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

An Operational Plan For Establishing A Small Employer Group Reinsurance Association

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 8

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STATE CORPORATION COMMISSION

October 30, 1992

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

We are pleased to transmit this Report of the the State Corporation Commission's Bureau of Insurance on An Operational Plan For Establishing a Small Employee Group Reinsurance Assication.

The study was initiated and the report prepared pursuant to Senate Joint Resolution 121 of the 1992 Session of the General Assembly of Virginia.

Respectfully submitted,

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I. Executive Summary

Senate Joint Resolution No. 121, adopted by the 1992 General Assembly, requested the State Corporation Commission's Bureau of Insurance (Bureau) to develop an operational plan for establishing a small employer group reinsurance association for the Commonwealth. The request was made as a result of the review of a previous study done by the Bureau that recommended market reforms to improve access to health care coverage for small employer groups. A requirement that insurers accept every small employer group applying for coverage (guaranteed issue) was not instituted when the other market reforms of guaranteed renewability, entire group coverage, and continuity of coverage were instituted. The General Assembly decided to delay implementation of a guaranteed issue requirement and rating reforms until further study of a reinsurance mechanism was conducted.

In accordance with Senate Joint Resolution No. 121, the State Corporation Commission's Bureau of Insurance recommends that:

(1) A retrospective reinsurance mechanism be implemented;

(2) Small employer group carriers be required to accept all groups applying for coverage; and

(3) Community rating be required for small employer groups.

The Bureau recommends that the above actions should apply to groups with at least two but less than 26 employees. The Bureau believes that groups with less than 26 employees are more likely to be uninsured because of lack of access to health insurance.

The Bureau has reviewed the market reform efforts of other states, as well as the National Association of Insurance Commissioners (NAIC) and other interested parties. The majority of the reforms reviewed have been instituted very recently and there are no conclusive results to point to as a guarantee that any particular approach will be the solution.

In recognition of what the Bureau believes are legitimate concerns of interested parties, and the Bureau's analysis of the shortcomings in the various options reviewed and/or implemented elsewhere, the Bureau proposal combines features of several proposals, including the NAIC model laws, and legislation and regulations enacted in Vermont. Some of the provisions will be unique to Virginia if they are adopted.

The Bureau recommends a retrospective reinsurance pool. We believe that a retrospective stop-loss insurance approach will be simpler to administer and monitor, as well as more effective than a prospective approach.

The Bureau also recommends that the community rating requirement be phased-in over a period of three years. A phase-in period would mitigate some of the impact community rating will have on small employer groups currently paying premiums that are considerably lower than the average.

The Bureau believes that the additional requirements of guaranteed issue and community rating will improve access to health insurance coverage for the small employer group market. The establishment of a reinsurance mechanism in conjunction with these market reforms will provide stability and protection for carriers participating in that market.

We recognize that the changes proposed in this report will not affect health care coverage for those covered by individual contracts or self-insured benefit programs. And, all individuals that are currently without health care benefits may not be assisted by the recommendations in this report. We do believe, however, that the recommendations, if implemented, will serve as a beginning for incremental improvement in access to health care coverage for the citizens of Virginia.

II. Introduction

Senate Joint Resolution No. 121, adopted by the 1992 General Assembly, requested the State Corporation Commission's Bureau of Insurance (Bureau) to develop an operational plan for establishing a small employer group reinsurance association for the Commonwealth. The study request is a result of the recommendations made by the Bureau in the 1992 report to the Governor and to the General Assembly in Senate Document No. 9: 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. The Bureau recommended the adoption of insurance market reforms that moderate rate increases and improve access to health insurance for small groups. A small group was defined, for the purposes of that study, as one with at least two but less than 50 employees. The report also proposed, for consideration by the General Assembly, a small employer group health reinsurance association.

This report contains a review of the options for the establishment of a group health reinsurance association. A recommendation on the type of reinsurance association best suited for Virginia is included. An operational plan that describes the steps and details necessary to implement such a reinsurance association in Virginia is also a part of this report.

III. 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 Virginia Employment Commission 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 may 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.

In recognition of the market for small employer groups, and after the study conducted pursuant to the 1991 General Assembly's Senate Joint Resolution 181, the Bureau recommended:

(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 were not designed to solve all of the problems in the small employer group market. The recommendations were envisioned as a first step in addressing some of the problems confronting small employer groups in the health insurance market. The Bureau acknowledged that other related issues, problems, and remedies may need to be addressed in the future.

Legislation that was enacted as a result of the Bureau study included 1992 Senate Bill 505, which took effect on July 1, 1992. Senate Bill 505 includes market reform provisions that limit the use of pre-existing condition restrictions, require guaranteed

renewability of coverage, and require that coverage be extended to the entire group if a group is accepted by a carrier.

The Bureau recommendations that would guarantee availability and restrict premium rates were not proposed in 1992. The Joint Commission on Health Care (JCHC), then known as the Commission on Health Care for All Virginians, decided to delay action on the issues of guaranteed availability and premium rate restrictions until an operational plan for a reinsurance association could be developed and reviewed.

1992 Senate Bill 506 was also introduced as a result of the study conducted by the Bureau. That bill requires a panel of experts and citizens to develop "essential" and "standard" health services plans. The panel is to use a cost benefit analysis to develop the specific components of each plan. The essential health services plan is to specify the services that must be made accessible to all Virginians regardless of circumstances, with emphasis on primary and preventive health services. The standard plan is to consist of services included in the essential plan and additional non-essential services. The panel is to complete an initial draft report by August 1, 1992 and forward it to the Special Advisory Commission on Mandated Health Insurance Benefits for review. A final report from the panel is to be submitted to the Governor, the General Assembly, and the JCHC by December 1, 1992.

The essential and standard plans are expected to be the contracts issued in the small employer group market.

IV. Methodology

The development of an operational plan for establishing a small employer reinsurance association required the Bureau to determine which of the options for a reinsurance association is most feasible for Virginia. The Bureau reviewed the types of reinsurance associations currently being operated, in addition to proposals for types of reinsurance associations that have not yet been implemented. The Bureau surveyed all states to determine (i) how many states are now operating a reinsurance association (ii) the type of reinsurance association being utilized (iii) the rationale used to make the determination as to the type of association to implement, and (iv) the experience that has resulted from the reinsurance association thus far.

The Bureau also reviewed the work of the National Association of Insurance Commissioners (NAIC) in this area. The NAIC adopted a Model Act in December, 1990, entitled "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups (Rates and Renewability)." The NAIC also adopted two Model Acts in 1991 to complement the market reforms in the Premium and Renewability Model and to address some of the problems in the small group market. The first is the Small Employer Health Insurance Availability Model Act (Allocation Model). The second is the Small Employer Health Insurance Availability Model Act (Prospective Reinsurance Model). The Allocation Model requires carriers either to provide coverage on a guaranteed issue basis or accept their fair share of high risk groups through allocation based on their amount of small employer group business. The Prospective Reinsurance Model establishes a program and allows carriers either to retain all small business risks themselves or cede some business to the reinsurance association.

A survey of insurers was conducted to obtain information about the Virginia small employer group market.

The Bureau also met with or reviewed information on the positions of various interested parties that are involved in the insurance industry in Virginia.

Additionally, assistance was obtained from one of the actuarial firms used on a consulting basis by the Bureau.

Virginia Small Employer Group Market

A survey of insurers licensed to write accident and sickness insurance in Virginia was conducted to obtain information about the small employer group market. The companies surveyed have Virginia annual written premiums in excess of $500,000. Companies with more than $500,000 in premiums were not included in the survey if they write only contracts to cover specific diseases or offer limited contracts such as hospital confinement indemnity insurance.

Insurers in the Small Group Market

Of the 100 companies surveyed, 67 companies responded to the survey request by August 28, 1992. The survey requested information about the insurers' market share and marketing practices in Virginia. Thirty-nine of the respondents indicated that they are currently writing employer groups with less than 100 employees. The remaining 28 companies do not write small group business. Five of the twenty-eight companies not writing small group business indicated that they had previously written this segment of the market, but had stopped writing small group business in all states.

The 39 companies writing small groups do not market to all small groups. The table that appears below summarizes the marketing practices of the responding companies:

100 companies surveyed
67 companies responded
39 companies write small employer groups
21 companies write all sizes 50 or less
9 companies do not write groups of 25 or less
9 companies have size minimums that vary from 3 to 20

Market Share

Eighteen of the thirty-nine insurers writing small groups indicated that they provide coverage to fewer than 100 small groups each. Another nine insurers write fewer than 500 small groups each. Five companies wrote the majority of the small group business insured by the survey respondents. (A number of companies did not respond to this question, citing their uncertainty as to the number of groups that they insure in each category.)

Effect of Small Employer Group Market Reform

Companies were asked if they had withdrawn from a state or states in the past two years. Some companies indicated that they had withdrawn from states as a result of declining market share and questionable profitability. However, a number of companies indicated they had withdrawn from states because of reforms introduced in the small group market. More companies (14) indicated that they had withdrawn from Vermont than any other state. Seven companies had withdrawn from Oregon and four companies from North Carolina and Florida.

Nine insurers said that it is likely that they would withdraw from the small group market in Virginia if guaranteed issue requirements are instituted along with rate restrictions without some type of reinsurance mechanism. Sixteen insurers were unsure as to whether they would continue without a reinsurance mechanism. Only two companies said they would likely withdraw even if there was a reinsurance mechanism.

V. Small Employer Group Reform Efforts

National Association of Insurance Commissioners Small Employer Group Market Reform

The NAIC Allocation Model creates a Small Employer Access Program. Each small employer carrier issuing health plans in the state must participate unless exempted by the Commissioner of Insurance based upon:

(1) The carrier's financial ability to support the assumption of the risk of the 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 employers; and

(4) The carrier's ability to assume and manage the risk of enrolling small employers without the protection of a reinsurance program.

Carriers granted an exemption must offer policies year-round without regard to health status or industry. The coverage must be at least as comprehensive as the basic and standard plans.

Participating carriers select the initial Board of Directors (Board) subject to the Commissioner's approval.

The Board of Directors of the program supervises and controls the program. (The Board has members appointed by the Commissioner of Insurance in the Prospective Reinsurance Model).

Small employers are eligible for coverage in the program if (i) they are uninsured and have been rejected by at least two small employer carriers; or (ii) if they have been covered by the program for two years and are applying for new coverage and have been refused by two carriers; or (iii) after notifying a current carrier they intend to terminate coverage they are refused by at least two carriers.

The program estimates the total number of uninsurable individuals in small employer groups in the state. Each carrier is assigned a target number of individuals that is in proportion to that carrier's share of the small group business in the state. (The market share is based on annual premiums.) Adjustments can be made based on geographic service areas. Small employers can pick a carrier from a list of participating carriers, subject to the carrier receiving its maximum number of employers.

The NAIC Prospective Reinsurance Model requires all insurers in the small employer group market to offer a basic health care plan, (one that is lower in cost than most plans offered to small

employers) and a standard plan, (one that is similar to those being offered in the current market). The plans must be offered on a guaranteed issue basis; i.e. all employers would be accepted, regardless of the health status of their employees.

The version of the Prospective Reinsuance Model that allows carriers to opt-out gives them the option of assuming the full risk of covering all the small employer groups that they insure by not participating in the program. The carrier would have to receive approval from the Commissioner of Insurance. The market reforms, including rate restrictions, would apply to the carriers that retain the risk themselves to the same extent they apply to the carriers participating. The carriers not participating would not be required to pay assessments for any losses of the reinsurance program. The other option of the prospective model is to require all carriers to be reinsuring carriers; i.e. no carrier is permitted to opt-out.

With this type of reinsurance, carriers use medical underwriting or other techniques to identify potential high risks. The carriers must identify the risk and reinsure it at initial enrollment. Carriers can reinsure entire groups or an individual member of a group. The carrier would have to pay a premium to reinsure the risk. (1.5 times the standard rate established by the Board for a group and 5.0 times the standard rate established by the Board for an individual).

Carriers would be required to pay the first $5,000 in covered expenses for each reinsured individual. The carrier would also have to pay 10% of the expenses, up to a maximum of $50,000, for which the reinsurance association is responsible. The Board is to adjust the level of claims and the maximum limit annually by not less than the medical component of the Consumer Price Index. The covered individual or group would neither be involved in nor aware of the ceding of coverage to the reinsurance association.

Premiums paid for reinsurance are the first source of funding to pay reinsurance claims. If additional funds are necessary, assessments are made against participating carriers.

The assessments are to be determined by a formula established by the Board based on each reinsuring carrier's share of the market of small employers in the state and each reinsuring carrier's market share of policies newly issued to small employers.

The Board is authorized to change the assessment formula as appropriate, and may provide for assessments based on total premium and previous year's premium to vary during a transition period.

The Board can make an adjustment for Health Maintenance Organizations.

Issues Identified For Further Clarification By the NAIC

A number of concerns have surfaced regarding the NAIC's Prospective Reinsurance Model, even though it is the direction most states that have acted have taken.

The major areas of concern are: (i) the ability of insurers to shift risk to the reinsurance mechanism; and (ii) the narrow effect of the rate restrictions on premiums.

An NAIC working group has been established to develop model regulations for the rating constraints in the model acts. The working group has identified three basic areas that need to be addressed in the regulation of rating constraints:

(1) Assuring that carriers comply with the 25% rating constraint for health plans within a class of business;

(2) Methods of testing compliance with the 20% constraint between classes of business; and

(3) The appropriate method for addressing substandard rating.

In June, 1992 the working group recommended that:

(1) Carriers be required to use only one rating manual for all health plans in a class of business;

(2) Specific guidance be developed by regulation to assure that differences between health plans in a class of business are reasonable and comply with the 25% and 20% constraints. (A detailed methodology for determining the value of differences in health plan design may be developed for the NAIC by an actuarial consultant.); and

(3) The addition of a substandard risk to a group not affect the risk status of that group until renewal. In other words, the substandard risks must be added to a group at a premium that is the same percentage of the standard premium as that of the group prior to the addition of the substandard risk.

The working group is also drafting language to deal with the issue of carriers that have blocks of small group business in force when market reforms are enacted and choose to stop issuing new policies. The questions raised are whether carriers should be allowed to retain their existing business in force and, if so, what conditions should apply to that business.

Technical amendments have been proposed to the Model Acts (Allocation and Prospective Reinsurance.) The proposals are:

(1) That insurers be allowed to elect whether they will be a risk-assuming or reinsuring carrier within 30 days after the approval of a plan of operation for the reinsurance association by the Commissioner of Insurance;

(2) The Board composition be changed to five members being "carriers", from five members being "reinsuring carriers", because the carriers would not have made their election by that time; and

(3) The time period for continuous coverage be extended to 90 days instead of 30 days.

The NAIC working group is also considering further definition of the following terms:

(1) case characteristics;
(2) established geographic service area;
(3) qualifying previous coverage; and
(4) qualifying existing coverage.

The following issues have also been suggested as needing further clarification:

(1) the treatment of individual policies under the Model;
(2) procedures and standards for insurers creating more than one class of business;
(3) procedures for notification and application for reentry into a state related to a decision to nonrenew coverage;
(4) standards for nonrenewal related to insurers doing business in only one service area in a state;
(5) procedures for application of the provisions on minimum participation requirements; and
(6) procedures related to the timing of periodic reports required under the periodic market evaluation section of the models.

