for the FHAC for fiscal year 1992

The small employer group risk-sharing program proposed for Virginia would be funded primarily by employer and employee premium contributions. Private donation and other sources of financing should also be encouraged One potential source of subsidization of the Program is the Virginia Indigent Health Care Trust Fund (Trust Fund) The Trust Fund was established in 1989 by the Virginia General Assembly in an attempt to equalize the burden of charity care costs among all private acute care hospitals in Virginia All Virginia licensed acute care hospitals are required to contribute, and the Commonwealth also makes annual appropriations to the Trust Fund. Total contributions for fiscal year 1991 are estimated to be $10 3 million

The case could be made that the Trust Fund would be more effective in reducing the amount of uncompensated care by purchasing coverage and shifting the cost of health care services to the private carrier market For this reason, consideration should be given to utilizing Trust Fund money for start-up costs and long-term subsidization associated with the small employer group risk-sharing program If these funds are to be utilized, the Virginia General Assembly may need to enact a statute to govern the operation of this private non-profit corporation and the use and accountability of these state funds

Program Evaluation

The Board should be required to study and report to the Commission on Health Care for All Virginians on the progress of this small employer group risk-sharing program by no later than December, 1993. The Board should be required to consider the effectiveness of this program's ability to aggregate small employer groups and procure coverage at more affordable rates

Proposal to Establish A Small Employer Group Health Reinsurance Association

Purpose

A small employer group reinsurance association, in conjunction with the proposed market reforms, would expand accessibility and affordability of health insurance for small employers The intent of the reinsurance association is to provide a reinsurance mechanism to spread risk among all small employer group carriers in the market This would direct the thrust of competition toward service, risk management, and product development rather than risk selection

Opponents of reinsurance associations argue that a reinsurance mechanism will not improve affordability or reduce costs The costs of procuring the reinsurance and the start-up administrative costs are passed on to the consumer in the form of higher premiums If the premiums or the reinsurance mechanism are subsidized in some manner, the cost still exists, it is merely shifted to the program providing the subsidy Other arguments against the reinsurance association are that it will be adversely selected against (i.e , only poor risks are ceded by carriers), and that carriers do not manage poor risks, rather, they simply avoid them However, many carriers may believe that without a reinsurance mechanism they could not afford to remain in Virginia's small group market if reform proposals are instituted. The Bureau does acknowledge that there is some expense associated with the formation of a reinsurance mechanism However, the benefit design of the products offered in the small employer group market combined with the proposed reform measures should result in rate stability in the market in the short-run and, hopefully, smaller rate increases in the long-run It is recognized that a reinsurance mechanism will be adversely selected against The function of a reinsurance mechanism is to provide coverage for the risks that will produce the greatest losses. The carrier, however, must pay for the reinsurance It is, therefore, to the carrier's advantage to reinsure no more risks than necessary.

Structure and Administration of the Association

A non-profit entity known as the Virginia Small Employer Group Health Reinsurance Association (Association) would need to be created. As a condition of doing business in the Commonwealth, all carriers in the small employer group health insurance market would be members of the Association The Association would have the general powers and authority granted under the laws of the SCC to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals.

The Association would be administered by a Board of Directors appointed by the members of the Association and approved by the State Corporation Commission. The Board would be responsible for submitting a plan of operation for SCC approval to assure the fair, reasonable, and equitable administration of the Association

The plan of operation, among other things, would

(1) Establish procedures for the handling and the accounting of Association assets and other funds for annual fiscal reporting purposes to the SCC,

(2) Establish terms of office and procedures for filling vacancies on the Board;

(3) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(4) Establish procedures for reinsuring risks;

(5) Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the Association and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made; and

(6) Provide for any additional matters at the discretion of the Board

Carrier Participation

All licensed carriers in the small employer group market should be required to participate in the reinsurance mechanism In some states, however, participation is voluntary If participation is voluntary in Virginia, a small employer group carrier could elect not to participate (opt-out), and thereby assume the full risk of insuring a small employer group (risk-assuming carrier)

Allowing carriers to opt-out would require some type of ongoing monitoring system to assure equity between carriers that opt-out and those that participate in the reinsurance mechanism. Requiring all carriers to participate would eliminate the need to compare risks assumed by carriers that participate in the reinsurance mechanism and those that do not It also provides the Association with a broader base over which to spread the cost of high risk cases However, larger financially stable carriers may argue that the opt-out would allow them to manage their own risk and not subsidize the cost of other carriers. Some states allow carriers to opt-out of the initial 5% assessment, but require all carriers in the small employer group market to participate in any additional assessments

Risk-Assuming Carriers

Under a voluntary participation program, a risk-assuming carrier would not be subject to the assessments of the Association. A small employer group carrier would apply to become a risk-assuming carrier by filing an application for approval with the SCC in a format prescribed by the SCC.

In determining whether to approve an application by a small employer group carrier to become a risk-assuming carrier, the SCC would consider the following

(1) The carrier's financial condition to support the assumption of the risk of small employer groups;

(2) The carrier's history of rating and underwriting small employer groups,

(3) The carrier's commitment to market fairly to all small employer groups in the Commonwealth or its service area, as applicable; and

(4) The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the Association

Small employer group carriers not participating in the reinsurance mechanism would still be required to guarantee the issue of standard and basic health insurance policies to small employer groups seeking coverage

A small employer group carrier who elects, at a later date, to become a risk-assuming carrier would be prohibited from reinsuring or continuing to reinsure any small employer group health benefits plan with the Association as soon as the carrier became a risk-assuming carrier A participating carrier who became a risk-assuming carrier would be required to pay a pro-rated assessment based upon business issued as a participating carrier for any portion of the year during which the business was reinsured

Reinsurance Options

The type of reinsurance that should be utilized is a point of controversy within the industry The two options for providing reinsurance that the NAIC considered are the prospective and retrospective methods The NAIC decided not to pursue the development of the retrospective method at this time

Under the NAIC's prospective method, a participating carrier would identify high-risk groups or individuals within a group at the time of initial enrollment and pay a premium to cede the risk of covering the high-risk group or individual to the Association The entire group would be permitted to be reinsured at a rate of 1 5 times the rate established by the Board for the policy premium the employer would pay if the group was a standard risk. An eligible employee or dependent could be reinsured at a rate that is up to 5 0 times the rate established by the Board for a standard individual A participating carrier would be permitted to terminate reinsurance for all of the reinsured employees or dependents of a small group employer on any plan anniversary date

The prospective method provides more direct financial protection for carriers, especially small carriers Since high risks are identified when coverage is issued, this method is arguably less subjective Discussions of this issue with representatives of Blue Cross and Blue Shield of Virginia (BCBSVA), revealed a concern that a prospective reinsurance pool would require greater underwriting skill The carriers who have invested in sophisticated underwriting techniques will be able to reinsure more successfully and the underwriting function will remain an issue in this market The goal of these measures is to emphasize service and other factors and decrease competition based on underwriting Also, under the prospective method, individuals who are not substandard risks would be reinsured in cases where the whole groups were reinsured (e g accidental injuries of standard risk would be covered)

Under the retrospective method, a participating small employer group carrier would not be required to identify the reinsured risk or pay the reinsurance premium at the time coverage is issued Instead, the small employer group carrier would cede a percentage of the risk of an individual whose claims exceeded a predetermined dollar amount (the stop-loss threshold) and who had a qualifying health condition The Board would develop a list of qualifying conditions The small employer group carrier would review an individual's medical history to determine if a qualifying health condition existed at the time of issue The stop-loss threshold could be adjusted to regulate the volume of claims ceded to the Association The threshold could also be adjusted by the size of the employer to provide protection for smaller carriers that insure high risk small employers

The retrospective method reduces the necessity for medical underwriting However, it does require a greater degree of subjective decision-making. For example, the list of conditions developed by the Board would require verification that reinsured individuals had a reinsurable condition at enrollment Verification of this nature may pose a problem for carriers that do not medically underwrite

Cost Control

A report of the actuarial subcommittee of the NAIC Advisory Committee on Access to Health Care suggests that claim volume would have the most significant effect on cost and assessments of a reinsurance pool In light of these findings and to ensure utilization management, reinsurance should be available to a carrier's new business only The NAIC advisory committee further suggests that cost-sharing in the form of deductibles and coinsurance be utilized More specifically, participating carriers would be required to

(1) Pay the first $5,000 in claims on ceded risk,

(2) Pay 10% of the first $50,000 in claims reinsured by the Association; and

(3) Apply their case management and claims handling techniques, consistently with both reinsured and non-reinsured business.

The Association would reinsure up to the level of coverage provided in a basic or standard health care policy The Association would not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier had paid $5,000 in claims in a calendar year for benefits covered by the Association

Consideration should be given to allowing carriers that have previously provided coverage to these groups on an open enrollment basis to reinsure their existing business in the Association This would reduce the burden on those carriers of (i) being in the Association and assessed on the total losses to the Association while (ii) carrying a book of business that produces losses at a higher level generally than the risks of other carriers

Financing the Association

Claims in the Association would be financed primarily by premiums for ceded groups and individuals If losses exceeded premium, participating small employer group carriers would be assessed an amount of up to 5% of the annual direct premiums from health benefit plans covering small employer groups If the 5% assessment proved to be inadequate to cover the shortfall, the Board would consider adjusting reinsurance thresholds or retention levels, or consider additional assessments

The Board would be responsible for developing an equitable formula for assessing participating carriers Consideration would be given to both the overall market share of participating small employer group carriers and their share of new business assumed during the preceding calendar year.

