

A PUBLIC POLICY PRACTICE NOTE

# Actuarial Certification of Restrictions Relating to Premium Rates in the Small Group Market

*December 2009*

American Academy of Actuaries  
Health Practice Financial Reporting Committee



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AMERICAN ACADEMY *of* ACTUARIES

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The American Academy of Actuaries is a professional association with over 16,000 members, whose mission is to assist public policymakers by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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## Introduction

This practice note was originally prepared in 1995 by a work group organized by the Committee on State Health Issues of the American Academy of Actuaries.<sup>1</sup> The practice note was prepared prior to the adoption of Actuarial Standard of Practice (ASOP) No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*. Its purpose was to provide assistance to actuaries who were faced with preparing small group actuarial certifications required by state laws and regulations.

This practice note has been updated by the Health Practice Financial Reporting Committee to incorporate the passage of ASOP No. 26, certain relevant revisions of small group certification requirements in various states, as well as to reflect practical changes that have transpired since the original publication.

The practice note is based on ASOP No. 26, as well as three original National Association of Insurance Commissioners (NAIC) Models: (1) the Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups Model Act (adopted in 1991; but subsequently repealed in 2005); (2) the Small Employer Health Insurance Availability Model Act (adopted in 1992) attached hereto as an Appendix; and (3) the Model Regulation to Implement the Small Employer Health Insurance Availability Model Act (adopted in 1993). Throughout the practice note, specific quotations from the various models are followed by the proper citations. When the more general reference to “NAIC Model Acts” is used, it applies to concepts and requirements that are found in all three models.

To the extent that the laws of a particular state differ from the NAIC Model Acts, practices described in this note may not be appropriate for use in that state.

It should be noted that the three NAIC Models, referred to above have been changed over the years by the NAIC. The NAIC has repealed the “Premium Rates and Renewability of Coverage” model, and it has significantly revised the other two models. Because most states enacted small group laws prior to the NAIC model law changes, and did not significantly update the rating portion of their laws when updating them for the requirements introduced by enactment of the Health Insurance Portability and Accountability Act, this practice note is based upon the original model laws and not the current models. Any reference in the practice note to an NAIC Model Law refers to these older model laws. Since these older models are not readily available for reference, the Small Employer Health Insurance Availability Model Act has been attached in the Appendix.

This practice note is not a promulgation of the Actuarial Standards Board, is not an actuarial standard of practice, is not binding upon any actuary and is not a definitive statement as to what constitutes generally accepted practice in the area under discussion. Events occurring subsequent to this publication of the practice note may make the practices described in this practice note irrelevant or obsolete.

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The members of the subgroup responsible for this revised practice note are Charles B. Smith, MAAA, FSA, Chairman; Stephen T. Custis, MAAA, FSA; Earl L. Hoffman, MAAA, FSA; Olga T. Jacobs, MAAA, FSA; James T. O'Connor, MAAA, FSA; and Russell D. Willard, MAAA, FSA. Comments are welcome as to the appropriateness of the practice notes, desirability of annual updates, substantive disagreements, etc. Comments should be sent to the Academy's State Health Policy Analyst [statehealthanalyst@actuary.org](mailto:statehealthanalyst@actuary.org).

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### **Appendix**

NAIC Model Act 118 (1992) Small Employer Health Insurance Availability Model Act  
(Prospective Reinsurance With or Without an Opt-out)

**Q1. Why is there a need for a practice note that addresses small group certification?**

**A1.** The NAIC Model Acts and the statutes enacted by many states require small group insurance carriers and health plans to file an actuarial certification that the small employer carrier is in compliance with provisions relating to premium rate restrictions and, depending on the jurisdiction, certain other aspects of the law. A number of situations have developed that require an actuary to use judgment in certifying compliance. The actuary is performing a certification of both the expectation and fact of compliance.

This practice note is intended to provide guidance to actuaries developing such certifications and to encourage reasonable consistency in the work being performed by different actuaries. It is not intended to mandate particular practices, or to discourage innovation in responding to regulatory requirements.

**Q2. What is an actuary certifying to when a statement of compliance with small group legislative and regulatory requirements is made?**

**A2.** If a state requires an “Actuarial Certification,” the state will define what the actuary is certifying to within the individual state’s laws and regulations. It is important for the actuary to thoroughly review and understand the specific state laws and regulations. If no specific state guidance or definitions are given, guidance may be found within the NAIC Model Acts.

