



## **NAIC's Model State Laws: Fact Sheets to Help Protect and Improve State Regulation**

The National Association of Insurance Commissioners (NAIC) is composed of the state government officials charged with regulating insurance companies in each state or territory. The NAIC has been developing Model State Laws for over 100 years to encourage uniformity in the regulation of insurance products.

To ensure that state regulators have the necessary state authority to monitor and enforce health insurers' compliance with the Patient Protection and Affordable Care Act (ACA), the NAIC has developed a set of Model State Laws to implement the ACA's consumer protections that became effective on Sept. 23, 2010. These Model Laws are intended to provide states with a minimum level of protection required by the federal law. States can decide to adopt more stringent requirements.

These fact sheets are intended to aid consumer advocates and legislators in understanding the purpose of the NAIC's Model State Laws, identifying opportunities to improve the laws from a consumer perspective, and highlighting potential efforts to weaken the state's law.

### **Model Laws**

- [Dependent Coverage for Individuals to Age of 26](#)
- [Elimination of Pre-existing Condition Exclusions for Children](#)
- [Grievances and Appeals](#)
- [Lifetime Annual Benefit Limits](#)
- [Prohibition on Rescissions of Coverage](#)

### **Additional Resources**

National Association of Insurance Commissioners <http://www.naic.org/>

U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, Regulations and Guidance, <http://www.hhs.gov/oclio/regulations/index.html>

U.S. Department of Labor, Employee Benefits Security Administration,  
<http://www.dol.gov/ebsa/healthreform/>

## Dependent Coverage for Individuals to Age of 26

In the case of the new requirement that health plans cover the adult children of policyholders up to age 26, the NAIC has drafted “Model Language for Dependent Coverage for Individuals to Age of 26.” This Model Language sets out the minimum requirements a state must have in place in order to comply with the ACA.

### What does the NAIC’s Model Language do?

In drafting the Model Language, the NAIC followed the provisions of the ACA and the interim final rule published by the US Departments of Health and Human Services, Labor, and Treasury. Consistent with federal law, the Model Language:

- Requires health plans that offer family policies to include children up to age 26, regardless of student status, whether they are married, or whether they live with or are legally dependent on their parents
- Requires health plans to offer adult children the same benefit package and premium rate as other “similarly situated” individuals (e.g., health plans must provide the same benefit package to a 23 year-old dependent as they provide to a 16 year-old dependent)
- Clarifies that health plans do not have to extend coverage to the children of adult children, unless their grandparent has legally adopted them
- Requires health plans to provide policyholders with written notices about the opportunity for adult children to enroll in coverage
- Requires health plans to provide adult children who had lost eligibility for their parents’ policy with a 30-day window to re-enroll
- Clarifies that grandfathered group health plans<sup>1</sup> do not have to provide coverage to an adult child if the adult child is eligible for employer-sponsored coverage on their own (note: this eligibility restriction lasts only until January 1, 2014)

Note that the NAIC’s Model Language does *not* provide a definition of “dependent” or “child.” This is left either to state regulation or to health plans to decide.

### Three Things That Could Improve the NAIC’s Model Language

The ACA, and the NAIC’s Model Language set out the *minimum* standard of consumer protections; any state can enact laws that are more protective. For example, states could improve on this Model Language in the following ways:

1. **Increase the age limit.** Nothing prevents a state from extending the dependent coverage requirement beyond age 26. For example, New York allows adult dependents up to age 29 to stay on their parent’s policy, as long as they are unmarried and not eligible for other insurance.
2. **Expand eligibility to working young adults.** The ACA, and the NAIC model language, allow grandfathered group health plans to deny coverage to young adults up to January 1, 2014, if they are eligible for employer-sponsored coverage. But many young people just starting their careers may have access only to very limited job-based coverage, such as a

“mini-med”<sup>2</sup> or high deductible plan. Having access to inadequate coverage shouldn’t disqualify these young adults from joining their parent’s plan if it is a better deal for them. States can improve upon the ACA by lifting this exemption for grandfathered group plans.

3. **Expand definition of “dependent.”** The NAIC Model Language (as well as the ACA and interim final rule) does not provide a definition of “dependent” or “child.” While some states may already have broad definitions for these terms that include not only biological children, but also stepchildren, adopted children, and foster children, others may not. Without a clear definition, the health plan would determine who is an eligible dependent, which means they could deny coverage to some of our most vulnerable citizens. States should be encouraged to provide an expansive definition of dependent that would clearly include stepchildren, adopted children, foster children, children being raised by legal guardians or other relatives, and children of a domestic partner that is eligible for and covered by the plan.