Cost Reduction

The reforms that would be initiated as a result of this proposal would assure the availability of health coverage for small employer groups However, the problem of the affordability of the coverage would not be addressed At the NAIC level, the NAIC Health Care Insurance Access Advisory Committee included the exemption of small employer group coverage from state mandated benefit and provider legislation as one means of addressing this problem In Virginia, however, the sale of a limited mandated benefit product has been authorized since July 1, 1990 Blue Cross and Blue Shield of Virginia was the first company to have such a product on the market. The level of acceptance by the public of the "First Option" policy thus far has been low As of August 1, 1991, only 26 policies covering 94 individuals were in effect

It must also be acknowledged that Virginia mandated benefits and providers were estimated to represent less than 20% of the premium for group coverage This estimate is based on information submitted to the Bureau of Insurance by insurers in 1989 when it conducted a study on the financial and social impact of mandated benefits pursuant to Senate Joint Resolution 215 (1989) A 20% reduction in premium may not be sufficient to attract some small employer groups to purchase insurance

In recognition of the fact that reduction in mandates alone will not necessarily make a small group product affordable, the Bureau would propose the possibility of utilizing funds from the Virginia Indigent Care Trust Fund to subsidize the reinsurance Association

Program Evaluation

The Board should be required to report to the State Corporation Commission on the effectiveness of the small employer health reinsurance association by no later than December, 1993 The report should analyze the effectiveness of the Association in promoting rate stability, as well as the accessibility of coverage Recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer group health insurance marketplace should be included The report should also address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employer groups in Virginia Recommendations for additional funding, market conduct, or other regulatory standards of action should also be contained in the report to the SCC

Options for Monitoring the Costs and Rates of Health Insurance Carriers

The Bureau surveyed all states and it appears that no state has a comprehensive system in place that monitors all of the costs and rates associated with health insurance at this time In view of this, it must be understood that none of the following options have been tested

The first option to be considered in monitoring costs and rates is to use information currently provided in the annual financial statement filed by insurers with the Bureau of Insurance. Schedule H of the Annual Statement provides some information on insurer expenses for health insurance A system could be implemented to monitor these costs It should be noted, however, that the information presented in Schedule H is minimal for monitoring purposes In

addition, changing the Annual Statement to obtain additional information requires action by the National Association of Insurance Commissioners. This is a lengthy process and one state cannot require that specific changes be made to this statement

The second option would be to require companies to report their costs and rates to the Bureau of Insurance. This could be accomplished by the General Assembly passing legislation similar to §38 2-3419 1 This law, passed by the 1990 General Assembly, requires insurers to report costs and utilization of mandated benefits to the Commission on an annual basis in a format prescribed by the Commission

The third option would be to review rates by measuring loss ratios Loss ratios measure the amount of each premium dollar spent on claims A 50% loss ratio indicates that $ 50 of each $1 00 in premium is spent on claims This is the usual method of evaluating individual accident and sickness insurance It is not used in group insurance except for Medicare supplement insurance The Bureau has an existing regulation in place, Insurance Regulation No 22, Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms, which includes requirements that must be met if a rate increase is requested on individual policies and group Medicare supplement policies The actuarially certified information that is required for rate increases, in addition to that required for original rate filings includes:

- A comparison of the revised premiums with the current premium scale,
- A statement as to whether the revision applies only to new business, only to in-force business, or to both;
- An estimated average annual premium per policy, before and after the requested rate increase,
- Past experience,
- Details and dates of all past rate increases on the policy form to which the rates apply;
- A description of how the revised rates were determined for expenses The percent of premium, dollars per policy, and/or dollars per unit of benefit must be included,
- Anticipated loss ratio for new business,
- Anticipated future loss ratio and estimated cumulative loss ratio if applicable to in-force business;
- Supporting documentation for premiums that do not produce a loss ratio equal to the required minimum, and
- The current number of Virginia policyholders and either premiums in force, premiums earned, or premiums collected for those policyholders during the year prior to the filing of the rate increase.

In Virginia, no review takes place other than at original filing or unless a rate increase is requested

Each of these options would involve considerable time and expense on both the part of the agency doing the monitoring, and the insurers being monitored In addition, standards would need to be developed for insurers to meet with regard to costs and rates This process would be difficult because no systems are currently in place for this purpose Accordingly, it would be more productive and cost effective to pursue the other initiatives described in this report first and then consider the implementation of a system to monitor costs and rates in the future

Conclusion

The Bureau recommends the adoption of insurance reforms that moderate rate increases and improve access to health insurance for small groups A small employer group health reinsurance association is also proposed for consideration A small business risk-sharing program should also be established The Bureau does not believe that it is necessary at this time to develop a comprehensive system to monitor all of the costs and rates associated with health insurance The proposals in this report should be initiated prior to the development of such a system

The Bureau recognizes that there are factors affecting the availability and affordability of health insurance for small employers that are not addressed by the proposals contained in this report. The Bureau believes, however, that these recommendations represent a first step to resolving the problems in the small employer group health insurance market

APPENDIX A

SENATE JOINT RESOLUTION NO 181

Requesting the Bureau of Insurance to develop proposals to increase health insurance access for small businesses and requesting the Small Business Advisory Board to promote the low-cost insurance packages for small businesses

Agreed to by the Senate, February 4, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, approximately 880,000 Virginians do not have health insurance, and of that uninsured population, approximately 60 percent of the households are headed by persons employed at least on a part-time basis; and

WHEREAS, many uninsured workers are employed by small businesses, and approximately 35 percent of the businesses with 50 or fewer employees do not offer health insurance, accounting for an estimated 165,000 employees; and

WHEREAS, structural changes have occurred in the economy, including a shift of jobs from larger businesses to smaller businesses; and

WHEREAS, the high cost of health insurance, volatility of insurance rates, and underwriting exclusions are among the principal impediments of small businesses' offering health insurance; and

WHEREAS, small businesses frequently lack information about insurance products and possess little negotiating power with insurance carriers; and

WHEREAS, Chapter 394 of the 1990 Acts of Assembly directed the Technical Advisory Panel of the Virginia Indigent Care Trust Fund to study the technical and operational considerations related to requiring employers who do not provide minimum health insurance benefits, as defined by the Commissioner of Insurance, to their employees or whose employees are not otherwise provided such benefits to make reasonable contributions to the Trust Fund by July 1, 1992; and

WHEREAS, the Technical Advisory Panel found that small businesses should be provided incentives so that they might voluntarily obtain health insurance for their employees prior to any mandates being enacted in the Commonwealth to require employers to provide health insurance options to their employees; and

WHEREAS, the Technical Advisory Panel suggested incentives that included the formation of a state-sponsored small business insurance pool to aggregate small businesses seeking to purchase health insurance, and the establishment of a reinsurance pool to cover losses of high-risk groups with all insurers in the small-group market participating, with possible restrictions on rate increases to small employers, prohibitions against canceling policies with adverse experience, restrictions on preexisting conditions, and requirements to accept or reject entire employer groups without excluding high risk individuals, and

WHEREAS, a tenet of the mission of the Commission on Health Care for All Virginians is to seek means to expand the availability and accessibility of health care for citizens of the Commonwealth, and a subcommittee of the Commission will continue to study business participation in the Virginia Indigent Care Trust Fund and insurance reform, and

WHEREAS, the Commission on Health Care for All Virginians has reviewed the findings of the Technical Advisory Panel and recommended measures to increase the accessibility of health insurance for small businesses, now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Bureau of Insurance be requested to develop a feasible proposal to establish a small business risk-sharing pool with insurance reforms that improve access and moderate rate increases and to evaluate options for monitoring costs and rates of health insurance carriers, and, be it

RESOLVED FURTHER, That the Small Business Advisory Board be requested to promote the availability of low-cost insurance packages for small businesses, when products are offered by multiple insurance carriers

All agencies of the Commonwealth shall provide information and assistance needed by the Bureau and the Board in their development of these proposals

The Bureau of Insurance and the Small Business Advisory Board shall report their findings and recommendations by November 1, 1991, to the Commission on Health Care for All Virginians, the Governor and the 1992 Session of the General Assembly as provided in the procedures of Legislative Automated Systems for the processing of legislative documents

APPENDIX B

State Provisions for Small Group Health Insurance

State	Citation	Provision
AL	No provision	
AK	SB 242 pending	Reinsurance association for small group employers shall design policies to be offered to employers with no more than 25 employees, Association shall design with cost containment features
AZ	No provision	
AR	HB 1117 (1991)	Allows issuance of limited benefit policies to individuals, groups and trusts Includes basic benefits to be covered Rating formula shall be approved, 65% loss ratio for individual, 75% for group Regulation pending
	Sections 23-86-201 to 23-86-209 (1991)	Model
CA	Revenue and Tax Code Section 17053 20 (1989)	Tax credit for employers with no more than 25 employees who offered health policies to employees
	SB 107 (1991)	Repeals 1989 law and substitutes different credit
	SB 248 pending	Policies offered to small groups of 50 or fewer employees and to individuals shall provide specified disclosure on rating and renewal practices Would limit rates and rate increases
	AB 2001 pending	Small group transitional plan
	AB 2070 pending	Model
CO	HB 1168 (1991)	Employers, with groups of no more than 25 employees, who have not offered group coverage to employees after 7/1/89, may offer coverage without mental health benefits Formula for limit in rate increases