The repealed NAIC Model Act, *Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups* (Premium Rates Model Act), defines an *actuarial certification* in Section 2(A) as a “written statement that a small employer carrier is in compliance with section 4 (Restrictions Relating to Premium Rates) of this act, based on a review of methods, actuarial assumptions, and appropriate records.” Furthermore, the NAIC Model Act, *Small Employer Health Insurance Availability Model Act* (Small Employer Model Act), defines an actuarial certification similarly in Section 3(A). Both of these NAIC Model Acts require that the certification be done annually and that the rating methods of the carrier be actuarially sound.

When the actuary *certifies compliance*, it generally means that the actuary has conducted appropriate tests and reviews and has determined that the carrier complies with the state’s definition of compliance. Using the NAIC Model Act as a guide to preparing opinions on compliance, the actuary may review the following:

1. Classes of business (defined in Q10) have been established in accordance with applicable laws.
2. Index rates (defined in Q6) have been calculated as required by law.
3. Premium rates (defined in Q9) for groups within a class do not vary from the index rate for that class by more than is allowed by the law, taking into account any differences in case characteristics (also defined in Q5), except for groups where transition period allowances are applicable and permitted by law.
4. The index rate for any class does not exceed the index rate for any other class by more than is allowed by law.

5. Rate increases from the prior rating period do not exceed the percentage increases allowed by law.
6. Rating restrictions associated with permitted case characteristics have been met and only allowable case characteristics have been used in adjusting the rates for compliance testing.
7. Rates have been calculated in compliance with applicable laws, and in compliance with any regulations established by the commissioner to implement the law.
8. Differences in rates for plan design are reasonable, reflect objective design differences, and do not include differences in the nature of groups assumed to elect a plan, to the extent permitted by law.
9. Rating methods and practices are in accordance with sound actuarial principles, to the extent permitted by law.

In addition, the actuary's examination generally includes a review of the appropriate records, assumptions, and methods used by the carrier in establishing premium rates for small employer health plans. This review typically is such that the actuary may gain assurance that non-compliance is not the result of inappropriate business practice.

The NAIC Model Acts specifically require that the actuarial certification cover a carrier's compliance with premium rate restrictions. However, for each jurisdiction, the legislation may have additional or different certification requirements on subjects such as underwriting, premium adequacy, or plan design.

Furthermore, if a state follows the NAIC Small Employer Model Act, the state's laws or regulations will contain a section pertaining to sales disclosure requirements. An actuary may choose to include the review of the sales material as part of his or her examination. If the actuary chooses to limit the actuarial certification to the development of premium rates only, then a limited opinion should be issued.

### **Q3. What coverage is subject to certification?**

**A3.** The coverage subject to certification is dependent upon the specific legislative requirements of each state. In general, the laws apply to small group health plans. Group dental, group life, group disability, group credit, group accident-only, and other limited benefit plans are not usually covered.

Individual health insurance issued to small employers may be addressed in state laws as well. Some states have made their small employer laws applicable to both individual and group insurance plans. Other states have passed separate individual accident and health insurance reform laws. Where individual health insurance is addressed in the small group legislation, it typically is incorporated into the certification process.

### **Q4. What is a *small employer group*?**

**A4.** A *small employer group* may be defined by state legislation and usually is any sole proprietor, firm, corporation, partnership, or association actively engaged in business whose total employed work force



consisted of a minimum and maximum (varies by state) number of eligible employees, the majority of whom are employed within the individual state on at least 50 percent of the small employer's working days during the preceding year (see Small Employer Model Act, section 3.BB).

The NAIC Model Acts define who is an eligible employee, and who must be included in determining whether a group is classified as small. The contract, policy, or corporate structure may define eligibility.

Companies that are affiliated or that are eligible to file a combined tax return for purposes of state taxation often are considered one employer for purposes of determining eligible employees. An eligible employee may include an employee on a part-time, temporary, or substitute basis. The statute or regulation will usually specify the minimum required work hours for eligibility.

**Q5. If a carrier is affiliated with other licensed carriers, health plans, or entities that also issue or renew small group benefit plans in a state, what additional considerations are required for the small group carrier to certify compliance?**

**A5.** Some states have affiliated carrier language in their small group rating laws. This wording typically requires that the carrier apply all premium rating restrictions and limitations as if all the affiliated carriers and health plans were issued by a single legal entity. Some states do have an exception for this in that they may allow a licensed HMO to be treated as a carrier separate from the insurer's other affiliated legal entities.