### **Things Consumer Advocates Should Watch Out For**

Some states have existing laws that are more protective of consumers than the ACA. For example, they might allow children up to 29 or 30 to stay on their parent’s plan. Some industry stakeholders may seek to weaken these stronger state protections by arguing that the ACA’s protections are adequate and should set a “ceiling” for any regulation. Consumer advocates should be prepared to defend against attempts to lower the state standard to the ACA’s minimum standard.

## Elimination of Pre-existing Condition Exclusions for Children

In the case of the new requirement that health plans cover children under age 19, no matter what their health status, the NAIC has drafted “Model Language for Prohibition on Preexisting Condition Exclusions for Individuals Under the Age of 19.” This Model Language sets out the minimum requirements a state must have in place in order to comply with the ACA.

### What does the NAIC’s Model Language do?

In drafting the Model Language, the NAIC followed the provisions of the ACA and the interim final rule published by the US Departments of Health and Human Services, Labor, and Treasury. Consistent with federal law, the Model Language:

- Clearly defines a “pre-existing condition exclusion” to include both a limitation or exclusion on benefits *and* any denial of coverage based on the child’s health status.
- Includes grandfathered group insurance plans, but not grandfathered individual policies.<sup>3</sup>
- Allows states to establish open enrollment periods for individual insurance coverage for children in order to discourage adverse selection.<sup>4</sup>
- Prohibits health insurers from denying or delaying issuance of a policy during open enrollment periods.
- Requires prominent public notice and written notice to policyholders of upcoming open enrollment periods.

### Three Things That Could Improve the NAIC’s Model Language

The ACA, and the NAIC’s Model Language set out the *minimum* standard of consumer protections; any state can enact laws that are more protective. For example, states could improve on this Model Language in the following ways:

1. **Require insurers, as a condition of participation in the individual insurance market, to accept applications from children under 19.** In a number of states, insurers have discontinued selling “child-only” insurance policies because they do not want to cover children with pre-existing conditions. To ensure that policies are available to all children, states can require these insurers to sell child-only policies if they want to sell any individual market policies. States that have already done this include California, Kentucky, New Hampshire and Washington.
2. **Limit insurers’ ability to charge higher premiums to children with pre-existing conditions.** The ACA, and the NAIC’s Model Language, expressly prohibit insurers from denying coverage or benefits to children with pre-existing conditions. But the law does not limit what an insurer can charge based on the child’s health status. In some states, this could be as much as nine times what the family of a healthy child would pay. To help make policies more affordable for families with sick children, a state can limit the amount a plan can surcharge families. For example, California limits the difference in premium to no more than two times the standard premium for a child, if the child signs up during an open enrollment period.

3. **Require insurers to provide a long initial open enrollment period**, and then a minimum of two 60-day open enrollment periods in subsequent years. In addition, the state could require the Insurance Department and insurance companies to conduct extensive public education about the families' new coverage options and the timing and duration of any open enrollment periods.

### **Three Things That Could Weaken the NAIC's Model Language**

Some industry stakeholders may engage in efforts to weaken the NAIC's Model Language and make the state laws less protective of consumers. Consumer advocates and state policymakers may need to respond to:

1. Efforts to allow insurers to deny coverage (often called "underwriting") to sick children outside open enrollment periods. Insurance companies say they need to underwrite policies in order to prevent adverse selection (i.e., a parent who waits to buy coverage until after the child becomes sick). HHS has issued guidance saying that plans cannot discriminate against sick children either inside or outside of open enrollment periods. Unfortunately, some insurers have pushed state officials to allow them to underwrite policies outside of open enrollment, in defiance of the HHS guidance. For example, South Dakota recently issued a regulation allowing this kind of underwriting.
2. "Anti-dumping" provisions that prevent children from accessing meaningful coverage. In many states, insurers are pushing for provisions that would allow them to deny coverage to any child that is eligible for coverage elsewhere, i.e., through Medicaid, CHIP, or a parent's employer plan. They are concerned that states and some employers may try to "dump" sick kids, now that insurers can no longer deny them coverage. While HHS has said that states can institute rules that would prevent dumping, it is important that any such rules do not leave children without meaningful coverage options.
3. Efforts to exempt certain kinds of health plans from the requirements. Some non-traditional sources of coverage, such as association health plans, mini-meds, and student health plans occupy a "gray area" of regulation, and HHS has not issued clear guidance on whether they must comply with all of the ACA's patient protections. In the absence of such guidance, some states may move to exempt these plans from the ACA's protections for children with pre-existing conditions.