State	Citation	Provision
CT	Sections 38a-564 to 38a-573 (1990)	New law establishes small employer health reinsurance pool for employers with no more than 25 employees Must contain specified benefits and provisions All insurers are members of reinsurance pool and may be assessed for losses of pool
	HB 6971 (1991)	Clarifies 1990 legislation
DE	HB 288 (1991)	Model
DC	No provision	
FL	Section 627 6693 (1990)	Small employers with less than 25 employees may offer a basic policy without many mandated benefits Several small employers may form group to purchase insurance
	Section 627 4106 (1991)	Model
GA	Section 33-30-12 (1990)	Pool rating experience for small groups of 50 or fewer employees
	Sections 33-47-1 to 33-47-4 (1991)	Commissioner shall develop basic health plan affordable to Georgians, and encourage insurers to market it
HI	No provision	
ID	No provision	
IL	Sections 351B-1 to 351B -7 (1990)	Small groups of not more than 25 employees may be issued policies without mandated benefits
	SB 1058 pending	Adds coverage for mental illness to 1990 law
IN	No provision	

State	Citation	Provision
IA	Sections 513B 1 to 513B 9 (1991)	Model, covers plans with less than 25 employees
	Sections 514H 1 to 514H 14	Small group employers (no more than 25 employees) may join together to purchase health insurance Tax credit for employers who pay for coverage Offer basic policy, with options to purchase other coverage
	HB 2440 pending	Would amend 1990 law to no more than 50 employees
	SB 179 pending	Rates for small groups of 50 or fewer employees shall be based on aggregate loss and expense experience of all such employers insured by the insurer Bill would also change statute adopted in 1990 to apply to employers with no more than 50 employees
KY	Sections 216 900 to 216 930 (1990)	Small group employers may be offered policies which include only basic benefits without mandated benefits
LA	HB 1200 pending	Allows the issuance of small group basic health insurance
ME	HB 507 pending	Insurer providing coverage to group of less than 25 members may not vary rate based on group's experience or composition of the group
	SB 654 pending	Reinsurance pool to assist small group insurer
	HB 1721 pending	Small groups of no more than 25 employees may be eligible for basic policy Rate restrictions, reinsurance provisions
	HB 1730 pending	Basic policy may be issued to small group of no more than 19 employees

State	Citation	Provision
MD	HB 1120 (1991)	May offer limited benefit policies to employers with no more than 25 employees Statute specifies benefits which must be included
MA	HB 1194 pending	Regulates rates for small employers, some parts from model Small employer defined as one with less than 24 employees
	HB 478 pending	Provides tax credit for businesses employing no more than 50 employees which provide health insurance under new law but have not in the past 3 years
	SB 576 pending	Authorizes insurers to offer basic policy without many mandated benefits to employers with less than 25 employees
	HB 5438 pending	Would regulate rates for small groups of not more than 25 employees
MI	HB 4930 pending	Model plus more, limited to less than 50 employees Reinsurance pool for insurers in small group market
	HB 725 pending	Minimum benefit plan may be offered to employees of employer with 50 or fewer employees if have not offered group plan during past 12 months Tax credits for employer
	HB 95 pending	May not base premiums on experience of group with less than 1000 members May aggregate small groups to yield at least 1000 individual members
	SB 501 pending	Loss ratio, reinsurance pool
MS	No provision	

State	Citation	Provision
MO	Section 376 995 (1990)	Limited mandate policies may be offered by employers who employ 50 or fewer persons Must clearly disclose nature of policy
MT	HB 693 (1991)	May issue limited benefit health policies to employers with less than 20 employees, or to disabled, self-employed or unemployed persons Law includes tax credit for employers
NE	LB 419 (1991)	Model
NV	SB 503 pending	Authorizes plan for small employers, establishes requirements concerning coverage
NH	SB 321 pending	Model proposed for purpose of assisting employers with 25 or fewer employees in providing affordable insurance coverage
	HB 718 pending	Basic policy
NJ	AB 4301 pending	Basic policy for groups of under 25 employees Model provision to protect against excessive rate changes plus reinsurance pool
	SB 3132, HB 4346 pending	Basic policies may be offered to employers who have not covered their employees during last 12 months
NM	SB 70 (1991)	Individuals, families and groups of fewer than 20 members may qualify for a policy with specified minimum benefits Mandated benefits need not be included Premiums from policy exempt from premium tax for first three years after issuance
	SB 504 (1991)	Model

State	Citation	Provision
NY	AB 3719 pending	Would allow insurance companies to offer small businesses a health insurance plan without state mandates
	AB 4665 pending	Would provide tax credits for small businesses that offer health insurance to their employees
	AB 6702 pending	Would require community rating on open enrollment basis for all individuals and groups of 50 or fewer
	Regulation pending	Would prohibit experience rating
NC	HB 1037 (1991)	Commissioner will appoint committees to recommend level of coverage of employers with 25 or fewer employees Includes provision for basic coverage without mandated benefits Limits on rate increases and provision for reinsurance pool
ND	HB 1042 (1991)	Small employers with fewer than 25 employees could offer basic policies without most mandated benefits
	HB 1539	Model
OH	HB 113 pending	Basic policy without mandates
OK	Title 36 Sections 6501 to 6507 (1990)	Board will develop state-certified basic benefits plan, approve entities who may offer, Employers shall pay at least 50% of premium
OR	Sections 653 705 to 653 991 (1989)	Creates insurance pools to provide coverage for employers which employ no more than 25 employees Offer basic package plus options for additional benefits
	Section 316 096 (1989)	Employers with no more than 25 employees qualify for tax credit when offer coverage to their employees

State	Citation	Provision
PA	HB 727 pending	Tax credit for small businesses which provide health insurance for employees
RI	Sections 27–18 3–1 to 27 18 3–13 (1990)	Provides basic health coverage for employers of small groups of 25 or less, or unemployed or self–employed individuals Exempt from mandated benefit requirements Managed care cost containment provisions included
	Regulation L pending	Implement statute
SC	Sections 28–71–910 to 28–71–990 (1991)	Model
SD	SB 229 (1991) eff 7–1–92	Model
TN	SB 1228 pending	Would limit renewal rates on group policies to average renewal rates offered to other subscribers
	HB 924, SB 1264 pending	May offer basic policy to employers with groups of fewer than 25 employees
	HB 1353 pending	Limited benefit policies
	SB 1403 pending	May offer limited mandate policies to groups of 25 employees or less Limited to groups which haven't been insured for last 18 months
TX	No provision	
UT	No provision	
VT	HB 176 (1991)	Would apply to employers with no more than 49 employees Registered small group carriers may offer plans, rates must be based on community rating and meet standards provided in statute
	HB 422 pending	Model plus more

State	Citation	Provision
VA	Sections 38 2–3425 to 38 2–3430 (1990)	Insurers may issue limited mandate health insurance policies to individuals, families and groups of less than 50 members Law spells out benefits to be included, provisions to control costs
WA	Section 48 21 045 (1990)	May offer basic group policy to employers with less than 25 employees
WV	Sections 33–16C–1 to 33–16C–10 (1991)	May offer basic policy without most mandates to employers who have not provided insurance to employees during past 12 months
	Sections 33–16D–1 to 33–16D–13 (1991)	NAIC Model, limited to employers with less than 50 employees
WI	AB 91 pending	Model, also established state programs with basic coverage where insurers join forces
WY	No provision	

Source National Association of Insurance Commissioners (NAIC), August, 1991

Note Model refers to the NAIC model law regarding "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups", adopted December 1990

APPENDIX C

PREMIUM RATES AND RENEWABILITY OF COVERAGE FOR HEALTH INSURANCE SOLD TO SMALL GROUPS

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Section 1 Purpose

The intent of this Act 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

Section 2 Definitions

A "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 4 of this Act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

B "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

C "Carrier" means any person who provides health insurance in this state. For the purposes of this Act, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement or any other person providing a plan of health insurance subject to state insurance regulation

D "Case characteristics" mean demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer Claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Act.

E "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans·

(a) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier,

(b) Have been acquired from another small employer carrier as a distinct grouping of plans,

(c) Are provided through an association with membership of not less than [insert number] small employers which has been formed for purposes other than obtaining insurance; or

(d) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in Subsection A(1)(a) of Section 4

(2) A small employer carrier may establish no more than two (2) additional groupings under each of the subparagraphs in Paragraph (1) on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace

F. "Commissioner" means the Commissioner of Insurance.

G "Department" means the Department of Insurance

H "Health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental or disability income insurance; coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical-payment insurance

I. "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate

J. "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage

K. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier

L. "Small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than twenty-five (25) eligible employees In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one employer

Drafting Note States may wish to consider a different threshold number of employees for the purposes of defining a "small employer," depending on the underwriting and marketing practices of carriers in the state and any other factors that the state finds relevant

M "Small employer carrier" means any carrier which offers health benefit plans covering the employees of a small employer

Section 3 Health Insurance Plans Subject to this Act

A Except as provided in Subsection B of this section, the provisions of this Act apply to any health benefit plan which provides coverage to one or more employees of a small employer

B The provisions of this Act shall not apply to individual health insurance policies which are subject to policy form and premium rate approval as provided in [insert reference to insurance code provisions for approval of individual forms and rates]

Section 4 Restrictions Relating to Premium Rates

A Premium rates for health benefit plans subject to this Act shall be subject to the following provisions

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%)

Paragraph (1) shall not apply to a class of business if all of the following apply:

(a) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status,

(b) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business, and

(c) The class of business is currently available for purchase

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate,

(b) An adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business, and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(4) In the case of health benefit plans issued prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges described in Subsection A(1) or (2) of this section for a period of five (5) years following the effective date of this Act. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

B Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business

C. A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue

Section 5. Provisions on Renewability of Coverage

A. Except as provided in Subsection B of this section, a health benefit plan subject to this Act shall be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons.