Small Employer Group Market Reform in Other States

A survey of all 49 other states and the District of Columbia was conducted to determine their current positions on small group market reform. Information was also obtained from the NAIC regarding state activity in this area. There are at least 34 states that have either instituted small group market reforms, or had legislation pending in July, 1992. The majority of those states have legislation and regulations similar to the NAIC models. Thirteen states have adopted provisions similar to the NAIC Prospective Reinsurance Model.

A number of states, including New York, Oregon and Vermont, have provisions that are viewed as more stringent than the NAIC models. The New York requirements apply to individual contracts as well as small groups, and mandate the use of community rating. Oregon has legislation very similar to the NAIC Prospective Reinsurance Model but imposes more restrictive rating bands. Vermont has instituted strict rating reforms along with a guaranteed issue requirement, but without a reinsurance mechanism.

The majority of states that responded to the Bureau's survey were uncertain of the exact number of insurers in the small employer group market in their state prior to the enactment of reforms. States that did respond to that question indicated that the number of carriers in their state varied from as few as three to up to ninety. It is still early in the development of small employer group market reform, and most states were uncertain as to whether they will lose many carriers.

A number of states enacted reforms in 1991 and 1992, and the changes that they are implementing will be effective this year. Connecticut and North Carolina have programs that are operational, and Bureau staff discussed the current status of the reinsurance operations and market reforms with officials in both states. Major concerns and issues are summarized below.

Connecticut

Connecticut was the first state to institute a reinsurance mechanism. The Connecticut reinsurance pool is prospective and similar in design to the NAIC Prospective Reinsurance Model.

The number of participating carriers in Connecticut was 48 as of March, 1992. At that time, 1,820 plans were issued to previously uninsured small businesses. Six hundred seventy-four of those plans covering 2,228 individuals, were reinsured with the pool.

The Connecticut plan has a number of critics who point to the low number of insureds that the program is covering. Connecticut has experienced some increase in the cost of insurance for small groups. There has also been an increase in the use of medical underwriting as companies attempt to determine who they should reinsure before they provide coverage. Critics also complain that the prospective approach slows service to insureds and allows the underwriting of risks to continue. Supporters make the point that the program is still in the initial stages of development and should be allowed the opportunity to adapt to any initial problems before the program is evaluated.

North Carolina

North Carolina's law is very similar to the NAIC Prospective Reinsurance Model. It includes rating provisions similar to the model, but allows a 25% variance from the index rate as opposed to the NAIC model's 20%, and a 35% variance for a class of business with similar case characteristics, not the model's 25%.

The North Carolina law allows carriers to decide if they wish to participate in the reinsurance association or assume the risk themselves. The plan allows individuals or entire groups to be reinsured. The individual or group must be reinsured within 60 days after coverage begins, which is also consistent with the NAIC model.

North Carolina currently expects 52 companies to participate in the reinsurance mechanism. Plans were marketed beginning September 1, 1992. Neither the reinsurance premiums nor the plan of operation for the reinsurance pool has yet been finalized.

The concerns in North Carolina at this point involve the difficulties in operating a reinsurance mechanism, and the monitoring and enforcement of the rating parameters they have adopted.

Vermont

The Vermont statute applies to groups with less than 50 employees. A small employer group carrier must offer one or more of the "Commonwealth Care Plans." The small employer group carrier rate structure must differentiate between single person, two person and family rates.

A carrier is required to use a community rating method that is acceptable to the Commissioner. Medical underwriting and screening, are prohibited. Carriers can use one or more risk classifications in their community rating method, but the premium that is charged must not deviate more than 20% above or below the community rate filed by the carrier. This includes demographic factors, claims experience, and duration of coverage factors.

Some association groups may be exempt from the preceding requirements.

Registered small employer group carriers must file an annual certification by a member of the American Academy of Actuaries as to the carrier's compliance with the community rating requirements.

The Vermont experience has thus far been surprising to many industry observers. Although some carriers have withdrawn from the state, other carriers not previously doing business in Vermont have applied to operate in the state. The Vermont law does not prohibit the development and operation of a reinsurance mechanism. Carriers in the market may establish a reinsurance mechanism if they so desire.

Vermont currently has 12 registered carriers. The carriers remaining in the Vermont market have been characterized as being the larger carriers. Those carriers withdrawing from the market reportedly had a very small share of the small employer group market.

The full effect of Vermont's community rating provisions will not be felt until 12 months after the July 1, 1992 effective date of the statute. However, the Vermont Insurance Department has not received consumer complaints of a substantial magnitude regarding the premiums for contracts that have been issued or renewed in the past few months.

Blue Cross and Blue Shield of Virginia Proposal

In June, 1992 Blue Cross and Blue Shield of Virginia (BCBSVA) made a proposal that would create a retrospective reinsurance association. Under this proposal reinsurance would be available only for claims that both: (i) exceed a deductible amount ($5,000 in the BCBSVA proposal) and (ii) are determined to have been caused by a medical condition on a list of "presumptive conditions" as established and maintained by the Board of Directors of the reinsurance association.

The BCBSVA proposal would require guaranteed issue of the essential and basic plans to groups of 2 to 25 employees. Those groups would be the only groups eligible for reinsurance through the association.

The BCBSVA proposal differs from the NAIC Prospective Reinsurance Model in that it is retrospective and relies on a presumptive conditions list. Another important distinction in the BCBSVA proposal is that it includes a ratio to be used as a benchmark to determine if high-risk individuals are fairly distributed among carriers. The BCBSVA proposal includes a provision that the guaranteed issue requirement is not applicable until "a fair distribution of risks is achieved."

The BCBSVA proposal also differs from the NAIC Prospective Reinsurance Model by requiring the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) to report on the effectiveness of the small employer market provisions. The NAIC model requires the Board of Directors of the association to make such a report, which is to address the stability, accessibility, and affordability of the small employer group market.

The BCBSVA proposal allows each carrier to elect to become either a risk-assuming or reinsuring carrier. The NAIC Prospective Reinsurance Model requires carriers to seek the approval of the Commissioner of Insurance to be risk-assuming carriers.

The BCBSVA proposal would require lengthy decision making regarding the presumptive conditions that would be eligible for the pool. Any such list would be subject to constant revision as medical conditions and treatments are recognized and reassessed. When this type of proposal was suggested on a national level it received only preliminary review because the majority of interested parties, including many Blue Cross and Blue Shield plans, did not like the concept. The presumptive conditions approach was regarded by most as difficult to administer and monitor.

A presumptive conditions approach would provide less financial protection for a small carrier. If a carrier had a number of losses in the $50,000 to $250,000 range that were not due to a condition on the predetermined list, the carrier would

have to pay for all of these losses. The losses would not be covered by the reinsurance pool.

One of the other areas of concern with the BCBSVA proposal is the effect of the provision that would allow a carrier to stop accepting small employer group business when the carrier had more than its fair distribution of risk. There would be great difficulty in determining what constitutes a fair distribution of risk. Assuming that this could be determined, the practical effect would be that a carrier could stop accepting coverage for a six-month period, risks could redistribute, and then the carrier would be required to accept small employer group business again. This type of activity could be difficult for agents as well as carriers. Agents would not know which carrier to approach and the placement of business and subsequent securing of coverage would be delayed. Monitoring of this activity by the Bureau of Insurance would also be difficult.

VI. Bureau of Insurance Proposal

The Bureau of Insurance recognizes the valid concerns expressed by interested parties regarding the possible ramifications of the adoption of small group reforms that restrict insurers' underwriting and pricing practices. The Bureau does, however, believe that it is in the best interest of the Commonwealth to proceed with market reform. With assistance from its consulting actuaries, the Bureau has developed a proposal that differs from the NAIC models, the BCBSVA June, 1992 proposal, and other state reforms.

The Bureau proposal is similar in operation to the NAIC model, but otherwise differs greatly from the NAIC model because it is retrospective reinsurance. The Bureau believes that a retrospective approach will prevent the "gaming" of the system that provides an advantage to companies with sophisticated underwriting techniques. When insurers "game" the system, they predict which insureds will generate losses and put only those risks in the pool. The insurer has then simply transferred the risk and not really changed its market practices.

The Bureau proposes a stop-loss approach that will address losses that are large (over $25,000). Companies would have to manage their small employer group business and its losses up to $25,000 themselves. The carriers could not merely shift the business to the reinsurance pool when losses exceed a lower amount ($5,000 in some alternatives). The stop-loss would provide direct financial protection to the smaller companies writing this business. Smaller companies have less protection to absorb losses that result from a guaranteed issue requirement than larger companies which benefit from a broader base of other business. The Bureau's proposal would not be limited to any category of losses or conditions. It would provide direct protection for all individuals, whether they had a chronic condition, an acute condition or were injured in an accident.

The Bureau believes that this retrospective proposal addresses the legitimate concerns of gaming while at the same time providing protection to all carriers as they participate in the market under guaranteed issue requirements.

The objectives of the Bureau's proposal are to provide adequate coverage, financial stability and integrity, and equity for carriers. The Bureau believes that the reinsurance mechanism also should be as simple to administer and monitor as possible. The Bureau also believes that initially, all carriers should be required to participate in the pool. This provides a larger and more viable basis for the pool.

We propose that initially, the reinsurance pool should be available for new business only. Although existing Virginia small group market reforms apply to groups with less than 50 employees, we believe that this proposal should be limited to groups with less than 26 employees. The Bureau believes that

less than 26 employees is appropriate for the guaranteed issue requirements and resulting reinsurance mechanism because of information obtained from our survey regarding insurers' current activity in the small group market. Additionally, national data, as well as information specific to Virginia obtained from an employer survey conducted in 1991 for the Department of Medical Assistance Services (DMAS) indicates that health coverage is accessible for employers with more than 26 employees.

Rate Restrictions

In the current market, the health insurer who sells his product at an average (community) rate to small groups will soon find that other insurers will target the younger, healthier groups, and offer them the lower rates associated with their young, and healthy characteristics. These other insurers will be successful in attracting those groups away from the community rater, and an adverse selection spiral may begin. The community rating insurer's average rate increases at a quicker pace because the younger, healthier groups are no longer in the average. These higher than normal increases cause more healthy small groups to seek coverage with an insurer who offers rates tailored to their specific needs. This cycle continues until the community rating insurer has only the sickest groups in its portfolio, and the highest premium rates. (See Exhibit 1 on page 20 for an example).

The BCBSVA proposal includes the rating parameters that are incorporated in the NAIC models. The NAIC model rating provisions are a valid starting point. However, the NAIC provisions are difficult to understand and administer.

The rating provisions are designed in an attempt to level the playing field among small group carriers.

The NAIC rating provisions basically provide that:

- Rates for groups of the same average age, gender, location, and benefit package can vary only plus and minus 25% from the average for adjustments related to claims experience, duration of coverage, and health status.

- Annual rate increases are limited to a normal trend factor for inflation and utilization changes, a factor for any change in the age, gender, location, or coverage of the group, plus a factor no greater than 15% for adverse changes in the duration, experience, and health status of the group.

The first provision means that if the average family rate for a group with an average employee age of 41, where half of the employees are male and half are female, located in Richmond, with major medical coverage, is $410 per month effective July 1, 1992, then all groups in Richmond with those same characteristics must have their rate limited to the range of $307.50 to $512.50 (25%

either side of $410) for experience, duration, and health status factors.

It must be kept in mind that the starting point in this example is $410 for average age 41, 50% male and 50% female, Richmond area, with major medical coverage. The problem with this approach is that there are too many other potential starting points to make the rate banding effective in leveling the playing field.

When one considers all of the rate variations that are associated with age and gender, there could be a 100% variation either side of an average rate before the bands are applied. After the bands are applied, the variation increases even further, as demonstrated in Exhibit 2 on page 21. The resulting effect is that "cherry picking" will still be a problem.

One suggested solution to the problem is to close the large gap between the lowest and highest possible rate by moving the bands closer together.

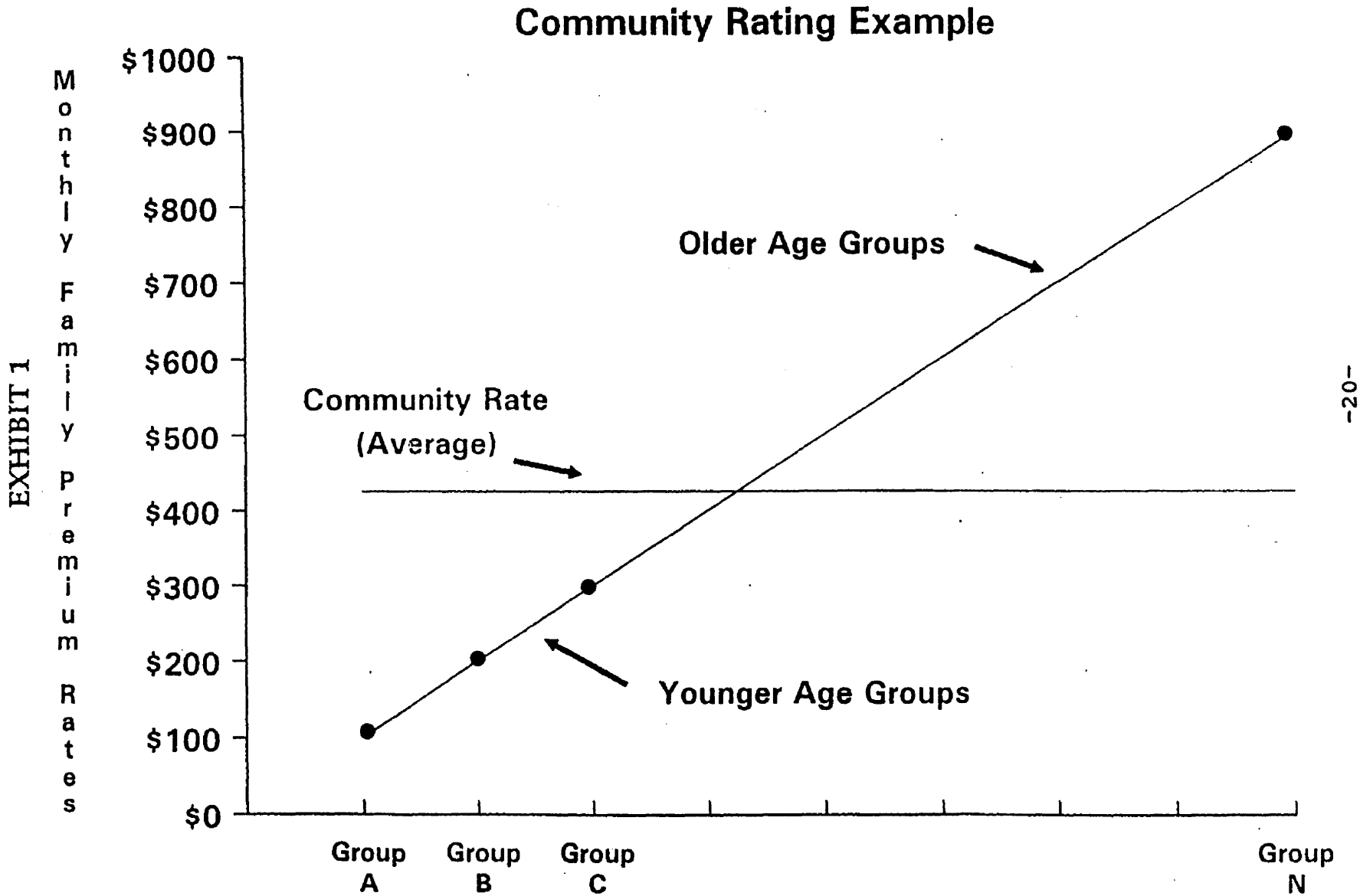
The New York model did this in an extreme way. There are no variations allowed in the community (average) rates other than rating based upon geographic area of the state. This means, for example, that insurer "A" has to charge the same rate (the community rate for "A" in Albany) for the same coverage for the same policy period to its small groups in the Albany area. Similarly, insurer "B" has to charge his same rate (community rate for "B" in Albany) for the same coverage for the same policy period to his small groups in the Albany area. Note that insurer "A's" rate may differ from insurer "B's" rate. They each develop their own community rates for their own products for each geographic rating area.