## Grievances and Appeals

For the new federal right to appeal certain health plan decisions, NAIC has updated two existing Model Laws: the “Health Carrier Grievance Procedure Model Act” and the “Utilization Review and Benefit Determination Model Act.” Both of these Models set out the minimum requirements a plan must meet to have an adequate *internal* process for reviewing consumer appeals. The ACA also gives consumers a right to access an independent, *external* review of their appeal. The NAIC has a longstanding Model Act on external appeals; it has not been updated, but any state that adopts the NAIC’s Model Act on external appeals will be in compliance with the ACA.

### What do the Model Acts do?

The NAIC’s Model Acts on internal review conform to the ACA’s minimum requirements by requiring the following specific protections:

- Provide consumers with the right to file an appeal with the health plan within six months of receiving a negative determination
- Allow consumers to appeal a broad range of plan decisions, including a decision to rescind (or retroactively cancel) a consumer’s coverage
- Require that the health plan ensure the independence and impartiality of its reviewers, primarily by prohibiting plans from using bonuses, promotions or other enticements to encourage reviewers to rule against the consumer
- Require health plans to maintain a written record of all appeals for at least six years
- Require health plans to provide the consumer with any and all documentation, without charge, relevant to the appeal
- Require health plans to make a decision no later than 60 days after receiving the appeal. For urgent care requests, plans must make a decision within 24 hours
- Require health plans to provide consumers with culturally and linguistically appropriate information
- Require health plans to continue coverage of services and treatment throughout the appeals process if the patient is undergoing a course of treatment;
- Require health plans to inform consumers of their right to contact their state insurance commissioner or ombudsman/consumer assistance program for help with their appeal.

### Three things that could improve the Model Acts

1. **Reduce administrative barriers.** Some health plans require consumers to go through *two* levels of internal review before they can access an independent external review panel. But studies have shown that the time and effort involved in the extra level of internal review discourage many consumers from pursuing their claims.<sup>5</sup> The federal rules allow consumers in *individual* market plans to skip the second internal review, but consumers in group plans don’t get that protection. States could improve on the NAIC’s Model Act by allowing all consumers in state-regulated insurance plans to access an independent external review if the plan rules against them after the first internal review.
2. **Expand the definition of rescissions.** The Models follow the ACA rules allowing consumers to appeal a health plan’s decision to “rescind” or retroactively cancel coverage, unless the consumer has committed fraud or lied on his or her application. But

neither the ACA nor the Model Laws address situations where a plan might cancel a consumer's coverage *prospectively*.

3. **Extend equal appeal rights to consumers in mini-med plans.**<sup>6</sup> Not all states regulate "mini-med" plans in the same way. The NAIC Models would allow states to exempt mini-meds from the requirements to have a full and fair internal review process. But states can provide all consumers with the same due process rights by clarifying that all plans, including mini-meds, must meet the new standards.

### **Three things that could weaken the Model Acts**

Some stakeholders may attempt to weaken the NAIC's Model Language and make the state laws less protective of consumers. Consumer advocates and state policymakers may need to address:

1. **Exempting grandfathered health plans.** The ACA's provisions providing consumers with new rights to internal and external appeals do not apply to consumers in grandfathered health plans.<sup>7</sup> However, the NAIC's Model Laws are more expansive than the federal law and provide the appeal protections to *all* state-regulated plans – new plans and grandfathered plans. Advocates should be on the lookout for insurance industry efforts to exempt grandfathered plans from the Model Laws.
2. **Lowering professional standards for reviewers.** The NAIC Model Laws are more stringent than the federal rules because they require insurers to designate a "clinical peer" of the "same or similar specialty" to review the appeal. In other words, if a pediatrician would typically manage a child's care, the health plan would be required to designate a pediatrician to review any appeal associated with that child's coverage. Because the federal rules give insurers more flexibility in who they appoint to review an appeal, advocates should be on guard for industry efforts to lower the standard.
3. **Reducing consumers' access to necessary information.** The NAIC Model Laws have tougher requirements than the federal rules on the following:
  - Timely access to documents. The NAIC model requires health plans to provide to the consumer all documents relevant to the case within three working days after the health plan receives the appeal. The federal rules don't include this timeliness requirement. Advocates should be aware that insurers may push to weaken the NAIC's requirement for prompt delivery of documents.
  - Access to a broad range of necessary documents. NAIC's model requires that, once a plan has made a decision on an internal appeal, it must provide to the consumer a range of documents that will help the consumer understand the decision. The federal rules don't require plans to provide the same breadth of documents, and health plans may lobby at the state level to allow plans to follow the less stringent federal requirements.