(1) Nonpayment of required premiums,

(2) Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or such individual's representative,

(3) Noncompliance with plan provisions,

(4) The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan, or

(5) The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

B. A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least ninety (90) days prior to termination of coverage. A carrier which exercises its right to cease to renew all plans in a class of business shall not

(1) Establish a new class of business for a period of five (5) years after the nonrenewal of the plans without prior approval of the commissioner; or

(2) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

Section 6 Disclosure of Rating Practices and Renewability Provisions

Each small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of the following

A The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer,

B The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates,

C A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans, and

D. The provisions relating to renewability of coverage

Section 7 Maintenance of Records

A Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles

B. Each small employer carrier shall file each March 1 with the commissioner an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound A copy of such certification shall be retained by the carrier at its principal place of business

C A small employer carrier shall make the information and documentation described in Subsection A of this section available to the commissioner upon request. 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 except as agreed to by the carrier or as ordered by a court of competent jurisdiction

Section 8 Discretion of the Commissioner

The commissioner may suspend all or any part of Section 4 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

Section 9. Effective Date

The provisions of this Act shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed or continued in this state after the effective date of this Act. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this Act

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Legislative History (all references are to the Proceedings of the NAIC).

1991 Proc. I (adopted).

APPENDIX D

Exposure Draft 6/11/91

SMALL EMPLOYER HEALTH COVERAGE REFORM MODEL ACT (PROSPECTIVE REINSURANCE WITH OR WITHOUT AN OPT-OUT)

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Section 1 Short Title

This Act shall be known and may be cited as the Small Employer Health Access Act

Section 2 Purpose

The purpose and intent of this Act is to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of "basic" and "standard" health care plans to be offered to all small employers, to provide for establishment of a reinsurance Program, and to improve the overall fairness and efficiency of the small group health insurance market This Act does not provide a comprehensive solution to the problem of affordability of health care or health insurance

Section 3 Definitions

A "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 5 of this Act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

B "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

C "Basic health care plan" means a low cost health care plan developed pursuant to Section 11

D "Board" means the board of directors of the Program

E "Carrier" means any person who provides health insurance in this state For the purposes of this part, insurer includes an insurance company, a prepaid hospital or medical care plan, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to state insurance regulation For purposes of this Act, companies that are affiliated companies or that are eligible to file a consolidated tax return shall

be treated as one carrier except that any insurance company, health service corporation, hospital service corporation or medical service corporation that is an affiliate of a health maintenance organization located in this state, or any health maintenance organization located in this state which is an affiliate of an insurance company, health service corporation, hospital service corporation or medical service corporation may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area of this state may be considered a separate carrier

F "Case characteristics" means demographic or other objective characteristics of a small employer, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer, provided, however, that claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Act

G "Class of business" means, all or a distinct grouping of small employers as shown on the records of the small employer carrier

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans·

(a) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier,

(b) Have been acquired from another small employer carrier as a distinct grouping of plans, or

(c) Are provided through an association with membership of not less than [insert number] small employers which has been formed for purposes other than obtaining insurance,

(2) A small employer carrier may establish no more than two (2) additional groupings under each of (a) through (c) in Subsection (1) on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer marketplace

H. "Commissioner" means the Insurance commissioner of this state

Drafting Note Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted

I "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee

J "Eligible employee" means an employee who works on a full-time basis, with a normal work week of thirty (30) or more hours and has met any applicable waiting period requirements The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health care plan of a small employer, but does not include employees who work on a part-time, temporary or substitute basis

L "Health benefit plan" means any hospital or medical policy or certificate, hospital or expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract Health insurance plan does not include accident-only, fixed indemnity, limited benefit, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical-payment insurance

M "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate

N. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period provided under the terms of the health benefit plan, provided that the initial enrollment period shall be a period of at least thirty (30) days However, an eligible employee or dependent shall not be considered a late enrollee if

(1) The individual

(a) Was covered under a public or private health insurance or health benefit arrangement at the time the individual was eligible to enroll,

(b) Has lost coverage under a public or private health insurance or other health benefit arrangement as a result of termination of employment, or eligibility the termination of the other plan's coverage, death of a spouse or divorce; and

(c) Requests enrollment within thirty (30) days after termination of coverage provided under a public or private health insurance or other health benefit arrangement,

(2) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period, or

(3) A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order

O "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged, offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage

P "Participating carrier" means all small employer carriers issuing health benefit plans in this state [except any small employer carrier electing to be a risk-assuming carrier]

Drafting Note Remove the wording in brackets if reinsurance is mandatory

Q "Plan of operation" means the plan of operation of the Program, including articles, bylaws and operating rules, adopted by the Board pursuant to Section 10

R "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage

S "Program" means the [State] Small Employer Health Access Program created by Section 10

T "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier

U "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers

V "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed at least [3] but no more than [25] eligible employees, the majority of whom were employed within this state In determining the number of eligible employees, companies which are affiliated companies, or which are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer

W "Standard health care plan" means a health care plan developed pursuant to Section 11

X "Committee" means the Health Benefit Plan Committee created pursuant to Section 11

Y "Risk-assuming carrier" means a small employer carrier electing to comply with the requirements set forth in Section 9

Z "Reinsuring carrier" means a small employer carrier electing to comply with the requirements set forth in Section 10

Drafting Note Delete Subsections Y and Z if reinsurance is mandatory

Section 4. Applicability and Scope

A This Act shall apply to any health benefit plan which provides coverage to a small employer in this state if either of the following conditions are met

(1) Any portion of the premium or benefits is paid by a small employer or any eligible employee or dependent covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium

(2) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or Program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code

B. The provisions of [insert appropriate state statutory citations referencing individual health insurance laws and health maintenance organization laws applicable to rate and form filings] shall not apply to individual health insurance policies or contracts to the extent subject to the provisions of this Act

Drafting Note. This paragraph included to avoid dual regulation of individual health benefit plans sold to small employers

Section 5. Restrictions Relating to Premium Rates

A. Premium rates for health benefit plans subject to this Act shall be subject to the following provisions.

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%), adjusted pro rata for periods less than a year

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business shall not vary from the index rate by more than twenty-five percent (25%) of the index rate, adjusted pro rata for rating periods of less than a year

(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period In the case where a small employer carrier is not issuing any new policies, but is only renewing policies, the carrier shall use the percentage change in the base premium rate,

(b) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business, and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business

(4) Adjustments in rates for claim experience, health status and duration from issue may not be charged to individual employees or dependents Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer

(5) Any adjustment in rates charged by a small employer carrier electing to be a reinsuring carrier caused by reinsurance is subject to the rating limitations set forth in this section

(6) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers in accordance with Section 8

(7) In any case where a small employer carrier utilizes industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than fifteen percent (15%) of such coverage

(8) In the case of health benefit plans issued prior to the effective date of this Act, a premium rate for a rating period, adjusted pro rata for rating periods of less than a year, may exceed the ranges set forth in Subsection A(1) and (2) of this section for a period of three (3) years following the effective date of this Act In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period In the case where a small employer carrier is not issuing any new policies, but is only renewing

policies, the small employer carrier shall use the percentage change in the base premium rate, and

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business

(9) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business

B A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

C The commissioner may suspend for a specified period the application of Subsection A(1) as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance

D In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following

(1) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of the small employer,

(2) The provisions concerning the small employer carrier's right to change premium rates and the factors other than claim experience which affect changes in premium rates,

(3) The provisions relating to renewability of policies and contracts; and

(4) The provisions relating to any preexisting condition provision

E (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting 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 small employer 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 small employer carrier are actuarially sound A copy of the certification shall be retained by the small employer carrier at its principal place of business

(3) A small employer carrier shall make the information and documentation described in Subsection E(1) available to the commissioner upon request. 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 except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Section 6 Renewability of Coverage

A A health benefit plan subject to this Act shall be renewable with respect to all eligible employees or dependents at the option of the employer except in the following cases

(1) Nonpayment of the required premiums,

(2) Fraud or misrepresentation of the employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) Repeated misuse of a provider network provision; or

(6) The small employer carrier elects not to renew all of its health benefit plans issued to small employers in this state. In such a case the carrier shall

(a) Provide advanced notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

(b) Provide notice of the decision not to renew coverage to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier Notice to the commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected plans

(7) The [commissioner] finds that the continuation of the coverage would:

(a) Not be in the best interests of the policyholders or certificate holders, or

(b) Impair the carrier's ability to meet its contractual obligations

In such instance the [commissioner] shall assist affected small employers in finding replacement coverage