The Vermont model was less extreme than New York's, but more effective than the NAIC model. It starts out the same as the New York model, but it then allows a 20% band on either side of the community rate for a given coverage in a given area. Demographic adjustment factors, claims experience factors, and duration of coverage factors for the small group can contribute to the 20% band. Factors associated with health status of the small group are prohibited. See Exhibit 3 on page 22 for an illustration.

The Bureau believes that the Vermont approach is the best approach that has been developed to date, in that it levels the playing field on the one hand, but provides for some rate variation on the other.

The Bureau suggests that there be a phase-in period of three years for the full enactment of this rating proposal. All parties must realize that this approach will result in increased rates for those small employers currently paying rates that are considerably less than the average. The phase-in period will allow for a gradual adjustment to modify the impact of a sudden and substantial increase.

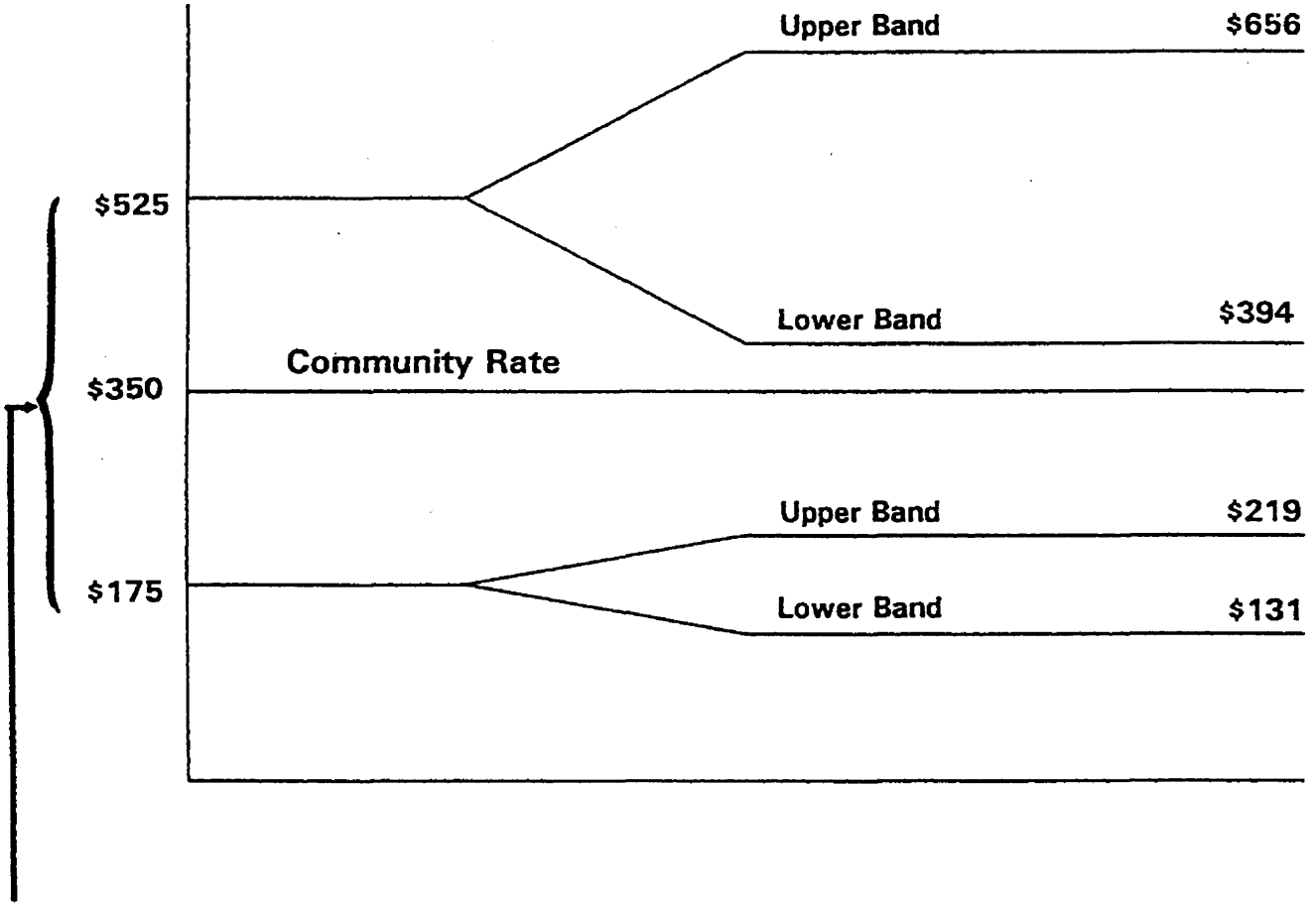
EXHIBIT 1



If Group A's rate is removed, the average increases

EXHIBIT 2
Hypothetical Example

NAIC Model Rate Banding

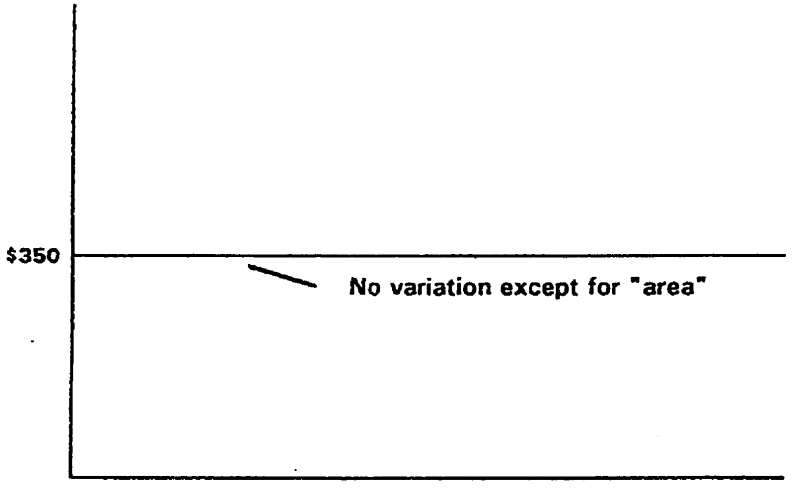


Age, Gender, and Other Case Characteristics are a "pass through" before rate bands are applied. Therefore the $350 community rate could vary from $175 to $525, in this example, before any bands are applied.

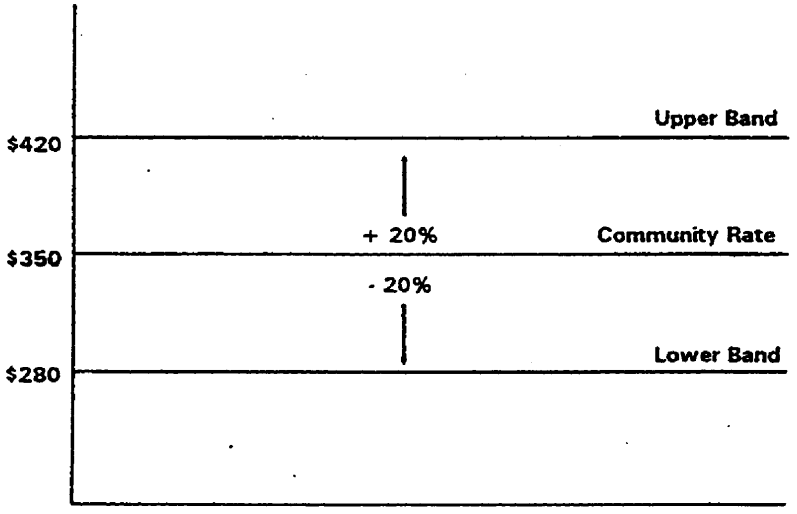
In this hypothetical example, the banding does little to compress the range of rates. The low rate is $131 and the high rate is $656. The community rater will charge the average $350 rate. The aggressive rater who is interested in "cherry picking" will offer the youngest groups the $131 rate an the oldest groups the $656 rate, with the results that the younger groups will be attracted, and the older group will cancel because they can purchase the same coverage from the community rater at $350.

EXHIBIT 3

New York



Vermont



Note: Claims experience, demographic adjustments, and duration of coverage adjustments can contribute to the ± 20% variation. However, adjustments related to the health status of the group cannot be used.

VII. Operational Plan

The following operational plan is based on the NAIC models with specific changes to address the proposed retrospective nature of Virginia's reinsurance mechanism. The Board of Directors of the program would have 180 days to submit a day-to-day plan of operation to the Commission for approval. A copy of the operational plan approved in Connecticut is attached as Appendix C to this report. The Connecticut plan could provide a starting point for the Board of Directors of the Virginia program.

A. There is hereby created a nonprofit entity to be known as the Virginia Small Employer Health Reinsurance Program.

B. The Program shall operate subject to the supervision and control of the Board. Subject to the provisions of Paragraph (1), the Board shall consist of eight members appointed by the Commissioner of Insurance plus the Commissioner or his designated representative, who shall serve as an ex officio member of the Board.

(1) In selecting the members of the Board, the Commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the Commissioner. At least five (5) of the members of the Board shall be representatives of reinsuring carriers and shall be selected from individuals nominated by small employer carriers in the Commonwealth pursuant to procedures and guidelines developed by the Commissioner.

(2) The initial Board members shall be appointed as follows: two (2) of the members to serve for a term of two (2) years; three (3) of the members to serve for a term of four (4) years; and three (3) of the members to serve for a term of six (6) years. Subsequent Board members shall serve for a term of three (3) years. A Board member's term shall continue until a successor is appointed.

(3) A vacancy in the Board shall be filled by the Commissioner. A Board member may be removed by the Commissioner for cause.

C. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the Commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this Commonwealth in the previous calendar year.

D. 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 if the Commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the Program, and to provide for the sharing of the Program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the Commissioner.

E. 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 subsection at the time a plan of operation is submitted by the Board and approved by the Commissioner.

F. 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 procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(3) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the Program; and

(5) Provide for any additional matters necessary for the implementation and administration of the Program.

G. The Program shall have the general powers and authority granted under the laws of this Commonwealth 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 such 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 to recover any assessments and penalties for, on behalf of, or against the Program or any reinsuring carriers;

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

(4) Define the health benefit plans 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 for reinsuring risks under the Program;

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

(7) Assess reinsuring carriers, 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 functions within the authority of the Program; and

(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.

Drafting Note: Source of Sections A through G NAIC Model

H. A reinsuring carrier may reinsure with the Program subject to the following:

(1) The Program shall reinsure eligible employees and their dependents who qualify for the primary small group market;

(2) The Program shall reinsure such risks or policies that were originally delivered or originally issued for delivery on or after the later of July 1, 1993 or the date upon which the Program makes reinsurance available;

(3) The Program shall reinsure eligible employees or the dependents of the primary small employer market according to the following:

(a) Reinsurance coverage shall begin after a $25,000 calendar year deductible. The amount of said deductible shall periodically be reviewed by the Board and adjusted for inflation, as determined by the Board. In addition, the member shall retain five percent of the additional benefit payments during a calendar year and the Program shall reinsure the remainder. The amount of said member's maximum liability shall periodically be reviewed by the Board and adjusted for inflation, as determined by the Board.

(b) Pool loss allocations by the Program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C §300 et seq., shall be reduced to reflect the restrictions and requirements of 42 U.S.C §300 et seq.

(c) Every reinsuring carrier must apply case management and claims handling techniques, including but not limited to utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured and non-reinsured business.

(4) The Program shall reinsure only the levels of benefits provided in the essential or standard health care plans established in accordance with subsection B of §38.2-3432.

(5) Reinsurance levels for the individual or Program shall also be adjusted to reflect cost containment features of the plan of operation that have proven to be effective including, but not limited to: preferred provider provisions, utilization review of medical necessity of hospital and physician services, case management benefit alternatives, and other managed care provisions or methods of operation, and fair treatment of all reinsuring carriers; and

(6) The Program shall incur debt or assess participating carriers for the initial funding of the Program.

Drafting Note: Section H is from Bureau of Insurance and BCBSVA Proposals

I. Each participating carrier will pay the same fixed percentage of its new small group earned premium for the

essential and basic benefit programs or their equivalents written during the initial policy year of the reinsurance pool.

The fixed percentage can be changed by the Board in succeeding policy years to reflect the changes in the deductible that will occur, changes in assumed utilization, and any other changes recommended by the Board.

J. Net losses for the year shall be recouped by assessments of members as follows:

(1) At the close of the policy year, after three additional months of incurred claim runout, an initial settlement will be calculated to determine net reinsurance pool losses. An initial assessment will be determined by converting any initial net pool losses to a fixed percentage of total earned premium in the policy year for new primary small group business written. That fixed percentage will be applied separately to each carrier's portion of the premium.

(2) A second settlement will be calculated with six months of claim runout. Any necessary adjustments to the initial settlements will be netted and billed to participating carriers.

(3) A final settlement will be calculated with twelve months of claim runout to determine the final assessments for each carrier.

For the purposes of this section, health benefit plan premiums earned by Multiple Employer Welfare Arrangements (MEWAs) and other benefit arrangements, shall be established by adding paid health benefit expenses, incurred but not reported health benefit expenses, and administrative and any other expenses or charges.

Subject to the approval of the Commissioner, the Board may make an adjustment to the assessment formula for any reinsuring carrier that is a health maintenance organization approved as a federally qualified health maintenance organization by the Secretary of Health and Human Services pursuant to 42 U.S.C §300 et seq. to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

If assessments exceed actual losses and adminstrative expenses of the Program, the excess shall be held at interest and allied to offset subsequent assessments and apportioned for that purpose in the same manner as the last preceding assessment. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

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

Drafting Note: Sections I and J are Bureau of Insurance Proposals

K. Neither the participation in the Program as reinsuring 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 reinsuring carriers either jointly or separately.

The Board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the Board shall take into the consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

The program shall be exempt from any and all taxes.

Drafting Note: Section K is consistent with NAIC Model and BCBSVA proposal.

VIII. Conclusion

The Bureau recommends the implementation of a retrospective reinsurance mechanism to provide financial stability in the small employer group market when guaranteed issue requirements are imposed. The Bureau also recommends a requirement that community rating be used for groups with less than 26 employees.

The Bureau recognizes that the small group market reforms that are currently being implemented in other states, as well as Virginia, are not the solution to all of the problems in the small group health insurance market. The Bureau believes, however, that the institution of a guaranteed issue requirement, community rating, and a retrospective reinsurance mechanism will improve the overall accessibility and affordability of the small employer group market in Virginia.

The Bureau believes that the daily operational plan for the reinsurance mechanism should be developed by the Board of Directors subject to approval by the Commissioner of Insurance. The board of directors can address the issues of equitable distribution of risks and day-to-day operations in the formulation of the plan of operation.