## Lifetime and Annual Benefit Limits

For the new consumer protections eliminating lifetime limits on benefits and restricting annual limits on benefits, the NAIC has developed a Model Law called “Model Language for Lifetime and Annual Limits,” that includes the necessary legislative language for states to enact the minimum federal requirements.

### What does the Model Language do?

The Model Language repeats the federal law’s requirements on lifetime and annual limits by:

- Prohibiting lifetime limits on the dollar value of the essential benefits<sup>8</sup> required under the ACA, beginning Sept. 23, 2010
- Prohibiting annual limits on the dollar value of the essential benefits required under the ACA, beginning January 1, 2014
  - Beginning Sept. 23, 2010 restricting annual limits to \$750,000
  - Beginning Sept. 23, 2011 restricting annual limits to \$1.2 million
  - Beginning Sept. 23, 2012 restricting annual limits to \$2 million
- If a plan receives a waiver from the U.S. Department of Health and Human Services (HHS), then the NAIC’s Model Language requires plans to notify consumers and policyholders – and the state’s insurance commissioner – that they are not subject to the restrictions on annual limits.
- Requiring plans to reinstate an individual who lost coverage because they had previously reached their lifetime limit on benefits. However, this protection only applies to people in group or family coverage, not to individuals who lost non-group coverage.

Consistent with the ACA, the prohibition on lifetime limits applies to all plans, while the provisions on annual limits apply to grandfathered *group* health plans, but not to grandfathered *individual* health plans.<sup>9</sup>

### Four things that could improve the Model Language

1. **Extend the law to grandfathered plans.** While the prohibition on lifetime limits applies to *all* health plans, the ACA exempts grandfathered individual market health plans from the restrictions on annual limits. However, because the ACA sets a floor for consumer protection, states could go beyond this rule to require grandfathered plans to comply with market reforms, including the restrictions on – and eventual prohibition of – annual limits.
2. **Expand restrictions on annual limits.** The law prohibits annual limits on the *dollar* value of benefits. But it does not prohibit plans from imposing *service* limits, such as the number of doctor’s visits, days in the hospital, or number of drug refills a patient can have each year. This creates a loophole as plans that currently impose annual dollar limits could simply switch to service limits and comply with the law. States could close that loophole by clarifying that *all* annual limits are prohibited, not just dollar limits.
3. **Ensure restrictions apply to all essential benefits.** The prohibitions on lifetime and annual limits apply only to the ACA’s essential benefits package. Because HHS has not

yet defined what must be in the essential benefit package, the law allows health plans to make “good faith” determinations of what would be covered and subject to the prohibitions on lifetime and annual limits. Because this leaves so much discretion to the health plans, states can and should authorize their insurance commissioners to conduct audits and enforcement activities to ensure plans are truly making these benefit determinations in good faith.

4. **Require plans to reinstate individuals who lost coverage because they hit their lifetime limits.** The law requires plans to reinstate someone who lost coverage because of a lifetime limit if they are part of an employer group or family with a current plan, but not people who lost *individual* coverage because they hit their lifetime limit. States can make sure they get the same protection by requiring plans to reinstate individuals in the same or a substantially similar policy.

## Prohibition on Rescissions of Coverage

In the case of the new prohibition on health plans retroactively cancelling coverage when someone gets sick, the NAIC has drafted “Model Language for Prohibition on Rescissions of Coverage.” This Model Language sets out the minimum requirements a state must have in place to comply with the ACA.