Section 7 Availability of Coverage

A Within 180 days after the commissioner's approval of the basic health care plan and the standard health care plans developed pursuant to Section 11, every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers at least two (2) health care plans One plan offered by each small employer carrier shall be a basic health care plan and one plan shall be a standard health care plan All small employer carriers shall issue the elected plans to every small employer that elects to be covered under either one of these plans and agrees to make the required premium payments and to satisfy the other reasonable provisions of the plan

B A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health care plan and the standard health care plan to be used by the carrier. A plan filed pursuant to this section may be used by a small employer carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use

C Health benefit plans covering small employers shall comply with the following provisions:

(1) Preexisting condition provisions shall not exclude coverage for a period beyond twelve (12) months following the individual's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage or as to a pregnancy existing on the effective day of coverage

(2) In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefit plans shall credit the time the person was previously covered by public or private health insurance or other health benefit arrangement if the previous coverage was continuous to a date not more than sixty (60) days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan

(3) Late enrollees may be excluded from coverage for the greater of eighteen (18) months or a eighteen-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months

(4) Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier A small employer carrier shall only vary application of minimum participation requirements and minimum employer contribution requirements by the size of the small employer group

(5) If a small employer carrier offers coverage to a small employer, it shall offer coverage to all of the small employer's eligible employees and their dependents A small employer carrier shall not offer coverage to only certain persons in a group or to only part of a group, except in the case of the enrollees as provided in paragraph (3) of this subsection

D (1) No health maintenance organization shall be required to offer coverage or accept applications pursuant to Subsection A in the case of the following

(a) To a small employer, where the small employer is not physically located in the health maintenance organization's approved service areas,

(b) To an employee, when the employee does not work or reside within the health maintenance organization's approved service areas, or

(c) Within an area where the health maintenance organization reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within the area in its network of providers to deliver service adequately to the members of such groups because of its obligations to existing group contractholders and enrollees.

(2) A health maintenance organization that cannot offer coverage pursuant to Subsection (D)(1)(c) may not offer coverage in the applicable area to new cases of employer groups with more than twenty-five (25) eligible employees or small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

E A small employer carrier shall not be required to offer coverage or accept applications pursuant to Subsection A of this section for as long as the commissioner finds that the acceptance of an application or applications would place the small employer carrier in a financially impaired condition

Section 8 Small Employer Carrier Election

A A small employer carrier shall elect to either become a risk-assuming carrier or a reinsuring carrier The election shall be binding for a five-year period except that the initial election shall be made within thirty days (30) of the effective date of this Act and shall be made for two (2) years The commissioner may permit a carrier to modify its election at any time for good cause shown, after a hearing

B A small employer carrier which elects to cease participating as a reinsuring carrier and elects to become a risk-assuming carrier shall be prohibited from reinsuring or continuing to reinsure any small employer health benefits plan pursuant to Sections 9 and 10 of this Act as soon as the carrier becomes a risk-assuming carrier However, a reinsuring carrier electing to become a risk-assuming carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured A small employer carrier which elects to cease participating as a reinsuring carrier shall be permitted to reinsure small employer health benefit plans under the terms set forth in Section 9 of this Act

Drafting Note Delete Section 8 if reinsurance is mandatory

Section 9 Carrier Election Process

A A small employer carrier may become a risk-assuming carrier by filing an application with the commissioner in a format and manner prescribed by the commissioner The commissioner may approve the application of a small employer carrier to become a risk-assuming carrier if the commissioner finds that the carrier is capable of assuming the status pursuant to the criteria set forth in Subsection B

B In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the commissioner shall consider

(1) The carrier's financial condition to support the assumption of the risk of small employer groups,

(2) The carrier's history of rating and underwriting small employer groups,

(3) The carrier's commitment to market fairly to all small employer in the state or its service area, as applicable, and

(4) The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance Program provided in Section 10

C. The commissioner shall provide public notice of an application by a small employer carrier for Section 9 status and shall provide at least a sixty (60) day period for public comment prior to making a decision on the application. If the application status is not acted upon within ninety (90) days of the receipt of the application by the commissioner, the carrier may request a hearing.

D. The commissioner may rescind the approval granted to a risk-assuming carrier under this section if the commissioner finds that the carrier no longer meets the criteria under Subsection B

E. The commissioner may limit or rescind an approval granted to any risk-assuming carrier under this section if the commissioner finds that its continuance would substantially impair the financial viability of the reinsurance program or other carriers.

F. A Risk-assuming carrier shall make available to all small employers in this state, on a year-round basis and without regard to the health status or industry of the eligible employees and dependents of the small employers, health benefit plans that provide at least the coverage of the basic health care plan and the standard health care plan and that comply with the requirements of Sections 5, 6 and 7

G. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of Section 10

Drafting Note. Delete this section if reinsurance is mandatory.

Section 10. Small Employer Carrier Reinsurance Program

A. A reinsuring carrier shall be subject to the provisions of this section

Drafting Note: Delete Subsection A if reinsurance is mandatory.

B. There is hereby created a nonprofit entity to be known as the [insert name of state] Small Employer Health Reinsurance Program.

C. Within sixty (60) days of the effective date of this Act, the commissioner shall give notice to all participating carriers of the time and place for the initial organizational meeting, which shall take place within 120 days of the effective date. The participating carriers shall select the initial board which shall be subject to approval by the commissioner The board shall be selected by a weighted vote based upon net health insurance premium derived from health benefit plans written in this state in the previous calendar year in the small employer market. The board shall consist of at least five (5) and not more than nine (9) representatives of participating carriers who shall serve three-year staggered terms. To the extent possible, the board shall include representation from. (1) Carriers whose principal health insurance business is in the small employer market; (2) Nonprofit health, hospital or medical service corporations; and (3) Health maintenance organizations. No one carrier including its

affiliates, shall be represented by a majority of the board The commissioner or the commissioner's designee shall be an ex-officio voting member of the board In approving the selection of the board, the commissioner shall assure that all participating carriers are fairly represented

D If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within fifteen (15) days of the organizational meeting

E Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable and equitable administration of the Program The commissioner may, after notice and hearing, approve the plan of operation provided the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the Program, and provides for the sharing of Program gains or losses on an equitable and proportionate basis in accordance with the provisions of Subsection M of this section The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available

F If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation The commissioner shall amend or rescind any plan adopted by him or her under this section at the time a plan of operation is submitted by the board and approved by the commissioner

G The plan of operation shall among other things

(1) Establish procedures for handling and accounting of Program assets and moneys and for an annual fiscal reporting to the commissioner,

(2) Establish terms of office and procedures for filling vacancies on the board, subject to the approval of the commissioner,

(3) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier,

(4) Establish procedures for reinsuring risks in accordance with the provisions of this Act,

(5) Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the Program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made, and

(6) Provide for any additional matters at the discretion of the board

H The Program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans pa directly to either groups or individuals In addition thereto, the Program shall have the specific authority to

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar Programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions,

(2) Sue or be sued, including taking any legal actions necessary or proper for recovering any assessments and penalties for, on behalf of, or against the Program or any participating carriers;

(3) Take any legal action necessary to avoid the payment of improper claims against the Program,

(4) Define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act,

(5) Establish rules, conditions and procedures pertaining to the reinsurance of participating carrier's risks by the Program,

(6) Establish actuarial functions as appropriate for the operation of the Program,

(7) Assess participating carriers in accordance with the provisions of Subsection G, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year,

(8) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the Program, policy and other contract design, and any other function within the authority of the Program,

(9) Borrow money to effect the purposes of the Program Any notes or other evidence of indebtedness of the Program not in default shall be legal investments for carriers and may be carried as admitted assets,

(10) To the extent necessary, adjust the $5,000 deductible reinsurance requirement contained in Subsection I(4) to reflect the effects of inflation Also, with the approval of the commissioner, the board may increase or decrease the amounts set forth in Subsections I(4), J(1) and J(2) if it is necessary to effectuate the purposes of this Act and does not require reinsuring carriers to retain an unreasonable level of risk

I A reinsuring carrier may reinsure with the Program as provided for in this subsection

(1) With respect to a basic health care plan or a standard health care plan, the Program shall reinsure the level of coverage provided and, with

respect to other plans, the Program shall reinsure up to the level of coverage provided in a basic or standard health care plan

(2) Expect in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days of the commencement of the coverage of the small employer A newly eligible employee or dependent may be reinsured within 60 days of the commencement of his or her coverage

(3) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under the plan The carrier may choose to reinsure newly eligible employees and dependents of a reinsured group pursuant to paragraph (2) of this subsection

(4) The program shall not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid a deductible of $5,000 in a calendar year for benefits covered by the program In addition, the participating carrier shall retain 10% of the next $50,000 of benefit payments during a calendar year and the program shall reinsure the remainder A participating carriers' liability under this paragraph shall not exceed a maximum limit of $10,000 in any one calendar year with respect to any one [commissioner], the board may adjust the deductible, retention percentage, or maximum limit to reflect increases in health care costs

(5) A small employer carrier may terminate reinsurance for all of the reinsured employees or dependents of a small employer on any plan anniversary.

(6) Premium rates charged for reinsurance by the program to a health maintenance organization which is federally qualified undue 42 U S C Sec 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than paragraph (3) of this subsection, shall be reduced to reflect that portion of the risk above the amount set forth in paragraph (3) that may not be ceded to the program, if any

J. Except as provided in Subsection K, premium rates charged by the Program for coverage reinsured by the Program for that classification or group with similar case characteristics and coverage shall be established as follows

(1) The entire group may be reinsured for a rate that one and one-half (1.5) times the rate established by the board.