APPENDIX A

SENATE JOINT RESOLUTION NO. 121

Requesting the Bureau of Insurance to develop operational plans to establish a small employer group reinsurance association.

Agreed to by the Senate, February 11, 1992
Agreed to by the House of Delegates, February 24, 1992

WHEREAS, approximately one million 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

WHEREAS, approximately 36 percent of all businesses do not offer health insurance, and 41 percent of the small businesses in the Commonwealth with fewer than 26 employees do not offer health insurance; and

WHEREAS, the high cost of health insurance, ever-rising insurance rates, and underwriting exclusions are some of the impediments of small businesses offering insurance; and

WHEREAS, the Bureau of Insurance issued a report on November 1, 1991, to the Commission on Health Care for All Virginians, which discussed the feasibility of establishing a small business risk-sharing pool with insurance reforms that improve access and moderate rate increases; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Bureau of Insurance be requested to develop an operational plan for establishing a small employer group reinsurance association for the Commonwealth to be operational July 1, 1993.

All agencies of the Commonwealth shall provide information and assistance needed by the Bureau in its development of this plan.

The Bureau of Insurance shall report its plan and recommendations by September 1, 1992, to the Commission on Health Care for All Virginians and shall submit its report to the Governor and the 1993 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing of legislative documents.

APPENDIX B

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

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Section 8. Availability of Coverage
Section 9. Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier
Section 10. Application to Become a Risk-Assuming Carrier
Section 11. Small Employer Carrier Reinsurance Program
Section 12. Health Benefit Plan Committee
Section 13. Periodic Market Evaluation
Section 14. Waiver of Certain State Laws
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Section 16. Standards to Assure Fair Marketing
Section 17. Separability
Section 18. Effective Date

Section 1. Short Title

This Act shall be known and may be cited as the Small Employer Health Insurance Availability Act.

Section 2. Purpose

The purpose and intent of this Act are 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 benefit 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 is not intended to 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 6 of this Act, based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

B. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

C. "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.

D. "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to Section 12.

E. "Board" means the board of directors of the program established pursuant to Section 11.

F. "Carrier" means any entity that provides health insurance in this state. For the purposes of this Act, carrier includes an insurance company, [insert appropriate reference for a prepaid hospital or medical care plan], [insert appropriate reference for a fraternal benefit society], a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Drafting Note: The term "multiple employer welfare arrangement" should be added to the list of carriers in those states that have separate certificates of authority for such arrangements.

In states that do not have separate licenses for self-funded multiple employer welfare arrangements, such arrangements should be treated as unauthorized insurers. States should enforce their laws against transaction of unauthorized insurance against such unauthorized self-funded multiple employer welfare arrangements.

G. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this Act.

H. "Class of business" means all or a separate grouping of small employers established pursuant to Section 5.

I. "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.

J. "Committee" means the Health Benefit Plan Committee created pursuant to Section 12.

K. "Control" shall be defined in the same manner as in Section [insert reference to state law corresponding to NAIC Model Holding Company Act].

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

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

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

Drafting Note: If using suggested definition, states should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law.

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

N. "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

O. "Health benefit plan" means any hospital or medical policy or certificate, [insert reference to subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan], or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, 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.

P. "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.

Q. "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 during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is 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 meets each of the following:

(a) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(b) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse or divorce; and

(c) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage;

(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 or dependent 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.

R. "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.

S. "Plan of operation" means the plan of operation of the program established pursuant to Section 11.

T. "Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

U. "Producer" means [incorporate reference to definition in state's law for licensing producers].

Drafting Note: States that have not adopted the NAIC Single License Procedure Model Act should substitute the terms "agent" and/or "broker" for the term "producer" as appropriate.

V. "Program" means the [State] Small Employer Reinsurance Program created by Section 11.

W. "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(1) Medicare or Medicaid;

(2) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(3) An individual health insurance policy (including coverage issued by a health maintenance organization, [insert appropriate reference for a prepaid hospital or medical care plan] and [insert appropriate reference for a fraternal benefit society]) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one year.

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

Y. "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to Section 11.

Z. "Restricted network provision" means any provision of a health benefit plan

that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [insert appropriate reference to state laws regulating health maintenance organizations and preferred provider organizations or arrangements] to provide health care services to covered individuals.

Drafting Note: States should modify this section to make reference to the types of restricted network arrangements authorized in the state.

AA. "Risk-assuming carrier" means a small employer carrier whose application is approved by the commissioner pursuant to Section 10.

Drafting Note: Delete Subsections Y and AA if participation in the reinsurance program is mandatory.

BB. "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 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 that are affiliated companies, or that 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 "small employer," depending on the underwriting and marketing practices in the state and other relevant factors.

CC. "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

DD. "Standard health benefit plan" means a health benefit plan developed pursuant to Section 12.

Section 4. Applicability and Scope

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

A. Any portion of the premium or benefits is paid by or on behalf of the small employer;

B. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

C. 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.

Drafting Note: In some cases, individual health benefit plans sold to small employers could be subject both to the provisions of this Act and to the provisions of the state's laws for individual health insurance. A state should consider whether inconsistencies in regulatory standards would result, especially in the provisions relating to premium rates. A state may wish to consider exempting individual health benefit plans from the rating provisions of this Act.

D. (1) Except as provided in Paragraph (2), for the purposes of this Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this Act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.

(2) An affiliated carrier that is a health maintenance organization having a certificate of authority under Section [insert reference to state health maintenance organization licensing act] may be considered to be a separate carrier for the purposes of this Act.

(3) Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. [The provisions of {insert applicable reference to state law on assumption reinsurance} shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.]

Drafting Note: The language in brackets should be included in states that have enacted laws regulating assumption reinsurance.

Section 5. Establishment of Classes of Business

A. A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) The small employer carrier has acquired a class of business from another small employer carrier; or

(3) The small employer carrier provides coverage to one or more association groups that meet the requirements of [insert appropriate statutory reference to Section 2E of the NAIC Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act].

B. A small employer carrier may establish up to nine (9) separate classes of business under Subsection A.

C. The commissioner may establish regulations to provide for a period of transitions in order for a small employer carrier to come into compliance with Subsection B in the instance of acquisition of an additional class of business from another small employer carrier.

D. The commissioner may approve the establishment of additional classes of business 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.

Section 6. Restrictions Relating to Premium Rates

Drafting Note: States that already have adopted the NAIC Model Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Employers Model Act will have provisions that substantially duplicate the provisions of this section. Some of the provisions in this model, however, are more favorable to policyholders and states may wish to modify their laws to conform to the provisions in this section.

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%).

(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 that 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 health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(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 of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to Section 11.

(6) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent (15%).

(7) In the case of health benefit plans delivered or issued for delivery prior to the effective date of this Act, a premium rate for a rating period may exceed the ranges set forth in Subsections A(1) and (2) for a period of three (3) years following the effective date of this Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall 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 health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided

that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(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.

(8) (a) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(b) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(9) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(10) The small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition and group size without prior approval of the commissioner.

(11) The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this Act, including regulations that:

(a) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design (not including differences due to the nature of the groups assumed to select particular health benefit plans); and

(b) Prescribe the manner in which case characteristics may be used by small employer carriers.

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 the 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 based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(2) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that 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. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. 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 7. Renewability of Coverage

Drafting Note: States that already have adopted the NAIC Model Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Employers Model Act will have provisions that substantially duplicate the provisions of this section. Some of the provisions in this model, however, are more favorable to policyholders and states may wish to modify their laws to conform to the provisions in this section.

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 small employer, except in any of the following cases:

(1) Nonpayment of the required premiums;

(2) Fraud or misrepresentation of the small 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;

(6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:

(a) Provide advance 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 small employers 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 small employers; or

(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.

B. A small employer carrier that elects not to renew a health benefit plan under Subsection A(6) shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the commissioner.

C. In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in that service area.

Section 8. Availability of Coverage

A. (1) 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 benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan.

(2) (a) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this Act.

(b) In the case of a small employer carrier that establishes more than one class of business pursuant to Section 5, the small employer carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(i) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(ii) The criteria are not related to the health status or claim experience of the small employer;

(iii) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(iv) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of this subparagraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(3) A small employer is eligible under Paragraph (2) if it employed at least three (3) or more eligible employees within this state on at least fifty percent (50%) of its working days during the preceding calendar quarter.

Drafting Note: The minimum group size of three (3) is included to protect small employer carriers from excessive adverse selection.

(4) The provisions of this subsection shall be effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to Section 12; provided, that if the Small Employer Health Reinsurance Program created pursuant to Section 11 is not yet operative on that date, the provisions of this paragraph shall be effective on the date that the program begins operation.

B. (1) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the commissioner disapproves its use.

(2) The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this Act.

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

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

(a) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;

(b) A condition 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

(c) A pregnancy existing on the effective date of coverage.

(2) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not less than thirty (30) days prior to the effective date of the new coverage. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(3) A health benefit plan may exclude coverage for late enrollees for the greater of eighteen (18) months or for an 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 from the date the individual enrolls for coverage under the health benefit plan.

(4) (a) Except as provided in Subparagraph (d), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(b) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(c) (i) Except as provided in Item (ii), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(ii) With respect to a small employer [with ten (10) or fewer eligible employees], a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

Drafting Note: In determining whether to include the bracketed language, states should consider the impact of dual choice on small employer carriers in relationship to both the number of health maintenance organizations in the state and the effect on small employers and their employees.

(d) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

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

(b) A small employer carrier shall not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

D. (1) A small employer carrier shall not 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 carrier's established geographic service area;

(b) To an employee, when the employee does not work or reside within the carrier's established geographic service area; or

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to Paragraph (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 to any 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 provide coverage to small employers pursuant to Subsection A for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of Subsection A would place the small employer carrier in a financially impaired condition.

Section 9. Notice of Intent to Operate as a Risk-Assuming Carrier or a Reinsuring Carrier

A. (1) Each small employer carrier shall notify the commissioner within thirty (30) days of the effective date of this Act of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 10.

(2) The decision shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The commissioner may permit a carrier to modify its decision at any time for good cause shown.

(3) The commissioner shall establish an application process for small employer carriers seeking to change their status under this subsection.

B. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a 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.

Drafting Note: Delete this section if participation in the reinsurance program is mandatory.

Section 10. Application to Become a Risk-Assuming Carrier

A. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

B. The commissioner shall consider the following factors in evaluating an application filed under Subsection A:

(1) The carrier's financial condition;

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

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

(4) The carrier's experience with managing the risk of small employer groups.

C. The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a

sixty-day period for public comment prior to making a decision on the application. If the application 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:

(1) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with Section 8 without the protection afforded by the program;

(2) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or

(3) The carrier has failed to provide coverage to eligible small employers as required in Section 8.

E. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of Section 11.

Drafting Note: States should consider establishing special rules for carriers whose charter and bylaws place limits on the types or kinds of individuals that can be insured by the carrier. Such carriers should be permitted to operate as risk-assuming carriers, provided that they accept all eligible small employers, regardless of health status or claims experience, that would be eligible for coverage pursuant to the charter and bylaws of the carrier.

Drafting Note: Delete this section if participation in the reinsurance program is mandatory.

Section 11. Small Employer Carrier Reinsurance Program

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

Drafting Note: Delete Subsection A if participation in the reinsurance program 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. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of Paragraph (2), the board shall consist of [eight] members appointed by the commissioner plus the commissioner or his or her designated representative, who shall serve as an ex officio member of the board.

(2) (a) In selecting the members of the board, the commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the commissioner. At least five (5) of the members of the board shall be representatives of reinsuring carriers and shall be selected from individuals nominated by small employer carriers in this state pursuant to procedures and guidelines developed by the commissioner.

(b) In the event that the program becomes eligible for additional financing pursuant to Subsection L(3), the board shall be expanded to include two (2) additional members who shall be appointed by the commissioner. In selecting the additional members of the board, the commissioner shall choose individuals who represent [include reference to representatives of sources for additional financing identified in Subsection L(3)(d)(ii)]. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing under Subsection L(3).

(3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.

(4) A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.

D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

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 if the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval 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 subsection 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 procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(3) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

(5) Provide for any additional matters necessary for the implementation and administration of the program.

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 to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

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

(4) Define the health benefit plans 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 for reinsuring risks under the program;

(6) Establish actuarial functions as appropriate for the operation of the program;

(7) Assess reinsuring carriers in accordance with the provisions of Subsection L, 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;

I. A reinsuring carrier may reinsure with the program as provided for in this subsection:

(1) With respect to a basic health benefit plan or a standard health benefit 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 benefit plan.

(2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.

(3) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.

(4) (a) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next $50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carriers' liability under this subparagraph shall not exceed a maximum limit of $10,000 in any one calendar year with respect to any reinsured individual.

(b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(5) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

[(6) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 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 those specified in Paragraph (4), shall be reduced to reflect that portion of the risk above the amount set forth in Paragraph (4) that may not be ceded to the program, if any.]

Drafting Note: Federal law prohibits federally-qualified health maintenance organizations from reinsuring the first $5,000 of covered benefits. States that adopt an initial retention level of less than $5,000 under Paragraph (4) should include the above language.

(7) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

J. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in Paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan (adjusted to reflect retention levels required under this Act).

(2) Premiums for the program shall be as follows:

(a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this paragraph.

(b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph.

(3) The board periodically shall review the methodology established under Paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

(4) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

K. If 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 meet the requirements relating to premium rates set forth in Section 6.

L. (1) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and 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 reinsuring carriers.

(a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(i) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(ii) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

(b) The formula established pursuant to Subparagraph (a) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150 percent of an amount which is based on the proportion of (i) the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (ii) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(c) The board may, with approval of the commissioner, change the assessment formula established pursuant to Subparagraph (a) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.

(d) 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 that are not imposed on other small employer carriers.

(e) Premiums earned by a reinsuring carrier that are less than an amount determined by the board to justify the cost of assessment collection shall not be considered for purposes of determining assessments.

(3) (a) Prior to March 1 of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in Subparagraph (c), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety (90) days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.

(c) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) (i) If assessments in each of two (2) consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Item (ii).

(ii) The additional funding provided for in Item (i) shall be obtained from [the state should specify one or more sources of additional revenue to fund the program. States may wish to consider the alternative revenue sources provided in the NAIC Model Health Plan for Uninsurable Individuals Model Act]. The amount of additional financing to be provided to the program shall be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five

percent (5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two (2) previous calendar years pursuant to this subparagraph, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose of the calculation in the previous sentence.

(iii) Additional financing received by the program pursuant to this subparagraph shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two (2) calendar years.

Drafting Note: The purpose of the five percent (5%) limitation is to prevent the program from placing too heavy of a burden on the small employer marketplace. States could also consider suspending the guarantee issue provision in Section 8 if assessments exceed the five percent (5%) threshold.

(4) If assessments exceed net losses 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.

(5) Each reinsuring 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 reinsuring carriers with the board.

(6) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(7) A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

M. Neither the participation in the program as reinsuring 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 reinsuring carriers either jointly or separately.

N. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

O. The program shall be exempt from any and all taxes.

Section 12. 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.

Drafting Note: A state may wish to add a representative of third-party administrators to the committee membership.

B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Section 8.

C. The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which 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:

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

(b) Case management;

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

(d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(e) Other managed care provisions.