If the state does not have affiliated carrier language, then each licensed entity in the state may be treated as a separate small employer carrier.

**Q6. What are *case characteristics*?**

**A6.** *Case characteristics* generally are the objective criteria or attributes of a small employer group that are used in the development of the group's premium rates (see the Small Employer Model Act, section 3.G). This practice note distinguishes "allowable case characteristics" from "permitted case characteristics" for the reasons explained below.

- *Allowable case characteristics*: these are rating factors for case characteristics whose variations do not need to be reflected in the range around the index rate and rate increase limitations. Alternatively stated, these are the case characteristics used to determine the index rate. When explicitly stated in the state's law, they usually include age, gender, and geographic area, and often also include industry and group size (factors for these last two are often limited). Variation by benefit plan, including restrictive provider network plans, is also permitted. Some states do not have an explicit list of "allowable" case characteristics, but require them to be objective in nature and not to include claims experience, health status, and duration of coverage since issue. Examples would be participation level of the group.
- *Other permitted case characteristics*: these are legitimate rating factors that may otherwise not be considered as "allowable" (i.e., factors that may not be reflected in the determination of the index rate). Alternatively stated, these factors are not used to determine the index rate, but are reflected in

the range around the index rate. If a state did not allow gender, group size, and industry, among others, as allowable, these could be considered “other permitted case characteristics,” unless the state expressly did not permit them to be used at all for rating. Another example includes rating factors based on the employer’s contribution level.

- *Not permitted case characteristics*: these are the rating factors that the state does not allow to be part of a rate determination, as opposed to not allowing their use in determining the index rate for testing purposes. For example, some states do not allow gender-based rating. As such, a carrier cannot vary rates by gender in these states.

Allowable case characteristics do not include claims experience, health status, or duration of coverage from the date of issue, even though these criteria are objective to some degree. These items generally are considered other permitted case characteristics to the extent they meet the limitations of the small group law.

The actuary should become familiar with the individual state's regulation, which may specify and limit the list of objective criteria that may be used in determining premium rates for small employers within that state. Some states may require the small employer carrier to demonstrate and obtain approval from the insurance department before using any case characteristic other than the specified list of allowable case characteristics contained in the state's regulation for testing compliance.

#### **Q7. What is a *midpoint* or *index rate*?**

**A7.** The NAIC Small Employer Model Act (section 3.P) defines an *index rate* as the arithmetic average of the lowest and the highest premium rate charged, or which could be charged, to small employers with the same rating period and similar allowable case characteristics (defined in Q5) and similar benefits. The index rate measures the midpoint of the rate range for each unique combination of benefits and allowable case characteristics.

For example, under the NAIC Model Acts, claims experience, health status, and duration are not allowed case characteristics. Thus, the index rate measures the midpoint of the rate range driven by claims experience, health status, and duration. All other rate distinctions (e.g., age, sex, and geographic area) generally are held constant or normalized in determining the index rate.

The “index rate” differs from the “average rate” or “community rate” that some states may use. The index rate is based solely on the average of the highest and lowest rates available or being charged, while the “average rate” and “community rate” are based upon a weighted average of the rates charged to all insured members.

The actuary should become familiar with the specific requirements of each state to which he or she is certifying since they may vary from the NAIC model.

#### **Q8. What is the *new business rate*?**

**A8.** The NAIC Small Employer Model Act (section 3.R) defines the *new business rate* as the “lowest

premium charged, or which could have been charged or offered, to a small employer with similar case characteristics and similar benefits.” The new business rate identifies the lowest possible rate for newly issued health benefit plans for a given group’s benefits and case characteristics after all underwriting and rating factors have been applied.

For example, if a carrier reflects duration and/or health status (which usually are not allowable case characteristics) in the carrier’s rate calculation, then the new business rate is usually determined by the maximum rate reduction for duration and/or health status. All allowable case characteristics (e.g., age, sex, and geographic area) generally are held constant in determining the new business rate.

**Q9. What is a *community rate*?**

**A9.** The NAIC Model Acts do not define a *community rate*. However, some variations on small group reform legislation do reference a community rate. When referenced, a *community rate* typically means a rate for coverage that applies to all members of a pool of risks and is independent of most or all case characteristics. Where some case characteristics are used (e.g., age), the resultant rate is known as a *modified or adjusted community rate*.