(2) An eligible employee or dependent may be reinsured for a rate that is five (5) times the rate established by the board

K In any case where a health benefit plan for a small employer is entirely or partially reinsured with the Program, the premium charged to the small employer for any rating period for the coverage issued shall be consistent with the requirements relating to premium rates set forth in Section 5A

L (1) Following the close of each fiscal year, the board shall determine the Program net loss for the year, the Program expenses for administration, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses

(2) Any net loss for the year shall be recouped by assessments of participating carriers

(a) The board shall determine an equitable assessment formula for the purpose of recouping assessments of participating carriers that takes into consideration both overall market share of small employer carriers that are participating carriers of the Program and the share of new business of the small employer carriers assumed during the preceding calendar year If an assessment is based on an adjustment made, the assessment shall not be less than fifty percent (50%) nor more than one hundred fifty percent (150%) of what it would have been if the assessment were based on the proportional relationship of the small employer carrier's total premiums for small employer coverage written in the year to total premiums of small employer coverage written by all small employer carriers in this state in this year The board shall also determine whether the assessment base used to determine assessments shall be made on a transitional basis or shall be permanent In no event shall assessments exceed five percent (5%) of total health benefit plan premium earned in this state from health benefit plans covering small employers or participating carriers during the calendar year coinciding with or ending during the fiscal year of the Program The board may change the assessment formula, including an assessment adjustment formula, if applicable, from time to time as appropriate

Health benefit plan premiums and benefit paid by a participating carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments

(b) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U S C Sec 300, et seq , to the extent, if any, that restrictions are placed on them other than those for which an adjustment has already been made in Subsections I(4), I(6) and I(7) of this section that are not imposed on other small employer carriers

(c) If the net loss is not recouped from reinsuring carriers before assessments totaling five percent (5%) of the premiums from health benefit plans covering small employers have been collected, additional assessments shall be provided from a broad-based funding source

(3) If assessments exceed actual losses and administrative expenses of the Program, the excess shall be held at interest and used by the board to offset future losses or to reduce Program premiums.

As used in this paragraph, "future losses" includes reserves for incurred but not reported claims

(4) Each participating carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the participating carriers with the board.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments

(6) A participating carrier may seek from the commissioner a deferment, in whole or in part, from any assessment issued by the board The commissioner may defer, in whole or in part, the assessment of a participating carrier if, in the opinion of the commissioner the payment of the assessment would place the participating carrier in a financially impaired condition. In the event an assessment against a participating carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this Section 10 The participating carrier receiving such deferment shall remain liable to the Program for the amount deferred and shall be prohibited from reinsuring any individuals or groups in the Program if it fails to pay assessments

M. Neither the participation in the Program as participating carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the Program or any of its participating carriers either jointly or separately

N. The Program shall be exempt from any and all taxes.

Section 11. Health Benefit Plan Committee

A. The [commissioner/governor] shall appoint a Health Benefit Plan Committee The committee shall be composed of representatives of carriers, small employers and employees, health care providers and producers.

B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Section 7

C. The committee shall recommend benefit levels, cost sharing factors, exclusions and limitations for the basic health care plan and the standard health care plan One basic health care plan and one standard health care plan shall contain

benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law

(1) The plans recommended by the committee may include cost containment features such as, but not limited to:

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(b) Case management benefit alternatives;

(c) Selective contracting with hospitals, physicians and other health care providers,

(d) Reasonable benefit differentials applicable to participating and nonparticipating providers; and

(e) Other managed care provisions.

(2) The committee shall submit the plans to the commissioner for approval within 180 days after the appointment of the committee pursuant to this section

Section 12 Periodic Market Evaluation

The board shall study and report at least every three years to the [commissioner] on the effectiveness of this Act. The report shall analyze the effectiveness of the Act in promoting rate stability, product availability, and affordability of coverage and may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group health insurance marketplace The report also shall address whether carriers and producers are fairly actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the Act and may contain recommendations for market conduct or other regulatory standards or action

Section 13 Waiver of Certain State Laws

No law requiring the coverage of a health care service or benefit or the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner shall apply to a basic health care plan issued pursuant to this Act.

Drafting Note: States should carefully examine how broadly or narrowly they allow the mandate preemption to apply Specifically, several mandates (e.g , newborn coverage, adoptive children coverage, and conversion requirements) may reinforce the

goals of access and continuity of coverage and hence should be maintained States which have an overly burdensome benefit mandates may want to consider their exclusion from other health benefit plans

Section 14 Administrative Procedures

The commissioner may issue regulations in accordance with [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable] for the implementation and administration of the Small Employer Health Coverage Reform Act.

Section 15 Separability

If any provision of this Act or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the Act and the application of its provisions to other persons or circumstances shall not be affected thereby

Section 16 Effective Date

The Act shall be effective on [insert date]

Drafting Note: Some or all of the provisions of this Act relating to small employer premium rates, disclosure and certification may be inappropriate for states which have adopted separate legislation relating to small employer premium rates, or require reinsurance to be mandatory

APPENDIX E

SMALL EMPLOYER HEALTH ACCESS MODEL ACT
(ALLOCATION WITH AN OPT-OUT)

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Section 1 Short Title

This Act shall be known and may be cited as the Small Employer Health Access Act

Section 2 Purpose

This model act provides for the establishment of an allocation program that would assure availability of appropriate benefit plans to small employers All carriers in the small employer marketplace are required to accept small employers allocated to them unless they provide coverage on a guaranteed issue basis

In addition, carriers in the small employer market are required to rate within prescribed limits, to guarantee the renewal of coverage, to guarantee the continuity of coverage as specified, to adhere to limitations on the use of preexisting condition limitations and to adhere to rules regarding minimum participation requirements This Act does not provide a comprehensive solution to the problem of affordability of health care or health insurance

Section 3 Definitions

As used in this Act

A. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of Section 5 of this Act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans

B "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

C "Basic health care plan" means a low cost health care plan developed pursuant to Section 11

D. "Board" means the board of directors of the program

E "Carrier" means any person who provides health insurance in this state For

the purposes of this Act, insurer includes an insurance company, a prepaid hospital or medical care plan, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to state insurance regulation For purposes of this Act, companies that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier except that any insurance company, health service corporation, hospital service corporation or medical service corporation that is an affiliate of a health maintenance organization located in this state, or any health maintenance organization located in this state which is an affiliate of an insurance company, health service corporation, hospital service corporation or medical service corporation may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area of this state may be considered a separate carrier

F "Case characteristics" means demographic or other objective characteristics of a small employer, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer, provided, however, that claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this Act

G "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans

(a) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for the small employer carrier,

(b) Have been acquired from another small employer carrier as a distinct grouping of plans, or

(c) Are provided through an association with membership of not less than [insert number] small employers which has been formed for purposes other than obtaining insurance

(2) A small employer carrier may establish no more than two (2) additional groupings under each of Subparagraphs (a) through (c) in Paragraph (1) on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

(3) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer marketplace

H "Commissioner" means the insurance commissioner of this state

Drafting Note Where the word "commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted

I "Committee" means the Health Benefit Plan Committee created pursuant to Section 11

J "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health care plan covering the employee

K "Eligible employee" means an employee who works on a full-time basis, with a normal work week of thirty (30) or more hours and has met any applicable waiting period requirements The term includes a sole proprietor, a partner of a partnership or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health care plan of a small employer, but does not include employees who work on a part-time, temporary or substitute basis

L "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract Health insurance plan does not include accident-only, fixed indemnity, hospital indemnity, credit, dental, vision, Medicare supplement, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical-payment insurance

M. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate

N "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period provided under the terms of the health benefit plan, provided that the initial enrollment period shall be a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if

(1) The individual

(a) Was covered under a public or private health insurance or other health benefit arrangement at the time the individual was eligible to enroll,

(b) Has lost coverage under a public or private health insurance or other health benefit arrangement as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse or divorce, and

(c) Requests enrollment within thirty (30) days after the termination of coverage provided under a public or private health insurance or other health benefit arrangement,

(2) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period, or

(3) A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order

O "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

P. "Participating carrier" means all carriers issuing health benefit plans in this state [except any small employer carrier electing to be a Section 7 carrier]

Drafting Note. Delete words in brackets if allocation is mandatory.