(2) The committee shall submit the health benefit plans described in Paragraph (1) to the commissioner for approval within 180 days after the appointment of the committee.

Section 13. Periodic Market Evaluation

The board, in consultation with members of the committee, 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 coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group health insurance marketplace. The report 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. The report may contain recommendations for market conduct or other regulatory standards or action.

Section 14. Waiver of Certain State Laws

No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to a basic health benefit plan delivered or issued for delivery to small employers in this state 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 overly burdensome benefit mandates may want to consider their exclusion from other health benefit plans.

Section 15. Administrative Procedures

The commissioner shall 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 16. Standards to Assure Fair Marketing

A. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

B. (1) Except as provided in Paragraph (2), no small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of Paragraph (1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

C. (1) Except as provided in Paragraph (2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

D. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

E. No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation or geographic location of the small employers placed by the producer with the small employer carrier.

F. No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

G. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

H. The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

I. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under [insert appropriate reference to state law corresponding to Section 4 of the NAIC Unfair Trade Practices Act].

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Section 17. 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 18. Effective Date

The Act shall be effective on [insert date].

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

1992 Proc. I (adopted).

APPENDIX C

Connecticut Small Employer Health Reinsurance Pool
Plan of Operation
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CONNECTICUT SMALL EMPLOYER HEALTH REINSURANCE POOL

PLAN OF OPERATION

Article I - Name

The Pool shall be known as the Connecticut Small Employer Health Reinsurance Pool, hereinafter referred to as the Pool, a nonprofit entity created pursuant to Section 20 of the Act Concerning the Recommendations of the Blue Ribbon Commission on State Health Insurance (Public Act No. 90-134), hereinafter referred to as the Act.

Article II - Members of Pool

Each Insurer (as defined in Section 12(5) of the Act) issuing health insurance in this state, and each Insurance Arrangement (as defined in Section 12(6) of the Act) providing health plan benefits in this state on and after July 1, 1990 shall be members of the Pool.

Article III - Purpose

The purposes of the Pool are:

A. To support the goal of the Act, which is to assure the availability of appropriate health care coverage to Connecticut residents on an affordable basis.

B. To assist in creating the means to assure access to health care coverage for residents of Connecticut, on an equitable financing basis and with effective cost controls.

C. To facilitate the provision of lower cost health care coverage for uninsured small employers.

D. To provide a reinsurance mechanism to facilitate the provision of small employer coverage.

Article IV - Definitions

As used in this Plan:

A. **Base Premium Rate** means, as to any Health Insurance Plan or Insurance Arrangement covering one or more employees of a Small Employer, the lowest new business premium rate charged by the Insurer or Insurance Arrangement for the same or similar coverage, which is

equivalent in value, under a plan or arrangement covering any Small Employer with similar case characteristics, other than claim experience, as determined by such Insurer or Insurance Arrangement.

B. **Board** means the Board of Directors of the Pool.

C. **Commissioner** means the Insurance Commissioner of the State of Connecticut.

D. **Department** means the Insurance Department.

E. **Director(s) of the Board** (hereinafter also referred to as **Director)** means a representative of a Pool Member elected to the Pool Board of Directors.

F. **Eligible Dependent** means the spouse or child of an Eligible Employee, subject to applicable terms of the Health Insurance Plan covering such employee. A spouse or child of a person who is not an Eligible Employee cannot be an Eligible Dependent.

G. **Eligible Employee** means an employee who works on a full-time basis, with a normal work week of thirty or more hours. This includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or contractor is included as an employee under a health care plan of a small employer. This definition does not include an employee who works on a part-time, temporary or substitute basis.

H. **Extra Eligibles** means other persons in addition to Eligible Employees and their Eligible Dependents who are covered under a Health Insurance Plan.

I. **Health Care Center** means a Health Care Center as defined in Section 33-179a of the General Statute.

J. **Health Insurance Plan** means any hospital and medical expense incurred policy, hospital or medical service plan contract and Health Care Center subscriber contract. It does not include policies or contracts covering only accident, credit, dental, vision, disability or long term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which beneficiaries are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

K. **Health Reinsurance Association** means the entity established and maintained in accordance with the provisions of Chapter 692 of the General Statutes.

L. **Individual Special Health Care Plan** means a Health Insurance Plan for individuals, issued by the Health Reinsurance Association in accordance with Section 22 of the Act or issued by an Insurer in accordance with Section 13 of the Act.

M. **Insurance Arrangement** means any "multiple employer welfare arrangement," as defined in Section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, except for any such arrangement which is fully insured within the meaning of Section 514(b)(6) of said Act, as amended.

N. **Insurer** means any insurance company, hospital or medical service corporation, or Health Care Center authorized to transact health insurance business in this state.

O. **Late Enrollee** means an Eligible Employee or dependent who requests enrollment in a Small Employer's Health Insurance Plan following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such Small Employer, provided an Eligible Employee or dependent shall not be considered a Late Enrollee if

1. The request for enrollment is made within thirty days after termination of coverage provided under another group Health Insurance Plan and if the individual had not initially requested coverage under such plan solely because he was covered under another group Health Insurance Plan and coverage under that plan has ceased due to termination of employment, death of a spouse, or divorce, or

2. The individual is employed by an employer who offers multiple Health Insurance Plans and the individual elects a different Health Insurance 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 plan and request for enrollment is made within thirty days after issuance of such court order, or

4. If the request for enrollment is made within thirty days after

the marriage of such employee or the birth or adoption of the first child by such employee after the later of the commencement of the employer's plan or the date the Pool becomes operational, and satisfactory evidence of such marriage, birth, or adoption is provided to the Small Employer Carrier.

P. **Low-income Eligible Employee** means an Eligible Employee of a Small Employer whose annualized wages from such Small Employer, determined as of the effective date of the Special Health Care Plan or as of any anniversary of such effective date as certified to the Insurer or Insurance Arrangement or the Health Reinsurance Association by such Small Employer, is less than two hundred per cent of the federal poverty level applicable to such person.

Q. **Low-income Individual** means an individual whose annualized wages from all employers for the individual and spouse, determined as of the date of application for the individual Special Health Care Plan or as of any anniversary of the effective date of the plan, as certified by such individual, is less than two hundred per cent of the applicable federal poverty level.

R. **Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

S. **Medicare Reimbursement Rate** means the amount which would be payable under Medicare for benefits normally reimbursed under Medicare.

T. **Member** means each Insurer and Insurance Arrangement participating in the Pool.

U. **Plan of Operation** means the Plan of Operation of the Pool, including articles, bylaws and operating rules, adopted by the Board pursuant to Section 20 of the Act.

V. **Pool** means the Connecticut Small Employer Health Reinsurance Pool, established under Section 20 of the Act.

W. **Pre-existing Conditions** provision means a policy provision which excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage for 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 diagnosis, care or treatment, or for

which medical advice, diagnosis, care or treatment was recommended or received, or for a pregnancy existing on the effective date of coverage.

X. **Reimbursement Rate** means, as to individuals covered under Special Health Care Plans or an Individual Special Health Care Plan, seventy-five per cent of the Medicare Reimbursement Rate for benefits normally reimbursable under Medicare. For services or supplies not reimbursed by Medicare, such reimbursement shall be seventy-five percent of the amount which would be payable under Medicare, if Medicare was responsible for benefit payments, under such plans for such services and supplies, as determined by the Board and approved by the Commissioner.

Y. **Small Employer** means any person, firm, corporation, partnership or association actively engaged in business which, on at least fifty per cent of its working days during the preceding year, employed no more than twenty-five Eligible Employees, the majority of whom were employed within the State of Connecticut. In determining the number of Eligible Employees, companies which are affiliated companies, as defined in Section 33-374a of the General Statutes, or which are eligible to file a combined tax return for purposes of taxation under Chapter 208 of the General Statutes shall be considered one employer. Except as otherwise specifically provided, provisions of Sections 12, 13, 17 to 23, inclusive of the Act, Section 12-201 of the General Statutes, as amended by Section 14 of the Act, Section 12-211 of the General Statutes, as amended by Section 15 of the Act and Section 12-212a of the General Statutes, as amended by Section 16 of the Act, which apply to a Small Employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

Z. **Small Employer Carrier** (hereinafter referred to as **Carrier)** means any Insurer or Insurance Arrangement which offers group Health Insurance Plans covering Eligible Employees of one or more Small Employers.

AA. **Small Employer Health Care Plan** means a Health Insurance Plan for Small Employers, established by the Board in accordance with Section 19 of the Act.

BB. **Special Health Care Plan** means a Health Insurance Plan for previously uninsured Small Employers, established by the Board in accordance with Section 13 of the Act or by the Health Reinsurance Association in accordance with Section 21 of the Act.

Article V - Powers of Pool

The Pool shall have the general powers and authority granted under the laws of Connecticut to insurance companies licensed to transact health insurance, and in addition thereto, the specific authority to:

A. Enter into contracts as are necessary or proper to carry out the duties of the Pool, 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;

B. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against Members;

C. Take such legal actions necessary to avoid the payment of improper claims against the Pool;

D. Define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of the Act;

E. Establish rules, conditions and procedures pertaining to the reinsurance of Members' risks by the Pool;

F. Establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the Pool;

G. Assess Members in accordance with the provisions of the Act, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses;

H. Appoint from among Members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the Pool, policy and other contract design, and any other function within the authority of the Pool;

I. Borrow money to effect the purposes of the Pool.

Article VI - Plan of Operation

The Pool shall perform its functions under this Plan of Operation, hereinafter referred to as the Plan, and in accordance with the Act. The Plan shall assure the fair, reasonable and equitable administration of the Pool, and provide for the sharing of Pool gains or losses on an equitable proportionate basis in accordance with the

provisions of Section 20(f) of the Act. The Plan shall become effective upon approval in writing by the Commissioner, as provided in Section 20(a)(4) of the Act.

Article VII - Board of Directors and Annual Meeting of Members

A. The Pool shall exercise its powers through a Board of Directors:

1. The Board shall be made up of nine representatives of Pool Members (such representatives referred to hereinafter as Directors of the Board or Directors). To the extent possible, the composition of the Board shall be as follows:

   a. at least one-third of the Directors of the Board shall represent domestic insurance companies;

   b. at least two-thirds of the Directors of the Board shall represent Small Employer carriers;

   c. at least one Director of the Board shall represent a Health Care Center; and

   d. at least one Director of the Board shall represent a Small Employer Carrier with less than one hundred million dollars in net Small Employer health insurance premium in this state, and the net premium amount shall be adjusted by the Board periodically for health care cost inflation.

   There shall be no more than two Directors of the Board representing any one Insurer or Insurance Arrangement. The Commissioner shall be an ex-officio non-voting member of the Board. There shall be a designated alternate, approved by the Commissioner, to represent each Director of the Board in the event of the Director's unavailability. In approving the selection of Directors of the Board, the Commissioner shall assure that all Members of the Pool are fairly represented.

2. Directors of the Board shall serve for a term of two years expiring on the date of the second subsequent annual meeting following their election. However, in order to provide for staggered terms, five Directors on the initial Board shall be elected for a three-year term expiring on the date of the third subsequent annual meeting following their election. Directors shall be eligible for reelection. No two Directors representing the same Member shall be subject to re-election at the same time.

3. Upon election of the Board, the Board shall notify the Commissioner and request written approval of the Board as elected.

4. Members elected to the Board shall elect a Chairman and a Secretary from among its members and such other officers as it deems appropriate, for such terms as it deems appropriate.

5. The Chairman shall appoint, from among the Directors of the Board, a Nominating Committee composed of four Directors. Such committee shall select nominees to succeed Directors whose terms expire at the annual meeting. Such nominees shall be representative of the Pool Members and shall be made known to the Pool Members at least ninety (90) days prior to the annual meeting. Pool Members may submit additional nominees for consideration at the annual meeting provided such nominees are submitted to the Board at least thirty (30) days prior to the annual meeting.

6. All nominees are to be voted on by Pool Members in person or by proxy at the annual meeting of Members. The vote of each Pool Member shall be weighted in accordance with the net health insurance premium derived in the state in the previous calendar year.

7. The previously elected Directors shall serve until their successors have been duly elected and approved by the Commissioner.

8. Vacancies occurring on the Board between annual meetings shall be filled for the remaining period of the term by the Board with the approval of the Commissioner. Insofar as practicable, each such vacancy shall be filled with a representative of the same Pool Member represented by the previous Director of the Board.

9. Directors of the Board shall serve at the pleasure of the Pool Members they represent. A Pool Member may, upon written notice to the Commissioner, replace a Director of the Board representing said Pool Member with a different representative acceptable to the Commissioner.

B. The votes of the Board shall be on a one person, one vote basis.

C. A majority of the Directors of the Board shall constitute a quorum for the transaction of business. The acts of the majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board,

except as provided in Section J below.

D. An annual meeting of Members and the Board shall be held at the offices of the Administering Carrier on the first Tuesday in June 1991, and on the first Tuesday in June in each subsequent year, unless the Board, upon at least a thirty (30) calendar day notice, designates some other date or place.

E. At each annual meeting the Board shall:

1. Review this Plan and submit proposed amendments, if any, to the Commissioner for approval.

2. Review reports of the Administering Carrier, including audited financial reports, reports on outstanding contracts and obligations, and all other material matters.

3. Review reports of the committees established by the Board.

4. Determine whether any technical corrections or amendments to the Act shall be recommended to the Commissioner.

5. Review and give consideration to the performance of the Pool in support of the goals of the Act.

6. Review the rates for reinsurance coverages, benefit plan design, reimbursement schedules under the Special Health Care Plans, and communication programs.

7. Review the net premiums, the Pool administration expenses and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

8. Determine if an assessment is necessary for the proper administration of the Pool.

9. Review, consider and act on any matters deemed by the Board to be necessary and proper for the administration of the Pool.

F. The Board shall hold other meetings upon the request of two or more Directors, at such times and with such frequency as it deems appropriate. These meetings may be held either in person, telephonically, or by a written vote circulated to the Directors, upon which the Directors will indicate in writing their rejection or approval of the measure at issue. Notice of such a meeting and its purpose shall be

provided to the Directors at least seven (7) working days prior to the meeting, unless such notice shall be waived by unanimous consent of all Directors. At meetings other than the annual meeting, the Board may perform any of the functions listed in Section E above.

G. The Board may establish administrative rules of practice of the Pool consistent with the Act and this Plan.

H. A written record of the proceedings of each Board meeting shall be made. The original of the record shall be retained by the Secretary of the Board.

I. Directors of the Board may be reimbursed from the monies of the Pool for expenses incurred by them as members upon approval of such expenses by the Board, but shall not otherwise be compensated by the Pool for their services.

J. Amendments to the Plan or suggestions of technical corrections to the Act shall require the concurrence of a majority of the entire Board.

Article VIII - Committees

Each Director of the Board shall be entitled to participate personally or to appoint a Member to any committee set forth in the Plan or otherwise established by the Board. A written record of the proceedings of each committee shall be maintained by a Secretary appointed from the membership of the committee.

A. Actuarial Committee

The mission of the Actuarial Committee is to:

1. Recommend to the Board appropriate reinsurance premium rates, rate schedules, rate adjustments, and rate classifications for individuals and groups reinsured with the Pool.