### What does the NAIC’s Model Language do?

In drafting the Model Language, the NAIC followed the provisions of the ACA and the interim final rule published by the U.S. Departments of Health and Human Services, Labor and Treasury. Consistent with federal law, the Model Act:

- Defines a “rescission” to be a cancellation of coverage with a *retroactive* effect (i.e., back to the initial date of enrollment, leaving the consumer on the hook for any claims made under the policy).
- Applies to *all* health plans, including grandfathered plans.<sup>10</sup>
- Prohibits health plans from rescinding coverage unless the consumer fails to pay premiums, performs an act of fraud or makes an “intentional misrepresentation of material fact” on their application for coverage.
- Requires health plans to provide written notice to the policyholder at least 30 days before any rescission goes into effect

### Four things that could improve the NAIC’s Model Language

The ACA, and the NAIC’s Model Language set out the *minimum* standard of consumer protections; any state can enact laws that are more protective. For example, states could improve on this Model Language in the following ways:

1. **Require the health plan to bear the “burden of proof.”** States could add a requirement in their laws requiring the insurance company to bear the responsibility to prove that a policyholder committed fraud in their application or made an “intentional misrepresentation of material fact.”
2. **Expand the definition of a rescission.** The Model Language defines a rescission to include only cancellations that have a *retroactive* effect. Thus, nothing prevents an insurer from cancelling a consumer’s coverage *prospectively*, even if they’ve only made an innocent mistake or omission on their application. To fully protect consumers, states could expand the definition of rescission to include cancellations that have a *prospective* effect.
3. **Provide right to an external appeal.** If a consumer feels their health insurer has unfairly or improperly rescinded their policy, the state can provide a right for them to appeal that decision to an independent, external review body. In addition, states should ensure that coverage can remain in effect until the review is complete and the enrollee is notified of the independent review organization’s decision to uphold the rescission.

4. **Expand the notice requirement.** The Model Language does not specify what information needs to be provided to consumers who receive a notice of impending rescission. States could expand on this by requiring disclosure of:
  - the reason for rescission
  - the date the rescission will occur, and the date to which the retroactive cancellation goes back
  - acknowledgment that the health plan bears the burden of proof
  - how to obtain copies of all the relevant information used to make the decision to rescind coverage
  - information about the consumer's right to appeal the decision
  - itemized list of pending and paid medical expenses that the plan will recoup

## Things Consumer Advocates Should Watch Out For

Some states have existing laws that are more protective of consumers than the ACA. For example, they might clearly state that the health plan bears the burden of proof in a case of rescission, or specify consumer-friendly content and format for the notice of rescission. Some industry stakeholders may seek to weaken these stronger state protections by arguing that the ACA's protections are adequate and should set a "ceiling" of regulation. Consumer advocates should be prepared to defend against attempts to lower the state standard to the ACA's minimum standard.

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<sup>1</sup> "Grandfathered" plans are those that were in existence prior to March 23, 2010. The ACA exempts them from many, but not all, of the ACA's consumer protections.

<sup>2</sup> "Mini-meds" are often defined as health plans that fail to meet the minimum definition of health insurance, either because they do not cover a comprehensive set of benefits or they have very low coverage limits.

<sup>3</sup> "Grandfathered" plans are those that were in existence prior to March 23, 2010. The ACA exempts them from many, but not all, of the ACA's consumer protections.

<sup>4</sup> Open enrollment is a period of time, typically 30 days, during the year when a consumer can apply for and purchase an insurance policy. Consumers can only purchase a policy outside of an open enrollment period if they experience a "qualifying event," such as job loss, birth of a child, adoption, or divorce. Adverse selection is the trend of people only purchasing insurance when they are sick and have significant health expenses; or the separation of healthier individuals into some insurance plans and sicker individuals into others.

<sup>5</sup> Geraldine Dallek and Karen Pollitz, "External Review of Health Plan Decisions: An Update ." The Henry J. Kaiser Family Foundation, May 2000.

<sup>6</sup> A "mini-med" plan is frequently defined as a plan that does not meet minimum state standards for health insurance coverage. They frequently cover only a limited range of services and have very low benefit caps.

<sup>7</sup> "Grandfathered" plans are those that were in existence prior to March 23, 2010. The ACA exempts them from many, but not all, of the ACA's consumer protections.

<sup>8</sup> The ACA requires new individual and small group health plans to provide a minimum range of essential benefits, which must include the following broad categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including

behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management services; and pediatric services, including oral and vision care.

<sup>9</sup> “Grandfathered” plans are those that were in existence prior to March 23, 2010. The ACA exempts them from many – but not all – of the ACA’s consumer protections.

<sup>10</sup> “Grandfathered” plans are those that were in existence prior to March 23, 2010. The ACA exempts them from many, but not all, of the ACA’s consumer protections.