Q. "Plan of operation" means the plan of operation of the program, including articles, bylaws and operating rules, adopted by the board pursuant to Section 8

R. "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

S. "Program" means the [State] Small Employer Health Access Program created by Section 8

T. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier

U. "Section 9 carrier" means a small employer carrier electing to comply with the requirements set forth in Section 9

V. "Section 10 carrier" means a small employer carrier electing to comply with the requirements set forth in Section 10

Drafting Note The definitions in Sections U and V can be deleted if allocation is mandatory

W. "Small employer" means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed

at least three (3) or more eligible employees but no more than twenty-five (25) eligible employees, the majority of whom were employed within this state In determining the number of eligible employees, companies which are affiliated companies, or which are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer

X "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers

Drafting Note In those states where either health coverage is guaranteed to be available to one and two employee groups on a year-round basis without regard to medical status, industry or other demographic characteristics by a carrier or carriers in the small employer marketplace in the state or where uninsurable risk pools permit one and two employee groups to purchase coverage, it is not necessary to extend this Act to one and two employee groups However, in states without either alternative, states should consider enacting uninsurable risk pools and permitting one or two employee groups access to such risk pools

Y. "Standard health care plan" means a health care plan developed pursuant to Section 11.

Section 4 Applicability and Scope

A This Act shall apply to any health benefit plan which provides coverage to a small employer in this state if either of the following conditions are met

(1) Any portion of the premium or benefits is paid by a small employer or eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium

(2) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code

B. The provisions of [insert appropriate state statutory cites referencing individual health insurance laws and health maintenance organization laws applicable to rate and form filings] shall not apply to individual health insurance policies or contracts to the extent subject to the provisions of this Act

Drafting Note This paragraph is included to avoid dual regulation of individual health benefit plans sold to small employers

Section 5 Restrictions Relating to Premium Rates

A Premium rates for health benefit plans subject to this Act shall be subject to the following provisions

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%), adjusted pro rata for periods less than a year.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to such employers under the rating system for that class of business shall not vary from the index rate by more than twenty-five percent (25%) of the index rate, adjusted pro rata for rating periods of less than a year.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period In the case where a small employer carrier is not issuing any new policies, but is only renewing policies, the carrier shall use the percentage change in the base premium rate,

(b) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(4) Adjustments in rates for claim experience, health status and duration from issue may not be charged to the individual employees or dependents Any such adjustment must be applied uniformly to the rates charged for all participants of the small employer

(5) In any case where a small employer carrier utilizes industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than fifteen percent (15%) of such coverage

(6) In the case of health benefit plans issued prior to the effective date of this Act, a premium rate for a rating period, adjusted pro rata for rating periods of less than a year, may exceed the ranges set forth in Subsection A(1) and (2) of this section for a period of three (3) years following the effective date of this Act In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period In the case where a small employer carrier is not issuing any new policies, but is only renewing policies, the small employer carrier shall use the percentage change in the base premium rate, and

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business

(7) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business

B A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue

C The commissioner may suspend the application of Subsection A(1) as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance

D In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following

(1) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of the small employer,

(2) The provisions concerning the small employer carrier's right to change premium rates and the factors other than claim experience which affect changes in premium rates,

(3) Provisions relating to renewability of policies and contracts, and

(4) Provisions relating to any preexisting condition provision

E (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting 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 small employer 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 small employer carrier are actuarially sound A copy of the certification shall be retained by the small employer carrier at its principal place of business

(3) A small employer carrier shall make the information and documentation described in Subsection E(1) available to the commissioner upon request 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 except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction

Section 6 Renewability of Coverage

A A health benefit plan subject to this Act shall be renewable with respect to all eligible employees or dependents at the option of the employer except in the following case

(1) Nonpayment of the required premiums,

(2) Fraud or misrepresentation of the employer or, with respect to coverage of individual insureds, the insureds or their representatives,

(3) Noncompliance with the carrier's minimum participation requirements,

(4) Noncompliance with the carrier's employer contribution requirements,

(5) Repeated misuse of a provider network provision, or

(6) The small employer carrier elects not to renew all of its health benefit plans issued to small employers in this state In such a case the carrier shall

(a) Provide advance notice of its decision under this subparagraph to the commissioner in each state in which it is licensed, and

(b) Provide notice of the decision not to renew coverage to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier Notice to the commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected health plans

(7) The commissioner finds that the continuation of the coverage would

(a) Not be in the best interests of the policyholders or certificate holders, or

(b) Impair the carrier's ability to meet its contractual obligations

In such instance the commissioner shall assist affected small employers in finding replacement coverage

Section 7 General Small Employer Carrier Requirements

A All health benefit plans covering small employers shall comply with the following provisions

(1) Preexisting conditions provisions shall not exclude coverage for a period beyond twelve (12) months following the individual's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage or as to a pregnancy existing on the effective day of coverage

(2) In determining whether a preexisting conditions provision applies to an eligible employee or dependent, all health benefit plans shall credit the time the person was previously covered by public or private health insurance or other health benefit arrangement if the previous coverage was continuous to a date not more than thirty (30) days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan

(3) Late enrollees may be excluded from coverage for the greater of eighteen (18) months or a eighteen-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months

(4) Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier A small employer carrier shall only vary application of minimum participation requirements and minimum employer contribution requirements by the size of the small employer group

(5) If a small employer carrier offers coverage to a small employer, it shall offer coverage to all of the small employer's eligible employees and their dependents A small employer carrier shall not offer coverage to only certain persons in a group or to only part of a group, except in the case of the enrollees as provided in Paragraph (3) of this subsection

Section 8 Small Employer Carrier Election

Each small employer carrier shall elect to either become a Section 9 carrier or a Section 10 carrier The election shall be binding for a five-year period except that the initial election shall be made within thirty (30) days of the effective date of this Act and shall be made for two (2) years The commissioner may permit a carrier to modify its election at any time for good cause shown, after a hearing

Section 9 Section 9 Carrier Election Process

A A small employer carrier may become a Section 9 carrier by filing an application with the commissioner in a format and manner prescribed by the commissioner The commissioner may approve the application of a small employer carrier to become a Section 9 carrier if the commissioner finds that the carrier is capable of assuming the status pursuant to the criteria set forth in Subsection B

B In determining whether to approve an application by a small employer carrier to become a Section 9 carrier, the commissioner shall consider

(1) The carrier's financial condition to support the assumption of the risk of small employer groups,

(2) The carrier's history of rating and underwriting small employer groups,

(3) The carrier's commitment to market fairly to all small employer in the state or its service area, as applicable, and

(4) The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance program provided in Section 10

C The commissioner shall provide public notice of an application by a small employer carrier for Section 9 status and shall provide at least a sixty-day period for public comment prior to making a decision on the application If the application status is not acted upon within ninety (90) days of the receipt of the application by the commissioner, the carrier may request a hearing

D The commissioner may rescind the approval granted to a Section 9 carrier under this section if the commissioner finds that the carrier no longer meets the criteria under Subsection B

E The commissioner may limit or rescind an approval granted to any Section 9 carrier under this section if the commissioner finds that its continuance would substantially impair the financial viability of the allocation program or other carriers

F A Section 9 carrier shall make available to all small employers in this state, on a year-round basis and without regard to the health status or industry of the eligible employees and dependents of the small employers, health benefit plans that provide at least the coverage of a basic health care plan and a standard health care plan and that comply with the requirements of Sections 5, 6, and 7

Section 10. Small Employer Health Insurance Access Provisions

A All small employer carriers issuing health benefit plans in this state on and after the operative date of this Act, unless they are Section 9 carriers, shall be required to meet the requirements of this section as a condition of authority to transact business in this state

B There is hereby created a nonprofit entity to be known as the [State] Small Employer Access Program All small employer carriers issuing health benefit plans in this state on and after the operative date of this Act shall be members of the program unless they are Section 9 carriers

C Within sixty (60) days of the effective date of this Act, the commissioner shall give notice to all participating carriers of the time and place for the initial organizational meeting, which shall take place within 120 days of the effective date The participating carriers shall select the initial board which shall be subject to approval by the commissioner The board shall be

selected by a weighted vote based upon net health insurance premium derived from health benefit plans written in this state in the previous calendar year in the small employer market The board shall consist of at least five (5) and not more than nine (9) representatives of participating carriers who shall serve three (3) year staggered terms To the extent possible, the board shall include representation from (1) carriers whose principal health insurance business is in the small employer market; (2) nonprofit health, hospital or medical service corporations, and (3) health maintenance organizations No one carrier, including its affiliates, shall be represented by a majority of the board The commissioner or the commissioner's designee shall be an ex-officio member of the board In approving the selection of the board, the commissioner shall assure that all participating carriers are fairly represented

D If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within fifteen (15) days of the organizational meeting

E Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program The commissioner may, after notice and hearing, approve the plan of operation provided the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of Subsection M of this section The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available Any plan of operation or amendments thereto, submitted to the commissioner by the board pursuant to this subsection shall be deemed approved by the commissioner if not expressly disapproved in writing by the commissioner within ninety (90) days of its receipt by the commissioner.