2. Recommend to the Board reports to be made by Members and the Administering Carrier.

3. Provide reports and other recommendations as directed by the Board.

4. Determine the incurred claim losses of the Pool including amounts for incurred but not reported claims.

B. Reimbursement Committee

The mission of the Reimbursement Committee is to establish the level of allowable charges under the Special Health Care Plans. Allowable charges for these plans are to be set at a level that is consistent with Medicare.

C. Operations Committee

The mission of the Operations Committee is to:

1. Periodically review the Plan and make recommendations to the Board.

2. Provide administrative interpretation as to the intent of the Plan and to provide administrative direction on issues referred to it by the Board of Directors or the Administering Carrier and Pool Members. This committee shall provide administrative assistance in communicating the spirit and purpose of the Act.

3. Identify items for which operating rules are needed and to propose them for adoption by the Board.

D. Legal Committee

The mission of the Legal Committee is to handle the following legal matters at the request of Board:

1. Interpret the provisions of the Act;

2. Review the Plan, amendments to the Plan, and the various benefit plans proposed by the Board for compliance with the Act;

3. Prepare proposed amendments to the Act for Board approval;

4. Coordinate with legal counsel for the Administering Carrier, as needed, on routine legal matters relating to the Pool operations, including proposed contracts and operational practices;

5. Prepare contracts and legal documents for the Pool as requested by the Board;

6. Be familiar with and provide assistance to the Board concerning all litigation and other disputes involving the Pool and its operations.

7. Maintain a written record of all questions received and responses provided, and shall provide copies of all such responses to the Board of Directors.

E. Benefits Committee

The mission of the Benefits Committee is to:

1. Recommend to the Board, on a timely basis, detailed plan designs of the two Special Health Care Plans described in Section 13 of the Act and an appropriate number of plan designs for the Small Employer Health Care Plans as defined in Section 19 of the Act.

F. Marketing and Communications Committee

The mission of the Marketing and Communications Committee is to develop marketing plans and communications plans for the Pool. The implementation of these plans will be the direct responsibility of the Pool Members or the Administering Carrier as directed by the Board.

G. Audit Committee

The mission of the Audit Committee shall include the following items, as well as any other appropriate tasks assigned to it by the Board:

1. Develop a uniform audit program to be utilized by independent auditors in their review of items related to reinsurance with the Pool and assessments for each Pool Member.

2. Establish standards of acceptability for the selection of independent auditors with regard to 1. above.

3. Assist the Board in the selection of an independent auditor for the annual audit of the Pool operations.

4. Assist the Board in the review of the reports prepared by the independent auditors in conjunction with 1. and 3. above and any other audit-related matters the Board deems necessary.

Article IX - Administering Carrier

The Administering Carrier is jointly responsible, along with the Board and the Pool Members, for the fair, equitable and reasonable administration of the Pool.

A. The Board shall select the Administering Carrier to act on its behalf.

B. The Administering Carrier shall perform the following functions as directed by the Board:

1. Establish procedures and install the systems needed to properly administer the operations of the Pool in accordance with the Act and this Plan.

2. Establish on behalf of the Pool one or more bank accounts for the transaction of Pool business. These bank accounts will be approved by the Board.

3. Accept, on behalf of the Pool, risks that are ceded by Pool Members.

4. Collect reinsurance premium for ceded risks and collect all other amounts due to the Pool on a timely basis.

5. Deposit all cash collected on behalf of the Pool in the established bank account(s) on a timely basis.

6. Perform reinsurance reimbursement for claims paid on ceded risks.

7. Issue checks or drafts on and/or approve charges against bank accounts of the Pool.

8. Keep all accounting, administrative and financial records of the Pool in accordance with this Plan.

9. Act as a communications resource for Insurers in reviewing their administrative operation under this Act and this Plan.

10. Calculate the assessment, in accordance with the methodology specified in this Plan, and collect appropriate amounts due.

11. Invest available cash in marketable securities as specified in this Plan and as approved by the Board.

12. Perform other necessary functions as directed by the Board.

13. Prepare an annual estimate of operating costs for the administration of Pool operations.

C. The Administering Carrier shall maintain all records as to premiums, reimbursements, and administrative expenses as to a calendar year or a

period of seven years following the end of such calendar year.

D. The Administering Carrier shall serve until the appointment by the Board of a successor Administering Carrier, until its resignation, or until it is otherwise removed by the Board. The Administering Carrier shall give the Board one hundred and eighty (180) days notice of the Administering Carrier's decision to resign, and the Board shall give the Administering Carrier forty-five (45) days notice of its decision to remove the Administering Carrier.

E. The Administering Carrier shall be reimbursed for its reasonable costs of administration.

F. The Administering Carrier must be either a third party administrator or an Insurer approved by the Commissioner.

G. The Administering Carrier will submit a written proposal for providing the administrative services which are required by this Plan and which have been approved by the Board.

H. The Administering Carrier will subcontract for services which cost in excess of $10,000 dollars only with the prior approval of the Board.

I. In performing hereunder the Administering Carrier shall retain the confidentiality of all information pertaining to insureds and Members in accordance with all applicable statutes, regulations and principles of common law pertaining to confidentiality and trade secrets including, without limitation, the Connecticut Insurance Information and Privacy Protection Act. Such information shall be used only for the purposes necessary for the operation of the reinsurance Pool, and shall be strictly segregated from other records, data or operations of the Administering Carrier. Unless specifically required, hereunder or under the Act, no information shall be retained or used by the Administering Carrier or disclosed to any third party which information identifies specific insureds or Pool Members.

Article X - Benefit Plans

The Board shall periodically review the level of benefits and scope of coverages of the Special Health Care Plans or the Small Employer Health Care Plans. The review should include such factors as inflation in health care costs, modifications needed to remain consistent with benefits typically offered in the small group marketplace, inability of existing plans to help meet the goals of the Act, or other reasons that the Board deems appropriate. The Board will file any revised benefit plan descriptions for

any of the aforementioned plans for the Commissioner's approval.

Article XI - Reimbursement to Providers for Special Health Care Plans

To simplify the determination and administration of the Reimbursement Rate provision of the Act, the following methodology will be used for Special Health Care Plans. The reimbursement to providers under Special Health Care Plans is 75% of the amount calculated in each of the following:

A. Medicare Part A Services

1. Providers covered under this methodology include:

    a. General Hospitals

    b. Psychiatric Hospitals

    c. Skilled Nursing Facilities

    d. Home Health Agencies

    e. Rehab Hospitals

    f. Substance Abuse Facilities

2. The Medicare Reimbursement Rate is determined based on the ratio of gross Medicare payments to gross Medicare charges. This ratio is to be multiplied times billed charges to determine the Medicare Reimbursement Rate. The sources of information to be used in determining the ratio are:

    a. General Hospitals - Use Commission on Hospitals & Health Care (CHHC) budget to develop a provider specific ratio.

    b. Psychiatric Hospitals - Use most recently "settled" Medicare cost report to develop a provider specific ratio.

    c. Other Providers - If CHHC budget is not available, use the most recently "settled" Medicare cost reports to determine a composite ratio to be applied to an entire class of provider.

3. For out-of-state claims, determine the statewide average ratio, by class of provider, for providers in the State of Connecticut. Apply this ratio to all bills from out-of-state providers.

B. Medicare Part B Services

1. Covered services and supplies under this methodology include:

   a. Non-Hospital Based Providers

   b. Hospital Based Providers

   c. Lab Tests

   d. Durable Medical Equipment and Supplies

2. Non-Hospital Based Physicians

   a. The Reimbursement Rate under the Special Health Care Plans for services covered under Medicare Part B will be contained in the Medicare Reimbursement Rate Schedule (MRRS).

   b. The MRRS will be developed by the Administering Carrier utilizing Prevailing Charge data as provided by the Medicare Part B intermediary carrier(s) for Medicare beneficiaries in the state of Connecticut. The schedule will be approved by the Board.

   c. The Medicare Reimbursement Rate will be set equal to the lower of the existing Prevailing Charge at the 50th percentile or the adjusted 75th percentile as shown on the Medicare Reimbursement Rate Schedule. For those procedures where an area specific Prevailing Charge rate is available, the Level C Prevailing Charge schedule will be used. For those procedures without sufficient exposure for Medicare to generate a Level C Prevailing Charge rate in a given area but a Level D (statewide) Prevailing Charge does exist for that procedure, the Level D charge will be used for that area.

   d. For procedures where no Medicare Prevailing rate on either a Level C or Level D basis is available, a Reimbursement Rate will be assigned based on the

overall ratio of existing Reimbursement Rates to a schedule of charges based on carriers' Connecticut experience, or some other schedule acceptable to the Commissioner.

e. For all out-of-state providers, the Level D (statewide) Prevailing charge basis will be used.

3. Hospital Based Providers

a. For Hospital Based Providers, the Medicare Reimbursement Rate will be set equal to the relationship of gross Medicare payments and gross Medicare charges, for a given Medicare area for each hospital department category used by Medicare.

b. For all out-of-state Hospital Based Providers, the rate will be based on the relationship for all hospitals in the state of Connecticut, by specific hospital department.

c. Fee Schedules

For the following classifications, Medicare fee schedules will be utilized to set the Medicare Reimbursement Rate:

1. Lab Services (statewide)

2. Durable Medical Equipment/Supplies (statewide)

3. Nuclear Medicine (Medicare area)

4. Radiology (Medicare area)

5. Portable Radiology Services (Medicare area)

C. Health Care Center Reimbursements

In light of the intent of the Act to ensure providers of health care services participate in implementation of the Act, that the price of the Plan is affordable to Small Employer groups and that Health Care Centers implement provisions of the Act consistent with its normal methods of operations, it is recognized that Health Care Centers be allowed flexibility in proposing methods to meet the economic goals envisioned in the Act.

Specific reference is made to the goal of reimbursing providers at 75% of the Medicare allowable charges for Special Health Care Plans.

Article XII - Reinsurance

Small Employer Carriers may reinsure with the Pool the coverage of an Eligible Employee of a Small Employer and/or the coverage of any Eligible Dependents.

A. Identifying Small Employer Carriers

1. All Insurers which offer Health Insurance Plans covering Eligible Employees of one or more Small Employers on or after July 1, 1990.

2. Insurance Arrangements providing health insurance benefits in this state on or after July 1, 1990 which have been approved by the Commissioner; and

3. The Health Reinsurance Association (Connecticut), which is also referred to as HRA.

B. Identifying Eligible Small Employers

1. Eligible employers are Small Employers, as described below:

   a. "Small Employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least 50% of its working days during the preceding year, employed no more than 25 Eligible Employees, the majority of whom were employed within the State of Connecticut.

   b. The preceding year is a period of twelve consecutive months ending no more than six months prior to the time at which the determination is made on the status of the firm as a Small Employer.

2. Whether a firm is a Small Employer is determined at the effective date of a Small Employer Carrier's coverage of the firm's Health Insurance Plan and redetermined at each subsequent plan anniversary. Plan anniversary for the purposes of this article can be the plan's renewal date provided that determinations based on said date are made not more than once every twelve months.

   a. This determination should be based on the most recent

Federal or State filing which reflects the number of full-time employees, accompanied by a Small Employer certification of this information; unless the Small Employer submits other verifiable information to the Carrier which modifies the previous filing.

b. Small Employer status remains applicable for the full plan year starting at the date at which the determination is made.

c. A firm with some employees covered under a Taft-Hartley Trust established pursuant to collective bargaining shall exclude employees covered under that Trust in counting the number of Eligible Employees to determine whether it is a Small Employer.

3. A Small Employer, as defined in Article IV, includes

a. Small Employers which control, are controlled by, or under common control with another Small employer and,

b. Small Employers who are eligible to file a combined tax return under Chapter 208, (Corporation Business Tax) of the Connecticut General Statutes.

c. Such a firm will be a Small Employer for purposes of this Plan only if the combined number of Eligible Employees of the parent and subsidiary (and any other affiliates in Connecticut or elsewhere) is 25 or less.

d. A recently-formed small firm which was not in business during the preceding year is eligible as a Small Employer as soon as it has filed at least two quarterly Federal or State filings, with Small Employer certification, or other verifiable information after going into business.

e. The determination of whether a firm is a Small Employer is unaffected by the Small Employer's decision to provide health benefits for its employees under a group policy issued directly to the Small Employer, or by becoming a participating Small Employer under a Multiple Employer Trust contract, or under a plan sponsored by a trade association, or by buying coverage under individual health policies for its employees, or by paying benefits directly to employees from its own funds.

f. A Carrier is responsible for ascertaining whether a specific firm is a Small Employer, for updating that determination each year, and for obtaining information from the Small Employer to document that determination. The Carrier is also responsible for certifying that determination to the Administering Carrier if any coverage under that firm's plan is to be reinsured. A subsequent determination that a Carrier has erroneously certified a firm to be a Small Employer nullifies any reinsurance of employees of that firm.

g. The Carrier is also responsible for any necessary editing of group policy provisions and/or other communications to the Small Employer to specify those provisions (e.g., minimum enrollment participation, guaranteed issue for new entrants without evidence, restrictions on non-renewal, Small Employer obligations to supply information to the Carrier, etc.) intended to be applicable only during plan years for which the group remains a Small Employer. The Carrier must specify any alternative provisions that will take effect (e.g., removal of restrictions on non-renewal, etc.) when and if that firm ceases to be a Small Employer.

C <u>Identifying Eligible Employees and Dependents/ Eligibility and Participation Requirements</u>

1. An Eligible Employee is a full-time employee who works a normal work week of 30 or more hours. A partner, sole proprietor or independent contractor who meets the full-time 30-hour requirement is an Eligible Employee if included under the firm's plan. A part-time, temporary or substitute employee cannot be an Eligible Employee.

   a. Some firms' plans will also cover some individuals ("Extra Eligibles") who are not Eligible Employees (e.g., part-timers working less than 30 hours per week, retirees or other former employees, etc.) or Eligible Dependents, but the coverage of those Extra Eligibles is not subject to this Plan of Operations.

   b. Employees covered under plans issued to or in accordance with a Taft-Hartley Trust established pursuant to collective bargaining which covers, in the aggregate, more than 25 employees, will not be

eligible for reinsurance.

2. "Spouse" may include a former spouse of an Eligible Employee, for whom a Carrier is contractually obligated to continue existing coverage, following divorce or legal separation under COBRA or other similar law or court decree, as an Eligible Dependent for the period of that contractual obligation.

3. "Child" includes a natural child, a legally adopted child, a child supported by the employee pursuant to a valid court order or a child for whom the employee is the legal guardian. It also includes a stepchild who lives with the employee. NOTE: No services or benefits will be extended to the grandchild of the Eligible Employee unless the grandchild meets the eligibility requirements of dependent and is enrolled as a dependent.

4. The All Eligible Rule: The right of Small Employers to purchase Health Insurance Plans and Insurance Arrangements without exclusion of individual employees or dependents due to actual or expected health conditions of such employees or dependents, for which reinsurance is available under the Act applies only to benefit plans provided by Small Employers under which coverage is available to all Eligible Employees and all of their Eligible Dependents (as defined by this plan), except as specifically authorized by the Board.

    a. An exception to the All-Eligible rule above is the case of a firm which is a party to a collective bargaining agreement under which certain classes of its hourly employees have coverage under a Taft-Hartley trust. (The employees covered under the Taft-Hartley trust will be excluded in determining whether the firm is a Small Employer.)

    b. A further exception to the All-Eligible rule above is the exclusion from eligibility in a Small Employer's plan of those classes of persons who might otherwise be Eligible Employees but for whom the Carrier determines that adequate documentation cannot be obtained to affirm that the individual's employment relationship continues to satisfy the full-time 30-hour work-week requirement.