**Q10. What is a *premium rate*?**

**A10.** The NAIC Small Employer Model Act (section 3.T) defines *premium* as “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.” This definition includes all monetary consideration paid by a small employer to obtain, prepay, or otherwise fund its health care costs according to a plan of benefits.

With this definition in mind, a *premium rate* may be defined as the specific amount of money per unit of coverage to be paid by a small employer for that coverage. The premium rate is typically determined by benefit level, health status, claims experience, duration, and case characteristics of the employer and its employees. The premium rates are determined by applying formulas and factors contained in a carrier’s rate manual.

Any policy and administrative fees (other than modal fees) charged to the group are usually considered to be part of the premium rate. Similarly, any rebates, refunds, or discounts are usually considered to be part of the premium rate. In practice, modal fees or modal discounts have typically not been included since the vast majority of groups pay on a monthly basis, although a strict interpretation of the NAIC Model Law would also include them.

An example using the four rate definitions follows.

*Assume the following*

1. A single set of health benefits and health care delivery arrangements.
2. Premium rates that vary by all allowed case characteristics plus health status, claims experience, and duration.

3. A small group with the following set of case characteristics:

Average Age: X years old

Location: Urban

Industry: Manufacturing

Percent Female: Y%

In a state rate with band allowance:  $\pm 35\%$

4. Rates and rate factors are as follows:

Premium rate for the group identified in (3) above: \$200

Due to health underwriting, claims experience, and duration loads and credits:

The lowest possible premium rate the carrier can charge to groups with these same allowable case characteristics: \$150

The highest possible premium rate the carrier can charge to groups with these same allowable case characteristics: \$311

5. For all groups with the same case characteristics and benefits,

50% are being charged: \$200

45% are being charged: \$170

5% are being charged: \$300

The various rates defined above are as follows:

- Index or midpoint rate  $= \frac{\$150 + \$311}{2} = \$230.50$
- New business rate = \$150
- Community rate  $= (.50 \times \$200) + (.45 \times \$170) + (.05 \times \$300) = \$191.50$
- Premium rate for the group identified in (3) = 200

**Q11. What is a *class of business*?**

**A11.** A *class of business* typically is a distinct grouping of a small employer carrier's small group health business (see the Small Employer Model Act). Some examples of bases for establishing a class of business under the NAIC Model Acts are as follows:

1. Health benefit plans that are marketed and sold through individuals and organizations that do not market or sell other distinct groupings of a carrier's small group health insurance business. For example, policies sold only through brokers might constitute a separate class from policies sold by direct marketing.
2. Blocks of business that have been acquired from another small employer carrier as a distinct

grouping of plans.

3. Health benefit plans that are provided through an association of small employers, in accordance with state rating reform law that was not formed for the purposes of obtaining insurance. The actuary generally would be prudent to be knowledgeable of the individual state's regulation because the NAIC Model Acts provide for a minimum number of small employers to be members of the association in order to qualify as a separate class, and that number may vary from state to state.
4. Health benefit plans that are in a class of business that meets the requirements for the exception to the premium rate restrictions between classes of business as approved by the commissioner.

In all of these cases however, substantial differences in expected claims experience or administrative costs must be expected for the block of business in order for it to be treated as a separate class. Based on the above criteria, a new policy form typically does not define a class of business.

Also, the NAIC Premium Rates Model Act provides that an insurer may establish a maximum of two additional groupings (or subclasses) under each of the above categories “on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.” This Act also provides for the insurance commissioner of a state to approve the establishment of additional classes of business that the commissioner finds would enhance the efficiency and fairness of the small employer marketplace. The actuary generally would be prudent to review the individual state's regulation to determine if additional classes of business may be defined.

## **Q12. How can compliance be demonstrated?**

**A12.** Each major requirement of the law (of the particular state) that is required to be included in the actuarial certification is addressed in the demonstration of compliance. The following are examples of such requirements based on various states' legislation:

1. Establishment of classes of business.
2. Restrictions relating to premium rates:
  - a. Between class limits (index rates).
  - b. Within class limits.
  - c. Increase limits (new business and existing business).
  - d. Uniform application of rate adjustments to individuals.
  - e. Limits on certain rating factors such as industry or group size.
  - f. Uniform application of rating factors.
  - g. Acceptable list of rating factors.
  - h. No involuntary transfers in or out of a class of business.
3. Renewability of coverage.
4. Other small employer carrier requirements (disclosure, records, other).