F If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation The commissioner shall amend or rescind any plan adopted under this section at the time a plan of operation is submitted by the board and approved by the commissioner

G The plan of operation shall

(1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner,

(2) Establish terms of office and procedures for filling vacancies on the board, subject to the approval of the commissioner,

(3) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier,

(4) Establish procedures for allocating small employers among small employer carriers in accordance with the provisions of this Act,

(5) Establish procedures for collecting assessments from all members subject to assessment to provide for administrative expenses incurred or estimated to be incurred for the period for which the assessment is made; and

(6) Provide for any additional matters at the discretion of the board

H The Program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals In addition thereto, the Program shall have the specific authority to

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions,

(2) Sue or be sued, including taking any legal actions necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any participating carriers;

(3) Establish rules, conditions and procedures pertaining to its functions under this Act,

(4) Assess participating carriers in accordance with the provisions of Subsection K of this section, and to make interim assessments as may be reasonable and necessary for organizational and interim operating expenses Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year,

(5) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the Program, policy and other contract design, and any other function within the authority of the program,

(6) Borrow money to effect the purposes of the program Any notes or other indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets,

(7) Perform other functions necessary and proper to carry out its responsibilities under this Act

I. (1) Every small employer that meets the eligibility requirements of this subsection may apply to the program for basic health care plan or standard health care plan coverage Eligibility for allocation shall be limited to the following

(a) Any small employer that is currently uninsured and has been rejected for coverage by at least two (2) small employer carriers,

(b) Any small employer that is currently insured by a small employer carrier pursuant to an allocation under this Act, that has been insured by that small employer carrier for two (2) or more years, and in the process of applying for coverage elsewhere has been refused coverage by at least two (2) small employer carriers,

(c) Any small employer that is currently insured by a small employer carrier and, after giving notice of termination to its small employer carrier, is refused coverage by at least two (2) other small employer carriers

(2) When, as a result of the addition of an eligible employee or dependent to those covered by a health benefit plan of a small employer, the small employer no longer meets the underwriting criteria of the small employer carrier, the carrier may, under the provisions of Subsection J(7), request that the small employer be treated as an allocated small employer

J In carrying out the program, the board shall establish procedures for receiving applications pursuant to Subsection I of this section and allocating small employers among all participating carriers In order to assure a fair allocation of risks among small employer carriers, every member shall receive allocated small employers as follows

(1) At the time the program is initiated and as of the beginning of each calendar year thereafter, the board shall estimate the total number of uninsurable individuals in small employer groups that will be allocated under this subsection during the year The board shall have the authority to determine how uninsurable individuals will be identified

(2) The board shall assign to each small employer carrier a target number of uninsurable individuals The target number for a small employer carrier shall bear the same proportional relationship to the total number of uninsurable individuals estimated under Paragraph (1) as the small employer carrier's annual net premiums for coverage of small employers bears to the annual net premiums of all small employer carriers for coverage of small employers In the case of a small employer carrier with an established geographic service area, the board may adjust the target number of uninsurable individuals to account for the carrier's increased or decreased exposure resulting from allocation

(3) Small employers that are eligible for allocation under Subsection I shall select a participating small employer carrier from the list developed under Section 9B The small employer shall be allocated to the selected participating small employer carrier unless, as a result of the addition of the small employer, the number of uninsurable individuals in small employer groups allocated to the carrier under this subsection would exceed the carrier's target number determined

under Paragraph (2) A small employer that is not allocated to the carrier that it initially selects shall continue to make selections of participating carriers until it is allocated

(4) As of the end of each year, the board shall determine the number of uninsurable individuals in small employer groups allocated to each small employer carrier (including uninsurable individuals in small employer groups allocated in a previous year) The board shall determine the number of uninsurable individuals that should have been allocated to each small employer carrier if the carrier had been allocated the same proportion of the total number of uninsurable individuals in allocated small employer groups as the small employer carrier's annual net premiums for coverage of small employers in that year bears to the annual net premiums of all small employer carriers for coverage of small employers in that year To the extent that the number of uninsurable individuals allocated to a carrier in a particular year is greater or less than the number that should have been allocated under the preceding sentence, the carrier shall receive a credit or debit, respectively, with respect to the allocation of uninsurable individuals for the subsequent year

(5) A small employer carrier shall not be required to accept allocated small employers that are not located within their established geographic service area

Drafting Note This is included to avoid allocation of small employers to geographically inaccessible small employer carriers

(6) The board shall periodically evaluate the program to assure equity in the distribution of allocated small employers The board shall have the authority to make adjustments to further the goal of equitable distribution of allocated small employers, including the authority to

(a) Adjust the future target number of uninsurable individuals assigned to small employer carriers;

(b) Adjust the formula for determining the target number of uninsurable individuals assigned to small employer carriers, and

(c) Adjust the future target number of uninsurable individuals assigned to small employer carriers based on the severity of risk of particular allocated small employers

(7) When, as a result of the addition of an eligible employee or dependent to those covered by a health benefit plan of a small employer, the small employer no longer meets the underwriting criteria of the small employer carrier, the carrier may request the board to treat the small employer as if it were allocated under this subsection In that event, if the additional individual meets the board's definition of an uninsurable individual, the board shall treat the additional individual as if the small employer had been allocated to it at the time of the addition of the employee or dependent.

(8) Any small employer shall have the right to nonrenew coverage under the plan and choose to be allocated to a different carrier after the small employer has been covered by a small employer carrier for two (2) years A small employer that exercises that right shall be allocated to a different small employer carrier only if the small employer applies to the program and meets the eligibility requirements of allocation under Subsection I

K (1) Following the close of each fiscal year, the administering carrier shall determine the program expenses of administration, taking into account investment income and other appropriate gains and losses. The net expense for the year shall be recouped by assessments of participating carriers The administering carrier also shall determine the claims expense for allocated small employers for each small employer carrier for both the basic and the standard health care plans, on an annual basis, using information collected from carriers under Subsection N of this section

(2) Assessments to cover the administrative expenses of the program shall be apportioned by the board among participating carriers in proportion to their respective shares of the total health benefit plan premiums earned in this state by all participating carriers from health benefit plans covering small employers during the calendar year coinciding with or ending during the fiscal year of the program. Health benefit plans and premiums paid by a participating carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments

(3) Each participating carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it

(4) Provisions shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(5) A participating carrier may seek from the commissioner a deferment in whole or in part, from any assessment issued by the board The commissioner may defer, in whole or in part, the assessment of a participating carrier if, in the opinion of the commissioner, the payment of the assessment would place the participating carrier in a financially impaired condition. In the event an assessment against a participating carrier is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other participating carriers in a manner consistent with the basis for the assessment set forth in this section The participating carrier receiving such deferment shall remain liable to the program for the amount deferred.

(6) Section 9 carriers shall not be subject to assessments or rebates, and premiums earned by Section 9 carriers shall not be considered in the calculation of assessments under Paragraph (2) of this subsection.

L Every Section 10 carrier shall accept applications from all small employers allocated to it by the program and shall offer such small employers a basic health care plan and a standard health care plan unless a small employer carrier is exempted from doing so as provided in Subsection M of this section A Section 10 carrier may also offer to a small employer allocated to it coverage that is greater than that required by this Act

M A Section 10 carrier shall not be required to offer coverage to or accept applications from small employers allocated pursuant to Subsection J(2) of this section for as long as the commissioner finds that the acceptance of an allocated small employer or small employers would place the small employer carrier in a financially impaired condition

N Each Section 10 carrier shall file with the commissioner and the board, in a form and manner to be prescribed by the commissioner, an annual report The report shall state the small employer carrier's net premium for new small employer coverage written in the previous twelve-month period The report also shall state the number of small employers allocated to it, the claims expense for those allocated small employers, the names and number of the small employers that canceled or terminated coverage with it during the preceding calendar year, and the reasons for such cancellations or terminations if known The report shall be filed on or before March 1 for the preceding calendar year

O Neither the participation in the program, the establishment of procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any participating carriers either jointly or separately

P The program shall be exempt from any and all taxes

Section 11 Health Benefit Plan Committee

A. The [commissioner/governor] shall appoint a Health Benefit Plan Committee The Committee shall be composed of representatives of carriers, small employers, employees, health care providers and producers

B The Committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Section 7

C The Committee shall recommend benefit levels, cost sharing factors, exclusions and limitations for the basic health care plan and the standard health care plan. One basic health care plan and one standard health care plan shall contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law

(1) The plans recommended by the Committee may include cost containment features such as, but not limited to.

(a) Utilization review of health care services, including review of medical necessity of hospital and physician services,

(b) Case management benefit alternatives;

(c) Selective contracting with hospitals, physicians and other health care providers,

(d) Reasonable benefit differentials applicable to participating and nonparticipating providers, and

(e) Other managed care provisions

(2) The Committee shall submit the plans to the commissioner for approval within 180 days after the appointment of the Committee pursuant to this section The plans shall be deemed approved unless expressly disapproved by the commissioner within sixty (60) days after the date the plans are submitted to the commissioner

(3) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health care plan and the standard health care plan to be used by the carrier. A plan filed pursuant to this section may be used by a small employer carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use

Section 12. Periodic Market Evaluation

A The board shall study and report at least every three (3) years to the commissioner on the effectiveness of this Act The report shall analyze the effectiveness of the Act in promoting rate stability, product availability, and affordability of coverage and may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group health insurance marketplace The report also shall address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the Act and may contain recommendations for market conduct or other regulatory standards or action.

B The board shall commission an actuarial study, by an independent actuary approved by the commissioner, within the first three (3) years of the program's operation to evaluate and measure the relative risks being assumed by differing types of small employer carriers as a result of this Act

Section 13 Waiver of Certain State Laws

No law requiring the coverage of a health care service or benefit on the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner shall apply to a basic health care plan issued pursuant to this Act

Drafting Note: States should carefully examine how broadly or narrowly they allow the mandate preemption to apply Specifically, several mandates (e g , newborn coverage, adoptive children coverage, and conversion requirements) may reinforce the goals of access and continuity of coverage and hence should maintained States which have an overly burdensome benefit mandates may want to consider their exclusion from other health benefit plans

Section 14. Administrative Procedures

The commissioner may issue regulations in accordance with [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable] for the implementation and administration of the Small Employer Health Coverage Reform Act

Section 15 Separability

If any provision of this Act or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 16 Effective Date

The Act shall be effective on [insert date]