5. If a Small Employer's plan covers Eligible Employees and their Eligible Dependents ("Statutory Eligibles") and also covers any other persons ("Extra Eligibles"), eligibility for insurance applies only to coverage under that plan for Statutory Eligibles. In such a situation, the Carrier's group policy provisions applicable to Extra Eligibles may differ from those applicable to Statutory Eligibles, and reinsurance is not available for coverage of Extra Eligibles.

6. For a Small Employer whose Eligible Employees are covered under a group policy which also covers some Extra Eligibles, the Carrier is responsible for ascertaining which covered persons are Eligible Employees and which are Extra Eligibles, for updating that determination each year and for certifying such information to the Administering Carrier if coverage under that firm's plan is to be reinsured.

7. Each Carrier also is required to maintain in its files, available for examination or audit, a description of its minimum enrollment participation requirements for Small Employer plans, including any variations in those requirements by size of group, and any provisions for applying or modifying them in situations where a Health Care Center option or other choice of plans is available and in situations where some Eligibles have coverage under another Small Employer's plan.

8. Carrier may either:

   a. require that all Eligible Employees and their Eligible Dependents must be insured for coverage under the plan, or

   b. set more liberal minimum participation requirements.

   In either event, the Carrier must apply its rules uniformly to all Small Employer groups.

9. Guaranteed issue applies and reinsurance is available only if a Small Employer group satisfies eligibility provisions and minimum participation requirements specified in the firm's benefit plan.

D. Late Enrollee Provisions

1. A Carrier has the right to decline coverage for a Late Enrollee as defined in Article IV.

2. For the purpose of determining Late Enrollee status, the initial enrollment period refers to the enrollee's earliest opportunity to enroll for coverage under any plan sponsored by this Small Employer (i.e., either this plan or any prior plan which it superseded).

3. The new Carrier of a transferred Small Employer plan may exclude a Late Enrollee from coverage under the plan only if that Late Enrollee was not covered under the prior Carrier plan at its termination.

4. If coverage is provided for a Late Enrollee, reinsurance will be available subject to the satisfaction of the pre-existing condition limitation specified for Special or Small Employer Health Care Plans.

E. Effective Date of Coverage

The Small Employer's benefit plan must specify the period of full-time employment which must be completed by newly hired Eligible Employees before coverage starts; provided that such period must be applied uniformly to all classes of Eligible Employees and determined on a basis without regard to the actual or expected health conditions of Eligible Employees or Eligible Dependents.

F. Reinsurance Ceding Rules and Premium Levels

1. Each Carrier proposing to cede reinsurance of the coverage provided under a Small Employer's plan for any group or individual is responsible for ascertaining and certifying:

   a. that the group is a Small Employer, and

   b. that the individual is an Eligible Employee or an Eligible Dependent, and

   c. that the reinsurance premium rate level payable to the Pool for that group or individual has been correctly determined in accordance with this Article.

   Each Carrier must also document the these determinations

in its reporting of reinsurance census data and reinsurance premiums to the Pool Administrator.

2. A Carrier may cede the whole group for reinsurance of coverage under a plan covering Eligible Employees of a Small Employer only at one of the following dates:

   a. the initial effective date of the Small Employer's plan.

   b. the effective date of transfer of the group from a prior Carrier.

   c. at the plan anniversary occurring on or after January 1, 1992, provided the group has been enrolled for at least three (3) years, and at every third plan anniversary thereafter.

   d. the effective date of a change in the group's coverage from a Special Health Care Plan to a Small Employer Health Care Plan, provided the group was reinsured while covered under the Special Health Care Plan.

   e. the plan anniversary coinciding with or following the attainment of Small Employer status, provided that such date coincides with or follows the third or later plan anniversary of the carrier's coverage of the group.

3. Availability of group reinsurance is subject to the following rules:

   a. The Small Employer's benefit plan can only be reinsured for the coverage provided under a Small Employer Health Care Plan or a Special Health Care Plan or up to a level of a Small Employer Health Care Plan.

   b. All new entrants to the groups will also be reinsured automatically at the effective dates of their coverage.

   c. Reinsurance is available on a prospective basis and may also be effective retro-actively to the effective date of the group's coverag

with the Carrier provided the Administering Carrier is notified within 60 days of the effective date of such coverage. Notification for the purpose of this provision means that the Administering Carrier has received all required information with respect to each individual whose coverage is reinsured.

d. If a Carrier has previously withdrawn reinsurance of coverage for any group, the same Carrier can again reinsure coverage of the same group at any third plan anniversary following the date when the initial reinsurance decision could have been made.

4. A Carrier may cede individual reinsurance of coverage for a specific person covered under a Small Employer's plan as an Eligible Employee or an Eligible Dependent only at one of the following dates:

a. the initial effective date of the Small Employer's plan.

b. the effective date of transfer of the group from a prior Carrier.

c. at the plan anniversary occurring on or after January 1, 1992, provided the group has been enrolled for at least three (3) years, and at every third plan anniversary thereafter.

d. the initial effective date of that person's coverage if other than the initial effective date of the employer's plan or the effective date of transfer of the group from a prior Carrier.

e. the date a person already covered as an Extra Eligible under the Small Employer's plan becomes an Eligible Employee or Eligible Dependent.

f. the effective date of a change in the group's coverage from a Special Health Care Plan to a Small Employer Health Care Plan, provided the individual was reinsured while covered under the Special Plan.

g. The plan anniversary coinciding with or following the attainment of Small Employer status, provided that such date coincides with or follows the third or later

plan anniversary of the carrier's coverage of the group.

5. Availability of individual reinsurance is subject to the following rules:

   a. The group must be a Small Employer at the effective date of reinsurance.

   b. If the Small Employer's plan includes any extra coverage beyond that provided under the Small Employer Health Care Plan, there is no reinsurance of that extra coverage.

   c. Each person whose coverage is reinsured must be an Eligible Employee or Eligible Dependent. (If the covered group includes any Extra Eligibles, none of their coverage can be reinsured.)

   d. The Carrier may reinsure coverage of an employee without reinsuring coverage of any specific dependent of that employee, or may reinsure coverage of a specific dependent without reinsuring coverage of the employee or his/her dependent.

   e. Reinsurance is available on a prospective basis and may also be effective retroactively to the effective date of the individual's coverage with the Carrier provided the Administering Carrier is notified within 60 days of the effective date of such coverage. Notification for the purpose of this provision means that the Administering Carrier has received all required information with respect to each individual whose coverage is reinsured.

   f. There is no automatic reinsurance of any newly-enrolled individual.

   g. If a Carrier has previously withdrawn reinsurance of coverage for any individual, the same Carrier can again reinsure the same individual at any third plan anniversary following the date when the initial reinsurance decision could have been made.

G. Level of Coverage

For Special Health Care Plans and Small Employer Health Care Plans, the Pool will reinsure the level of coverage provided to the employee subject to the deductible amount specified in Section L. 1. For other plans, the Pool will reinsure the level of coverage provided to the employee up to, but not exceeding, the level provided in a Small Employer Health Care Plan. Pre-existing Conditions are covered to the extent specified in the applicable Small Employer Health Care Plan or Special Health Care Plan.

H. Notification of Reinsurance

For reinsurance effective on the effective date of the group's, employee's or dependent's coverage, notice must be provided to the Pool within sixty days following the effective date or such other period as may be authorized by the Board. For reinsurance effective on a third or later plan anniversary, notice must be provided at least 30 days prior to the plan anniversary.

I. Period of Reinsurance

1. Reinsurance may continue as long as coverage for the Eligible Employee and Dependents remains in effect, but reinsurance will end on the first plan anniversary after a Small Employer ceases to be a Small Employer.

2. A Carrier may withdraw a group or individual from the Pool while the coverage continues to be in effect under the Small Employer's plan. Withdrawals will be effective on a plan anniversary. Written notice must be provided at least 30 days in advance of the withdrawal. Once withdrawn, reinsurance cannot be reinstated until any third plan anniversary after the initial reinsurance decision could have been made.

3. Reinsurance of an individual's coverage under a Small Employer's plan ceases at the termination of the individual's status as an Eligible Employee or Eligible Dependent (e.g., at retirement or other termination of active employment, divorce of a spouse, or a child's attainment of age 25, or termination of full-time student status after age 19, etc.), except to the extent that coverage continues as required by law. If the Carrier provides coverage for such persons beyond either of the dates

indicated above, for contractual or other reasons, reinsurance will be available for a maximum of 30 days beyond said date.

4. Reinsurance ceases for any coverage of an individual covered under a Small Employer's plan (including an individual whose coverage under that plan has continued as required by law) at termination of the Carrier's coverage of the group in which that individual was previously covered as an Eligible Employee or Eligible Dependent.

5. Reinsurance of all coverage of individuals covered under a Small Employer's plan ceases at any plan anniversary at which the firm is no longer classified as a Small Employer.

J. Determination of Reinsurance Premium

1. Tables of reinsurance premium rates for ceding Insurers, as determined by the Actuarial Committee, and approved by the Board, will be communicated to Member companies. Separate tables will be prescribed for Health Care Centers.

2. For any reinsured individual, the reinsurance premium is 500% of the rate established by the Pool for that classification or group with similar characteristics and coverage. The ceding company will determine the reinsurance premium for each individual reinsured.

3. For any insured group, the reinsurance premium is 150% of the rate established by the Pool for that classification or group with similar characteristics and coverage. The ceding company will determine the reinsurance premium for each group reinsured.

4. Premium Rate Tables for certain Health Care Centers will be adjusted to reflect the limitations on the amount of risk that may be ceded by Federally qualified health maintenance organizations.

K. Billing and Payment

1. Reinsurance bills will be handled on a "self- billed" basis. Monthly, the ceding company will provide the Administering Carrier with a listing of the individuals reinsured and the premium for each individual and such other information as

may be required by the Pool. The Administering Carrier will make any necessary corrections and send the corrected statement to the ceding company.

2. The reinsurance premiums charged by the Pool for each individual will be determined by the Table of Rates in effect on the later of the effective date of the Small Employer's plan with the Carrier or the most recent coincident plan anniversary.

3. Premiums are determined as of the first of the month and are due by the twentieth of the month.

4. Reinsurance premium amounts are to be paid based on whole month increments only. If a Carrier's reinsured coverage is effective between the 1st and the 15th of the month, the entire month is paid in full. When coverage becomes effective between the 16th and the last day of the month, no premiums will be payable until the first month following the effective date.

5. Conversely, terminations effective between the 1st and the 15th of the month will be allowed refunds for the entire month, and terminations effective between the 16th and the last day of the month will not be allowed a premium refund.

6. Reinsurance premium is due monthly to the Pool regardless of the ceding company's ability to charge back or collect the small employer's premiums. The Pool has no responsibility for the collection of Small Employer's premiums.

7. Reinsurance premiums may be paid to the Administering Carrier net of any reinsurance claims paid and adjustments. If the sum of the claims paid exceeds the reinsurance premium due, the Pool will pay the ceding company this excess provided that no payments will made unless the accumulated amount due as of the end of any month exceeds $50,000. Regardless of this limitation, all balances due will be paid by the Pool to ceding Carriers no less often than every six months.

L. Reinsurance Claim

1. Statement of Reinsurance

The Pool shall indemnify Carriers for the Covered Claims incurred with respect to employees and dependents whose coverage with the Carrier is reinsured with the Pool as described in section 20 (b) of the Act and subject to the following:

a. No reinsurance shall be provided until the dollar amount in benefit payments, as specified by the Board, have been made for services provided during a calendar year for a reinsured employee or dependent which payments would have been reimbursed through said reinsurance in the absence of said deductible. The deductible has been set at $5,000.00 for all plans except plans which supplement the basic hospital plan or the basic hospital plus surgical plans, in which case the deductible is $2,000.00. These deductible amounts shall be periodically reviewed by the Board and may be adjusted for appropriate factors as determined by the Board.

b. Coverage provided by Carriers under other plans reinsured with the Pool shall be reinsured up to the lesser of the benefits provided under the other plan or the Small Employer Health Care Plan for which reinsurance premiums have been paid.

c. Reinsurance provided to Health Care Centers shall reflect the portion of risk they are allowed by law to cede.

d. "Covered Claims" - For the purposes of this section, "Covered Claims" shall mean only such amounts as are actually paid by the Carriers for benefits provided for individuals reinsured by the Pool, but Covered Claims shall not include:

    1. Claim expenses or salaries paid to employees of the Carriers who are not providers of health care services;

    2. Court costs, attorney's fees or other legal expenses;

    3. Any amount paid by the Insurers for:

(i) Punitive or exemplary damages; or

(ii) Compensatory or other damages awarded to the Insured, arising out of the conduct of the Carriers in the investigation, trial, or settlement of any claim or failure to pay or delay in payment of any benefits under any policy; or the operation of any managed care, cost containment, or related programs;

4. any statutory penalty imposed upon a Carrier on account of any unfair trade practice or any unfair insurance practice.

2. General Requirements

a. The Carriers agree that they will promptly investigate settle or defend all claims arising under the risks reinsured and that they will forward promptly to the Pool copies of such reports of investigation as may be requested by the Pool.

b. Carriers will adjudicate all claims on ceded risks

c. The Carriers agree to use their normal large case management and psychiatric/alcoholism/substance abuse case management programs to control costs on reinsured basis to the same extent that they would use such programs on their direct business. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Board.

d. The Pool shall have the right, at its own expense, to participate jointly with a Carrier in the investigation, adjustment or defense of any claim. Carriers will be required to assure that their claim management practices are consistent for reinsured and non-reinsured risks. The failure to follow such procedures will result in the denial or reduction of

reinsurance claim payments, as determined by the Board.

e. The Pool shall have the right to inspect the records of the Carrier in connection with the risks reinsured with the Pool and the Carrier shall submit to the Pool any additional information it may require in connection with claims submitted to the Pool for reimbursement. Carriers shall secure necessary authorizations from insureds for this purpose.

f. All information disclosed to the Pool by the Carrier or to the Carrier by the Pool, in connection with this plan, shall be considered to be privileged information by both the Carrier and the Pool.

g. If any payment is made by the Pool under this Article and the Carrier is reimbursed by another party for the same expenses, the Pool shall be reimbursed to the extent that the Carrier is reimbursed. The Carrier shall execute and deliver instruments and do whatever is necessary to preserve and secure such reimbursement rights.

h. Health care centers or other carriers which pay for certain provider services on a basis other than fee for service will be allowed reimbursement for those costs on reinsured persons from the Pool through a methodology approved by the Board.

i. Except as approved by the Board, reinsurance will be provided only for covered claims submitted within two years from the date the expenses on which the claim is based were incurred.

3. Claims Reporting

a. Within 20 days after the close of each quarter/month as the carriers desire, the Carriers shall furnish to the Pool the following information with respect to reinsured losses submitted to the Pool by the Carrier during said month:

(i) the Small Employer's identification;
(ii) the employee's name and social security

number;
(iii) the claimant's name and date of birth;
(iv) the claim incurral date and paid date;
(v) the reinsurance claim amount;
(vi) the claim coding as required by the Board (e.g., CPT and ICD9).

b. Carriers shall notify the Pool as soon as reasonably possible of all claims or potential claims for a reinsured employee or dependent where the losses expected to be paid by the Carriers will exceed $100,000 in the aggregate.

Article XIII - Audit Functions

A. Each Member of the Pool shall hire a Certified Public Accountant (CPA) or other party approved by the Board to conduct audits of various items related to Pool reinsurance and assessments. To be acceptable, the auditor must be independent, in accordance with standards established by the Audit Committee. The audits must be made in accordance with generally accepted auditing standards as adopted by the membership of the American Institute of Certified Public Accountants.

B. The audits shall be conducted in accordance with a uniform audit program (herein after called "Program") for Pool Members, as developed by the Board. This Program shall clearly specify all items to be audited. It shall include a certification statement form, to be completed by the auditor, to verify the completion of all prescribed audit procedures as dictated by the Program. Also, details regarding the number and types of records reviewed and any errors found shall be submitted in a report which accompanies the certification statement. A copy of this report and the certification statement shall be submitted to the Board by the auditor.

C. The Program shall include, but not be limited to, detail testing of representative samples of the following items:

1. Reinsurance claims submitted to the Pool, in particular:

a. Eligibility of claimants and their Small Employers for reinsurance by the Pool;

b. Proper determination of reinsurance claim amount by the Carrier;

2. Reinsurance premiums submitted to the Pool, including:

a. Eligibility of those lives for whom premium is paid for reinsurance by the Pool;

b. Proper determination of reinsurance premium amounts paid, and administrative expense allowances (as specified in Article XII - Reinsurance);

3. Data submitted to the Pool for use in the calculation of Member assessments for net losses.

4. The frequency of these audits shall be determined by the Audit Committee. The cost of the audit of a Member shall be borne by that Member.

D. Random audits of provider bills or other records shall be conducted as deemed necessary by the Audit Committee to verify the accuracy and appropriateness of reinsurance claim submissions.

E. The Board shall have the right to conduct such additional audits of Members as it deems appropriate.

F. All information disclosed in the course of the audit of a Member company shall be considered privileged information by the Member company, the auditing firm and the Pool.

G. The Pool shall have an annual audit of its operations conducted by an independent Certified Public Accountant, as approved by the Board. The Board shall file this annual audit with the Commissioner for his review.

This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for the Pool;

2. The annual fiscal report of the Pool;

3. The calculation of the premium rates charged for reinsurance by the Pool;

4. The calculation and the collection of any assessments of Members for net losses;

5. The reinsurance premiums due to the Pool and the claim reimbursements made to the Members.

Article XIV - Assessments

A. Initial Assessment

An initial assessment of $20,000 each shall be made on the 15 largest Members as measured by shares of total health premium earned on Connecticut Health Insurance Plans in 1989. The initial assessments shall be allowed as offsets to future assessments.

B. Net Fund Earnings

Each year, the Pool's net earnings shall be determined. Net earnings are earned reinsurance premiums plus investment income plus prior assessments in excess of need less administrative and investment expenses, incurred claims, expense allowances paid, and taxes incurred. If the net earnings are negative (i.e., the Pool has operated at a loss), the loss shall be recovered by assessments from the Pool Members as set forth in (C) and (D) below. If the net earnings are positive, no assessment shall be made and the earnings shall be retained by the Pool to offset future assessments.

C. Assessments on Small Employer Carriers

Losses up to and including an amount equal to 5% of total health insurance premium earned in Connecticut from Health Insurance Plans and Insurance Arrangements covering Small Employers during the calendar year coinciding with or ending during the fiscal year of the Pool shall be allocated to Carriers based on their proportionate share of that total earned premium. In no event may this Small Employer allocation percent exceed 5%. For the purposes of this Paragraph C, the amount of health insurance premiums shall be based upon the total health insurance premiums of a Carrier earned on new business effective during such year and existing business identified as Small Employer health insurance business reaching an anniversary date during such year. These premium amounts shall exclude premiums earned on Extra Eligibles.

D. Residual Assessments

If the loss for any calendar year exceeds 5% of the earned premiums utilized in C. of this Article for all Members combined, then the excess of such loss above this 5% shall be allocated to all Members of the Pool in proportion to their respective shares of the total health insurance premiums earned in this state from other individual and group plans and arrangements, exclusive of any individual Medicare Supplement policies

as defined in section 38-174m of the general statutes.

E. Special Limits

If the assessments of (C) or (D) for any Member exceed forty percent of the total assessment for all Members for each such paragraph for 1991 or fifty percent for 1992, then the amounts in excess shall be apportioned among the remaining Members of the Pool in accordance with paragraphs (C) and (D).

F. Disproportionate Share

For the purpose of section 20(f) (6) (B) of the Act, a Health Care Center shall be deemed to have written and reinsured in their entirety a disproportionate number of Special Health Care Plans if that number as a percent of all its Special Health Care Plans exceeds 1.5 times the proportion of Special Health Care Plans reinsured in their entirety by all Members combined. The portion of the assessment of such a Health Care Center related to such Special Health Care Plans shall be deferred for three years and the amount assessed to other Members in accordance with (C) or (D) above. The Board may approve a larger deferral if appropriate, upon application by the Health Care Center. A plan receiving such a deferral shall remain liable to the Pool for the amount deferred, and interest shall accrue at the prime rate plus 1%.

G. Health Care Center Assessment Deferral

On application to the Board, assessments to a Health Care Center may be deferred whenever the Health Care Center's statutory net worth is at or below the minimum required by the Insurance Department. The deferral will continue for the period approved by the Board or until the Health Care Center's net worth exceeds statutory requirements.

When the deferral period is over, a Health Care Center must pay the accumulated assessments over a three year period. No interest will be charged on deferral for financial impairment.

At the discretion of the Commissioner, a Health Care Center may be deemed eligible for a financial impairment deferral if for any reason the Health Care Center is unable to meet its financial obligations.

H. De Minimis Assessments

Any assessment of less than $100.00 shall not be billed to a Member, but will be accumulated as a deferred assessment until the cumulative

amount deferred exceeds $100.00. Any assessment of less than $10 shall be forgiven.

I. Late Payments

Assessments shall be paid when billed. If the assessment is not received by the Administering Carrier within 30 days of the billing date, the Member shall pay interest on the assessment from the billing date at the annual rate of prime plus 3%. The Board may suspend reinsurance rights if payments are not made in accordance with this article.

J. Special Rules for Health Care Centers

An appropriate adjustment will be made to that portion of a Federally qualified Health Care Center's earned premiums obtained from Federally qualified plans sold to Small Employers in recognition of the Federal Health Maintenance Organization Act requirements:

1. No pre-existing condition exclusion;

2. Required Health Care Center benefits in excess of the typical health care benefits offered to Small Employers;

The adjustment formula will be approved by the Board for the 1991 assessments and will be annually reevaluated.

Those portions of earned premiums which are not included in the Small Employer premiums due to the above will be part of the Health Care Center's total earned premium for the purpose of the residual assessments.

K. Definition of Earned Premium

Earned premium shall be the premium or subscriber payments for Health Insurance Plans earned during the accounting period. It does not include:

1. Accident only

2. Credit, dental, disability or vision insurance as separate policies or riders

3. Coverage issued as a supplement to liability insurance

4. Worker's compensation

5. Individual Medicare Supplement

6. Automobile medical-payment insurance

7. Insurance statutorily required in liability insurance policies

Insurance arrangements shall report claim payments made and administrative expenses incurred during the accounting period in lieu of earned premiums.

Article XV - Reports of Members and Administering Carrier

A. Information Required by Pool

1. Unless otherwise specified by the Board, the following information shall be required by the Pool for reinsured risks:

   a. Identification of the Carrier

   b. Name, date of birth, sex and the Carrier identification number of the person being reinsured;

   c. Identification of the reinsured as an employee, spouse or child;

   d. Employee name (if different) and social security number;

   e. Plan anniversary date;

   f. Employer's name, address, zip code and SIC code;

   g. Reinsurance plan indicator;

   h. Effective date of Small Employer coverage;

   i. Effective date of reinsurance;

   j. Date of applicable employee's employment;

   k. Status code as required by the Board;

   l. Other information required by the Board.

2. Changes in Reinsurance Coverage require the following information:

    a. The reinsured's name and identification number;

    b. The employee's name (if different) and social security number;

    c. Effective date of status change;

    d. Status code for change as required by the Board;

    e. Other information required by the Board.

Article XVI - Financial Administration

A. Books and Records

The administrator shall maintain the books and records of the Pool so that financial statements can be prepared to satisfy Section 20 (a)(5) of the Act. Further, these books shall satisfy any additional requirements as may be deemed necessary to meet the needs of the Board and the outside auditors.

1. The receipt and disbursement of cash by the Pool shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when the asset or the liability should be realized by the Pool in accordance with generally accepted accounting principles.

3. Assets and liabilities of the Pool, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to/from the Pool shall be calculated for each Pool Member and confirmed with Pool Members as deemed appropriate by the Board or when requested by the respective Pool Member. These balances should be supported by a record of each individual Pool Member's financial transactions with the Pool. These records include:

    a. Initial assessment, if applicable to the particular Pool Member.

    b. located net earnings/losses of the Pool based upon

the assessments methodology contained in this Plan.

c. Any adjustments to assessments as explained in this Plan.

d. The amount of reinsurance premium due to the Pool for risks ceded and accepted by the Pool.

e. The amount of reimbursement due from the Pool for claims paid by the Pool Member for risks previously ceded and accepted by the Pool.

f. Adjustment to the amount due to/from the Pool based upon corrections to the Pool Member submissions.

g. Interest charges due from the Pool Member for late payment of amounts due to the Pool.

h. Such other records as may be required by the Board.

5. The Pool shall maintain a general ledger whose balances are used to produce the Pool's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

B. Handling and Accounting of Assets and Money

Money and marketable securities shall be kept in bank accounts and investment accounts as approved by the Board. The Administering Carrier shall deposit receipts and make disbursements from these accounts.

C. Bank Accounts

All bank accounts/checking accounts shall be established in the name of the Connecticut Small Employer Health Reinsurance Pool, and shall be approved by the Board of Directors. Authorized check signers shall be approved by the Board.

D. Lines of Credit

All lines of credit shall be established in the name of the Connecticut Small Employer Health Reinsurance Pool, and shall be approved by the Board of Directors. Lines of credit shall be used to meet cash shortfalls.

E. Investment Policy

All cash shall be invested in available investment vehicles deemed appropriate by the Board.

Article XVII - Marketing and Communications

A. The Board, in consultation with the Commissioner, shall develop an overall marketing and communications plan consistent with the purposes of the Act, including:

1. Information for use by Members in communicating to Small Employers.

2. Information for use by agents, brokers and others involved in marketing and selling Health Insurance Plans and Insurance Arrangements to Small Employers.

3. Information for communication with trade associations and other representatives of Small Employer health care providers.

4. Public service and other programs utilizing the mass media to the extent possible.

5. Other programs developed by the Board.

B. In order to help assure that information concerning the Act is made available to Small Employers, the Board may, from time to time, require reports from Members concerning their marketing, communication, sales and other activities related to the Act.

Article XVIII - Penalties/Adjustments and Dispute Resolution

A. Penalties/Adjustments

1. Given numerous factual determinations and tasks to be performed by Members relative to their participation in the Pool, it is expected that all Members will exercise the highest degree of good faith and due diligence in all

aspects of their relationship with the Pool. Errors will occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

2. Errors related to reinsurance:

   a. Ineligible Small Employers/employees/dependents (initial placement of ineligible persons or failure to remove persons becoming ineligible). Reinsurance coverage for the individuals involved shall be terminated as of the first date of ineligibility. Claims paid by the Pool in excess of premiums received are to be returned to the Pool with interest. Premiums paid in excess of claims will be refunded without interest. An administrative charge established by the Board will be assessed in such situations.

   b. Reinsuring employees/dependents at the incorrect premium rate (failure to use correct Pool rates and/or to apply correct rates to persons reinsured). Reinsurance premiums for the persons involved should be recalculated and immediate payment of additional premiums must be made, plus interest and an administrative charge. Excess payments will be refunded without interest, subject to the limitation on premium refund provision.

   c. Reinsuring incorrect plan. Premiums will be recalculated on the basis of the correct plan and all additional premiums due will be paid immediately, with interest and the administrative charge. Excess premiums will be refunded without interest and subject to the limitation on premium refunds provision.

   d. Incorrect claim payments/submissions. The claim will be recalculated and any amount due to the Pool will be repaid immediately, with interest. Adjustments of claim payments for amounts recovered by the Member under coordination of benefit, subrogation or similar provisions shall not be considered errors for which interest or any administrative charge shall be due.

3. Errors related to assessments: All Member errors related to the assessment shall require the immediate payment of additional amounts due plus interest calculated from the date such sum should have been paid, plus an administrative charge as established by the Board.

4. Errors not listed: All additional sums due to the Pool as a result of errors made by Members other than those listed above shall be paid immediately, with interest, on the applicable administrative charge.

5. Gross negligence and intentional misconduct: If the Board determines that the nature or extent of the errors related to the use of the reinsurance mechanism or otherwise by a particular Member evidences gross negligence or intentional misconduct, the Board may, after notice and a hearing, terminate some or all current reinsurance for the Member and/or suspend the right of the Member to use the reinsurance mechanism for an appropriate period of time. All such actions shall require the concurrence of the Insurance Commissioner before becoming effective. The Board will ensure, to the extent possible, that the suspension or termination of reinsurance for the Member shall not adversely affect individuals already insured by the Member.

6. Interest and Administrative Charges: All interest payments required under this Article shall be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment. The rate of interest and the administrative charge shall be established by the Board and may be waived by the Board. Errors reported by Members within 90 days of their occurrence shall not be subject to interest or any administrative charges.

7. Limitation on Premium Refunds: All premium refunds due under this Article shall be limited to a period of 12 months from the date the error was corrected unless otherwise agreed to by the Board.

B. Member Appeal of Disputes to Board

The Administrating Carrier will act on behalf of the Board in the attempt to resolve disputes between a Member and the Pool;

however, Members may request permission to appear before the Board at any time in connection with any dispute with the Pool.

Article XIX - Indemnification

A. Neither participation in the Pool as Members, the establishment of rates, forms or procedures nor any other joint or collective action required by Section 20 of the Act shall be the basis of any legal action, criminal or civil liability or penalty against the Pool or any of its Members.

B. Persons or Members made a party to any action, suit, or proceeding because the person or Member serves on the Board or on a committee or was an officer or employee of the Pool shall be held harmless and be indemnified by the Pool against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. This indemnification shall not be provided on any matter in which the person or Member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all Members.

Article XX - Amendment

Amendments to this Plan may be suggested by any Pool Member and may be made by the Board at any time. Amendments to this Plan shall be subject to the approval of the Commissioner. Amendments submitted to the Commissioner shall be deemed approved if not acted upon within 60 days.

Article XXI - Termination

The Pool shall continue in existence subject to termination in accordance with the requirements of a law or laws of the State of Connecticut or the United States of America. In case of enactment of a law or laws which in the determination of the Board and the Commissioner shall result in the termination of the Pool, the Pool shall terminate and conclude its affairs in a manner to be determined by the Board with the approval of the Commissioner. Any funds or assets of any nature held by the Pool following termination and the payment of all claims and expenses of the Pool shall be distributed to the Pool Members existing at that time in accordance with the then-existing assessment formula.