Compliance usually may be demonstrated most efficiently by describing the practice and procedures in place that assure compliance. For example, if all rates are determined as a risk factor multiplied by a single rate table, compliance with “within class limits” may be shown by indicating that risk factors are required by the rating system to be in a specified range (e.g., 0.75 to 1.25). Reference may be made to any tests done to audit the operation of the rating system.

Where structures or procedures do not guarantee compliance, calculations usually may be shown that measure the restricted quantities. For example, if rating factors differ for two classes of business, index rates generally are calculated and compared for appropriate test populations. A test at one point in time during the year is usually sufficient, as long as rate change information is provided to show that compliance existed at each point during the year. If such rate change information is not available, then testing would need to be done for each month in order to demonstrate compliance.

**Q13. How are limitations to the percentage increase in renewal premium rates applied by carriers?**

**A13.** For reference, most state regulations (where underwriting is allowed) reference three separate increases to be considered:

1. The percentage change in the new business rate during the rating period. When a block is closed, this is the percentage change in the base premium rate. (BASE CHANGE)
2. An adjustment, generally not to exceed 15 percent, due to claim experience, health status, or duration of coverage. (EXPERIENCE CHANGE)
3. An adjustment due to change in coverage or the change in case characteristics of the small employer. (DEMOGRAPHIC CHANGE)

The actuary is verifying that the carrier is in compliance regarding the 15 percent restriction in the EXPERIENCE CHANGE.

The complicating factor with the EXPERIENCE CHANGE restriction is that an additive restriction (sum of the changes) is applied to a multiplicative calculation (the rate increase).

Carriers test this restriction in different ways. Some of the methods in use include:

- Subtracting the BASE CHANGE and DEMOGRAPHIC CHANGE from the overall rate increase. If the resulting value is less than or equal to 15 percent, the rate increase is determined to be in compliance.
- Comparing the rate increase to the rate increase without the EXPERIENCE CHANGE. If the difference is less than or equal to 15 percent, the rate increase is determined to be in compliance.
- Carriers that have difficulty separating the three increases may compare the relative rate levels vs. the index rate before and after the rate increase. If the increase is less than 15 percent, the rate increase is determined to be in compliance. For example, an account that increased from 80 percent to 94 percent of the index rate is determined to be in compliance. An account increasing from 109 percent to 125 percent is determined to be out of compliance. This is the computationally easiest method to calculate, but it may result in different accounts being judged

to be in compliance, especially for accounts that had pre-renewal rate levels near the minimum, relative to the index rate. (Note in the above example, the compliance decision would have been the opposite for actuaries using a “multiplicative” interpretation since  $94\%/80\% = 1.175$  and  $125\%/109\% = 1.147$ .)

Practicing actuaries have had discussions with state insurance departments which have offered guidance that either a multiplicative or an additive test is acceptable. However, some state insurance departments have directed that the additive test must be used. For those states that are silent on the issue, what is of utmost importance is that the methodology used by a carrier is consistent. If an actuary chooses to perform the test on a multiplicative basis, it is recommended that he or she do so for all groups in that state for that year. Likewise, if an actuary chooses to perform the test on an additive basis, it is recommended that he or she do so for all groups in that state for that year.

**Q14. How does the state’s renewal rate limitation for health status (e.g., 15 percent in the NAIC model law) apply to groups that are renewing for rating periods less than or more than twelve months?**

**A14.** State laws usually require that the limitation be applied on a pro rata basis for rating period of less than 12 months. The laws are generally silent concerning rating periods of more than 12 months. From an actuarial perspective, pro rata would be reasonable for those as well. It can be read to mean that the 15 percent is applied on a per annum basis, but it could also be viewed as requiring the same rate increase limitation as allowed for 12 months (e.g., 15 percent) in order to discourage rating periods longer than 12 months, otherwise the statement would not have singled out periods of “less than 12 months.” Prevailing practice limits rate increases for more than a twelve month rating period to a maximum of 15 percent.

**Q15. Is the application of the renewal rate limitation prospective or retrospective for rating periods of different lengths?**

**A15.** This question refers to a situation in which a rate change for a group may be for less than one year, but the next change will be 12 months later, or vice versa. This provision of the rating laws usually states that “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...”

While the determination of the “new business rate change” is retrospective based upon the length of time between the first day of the prior rating period and the first day of the new rating period, the 15 percent clause refers to the “new rating period” in the root of the provision and not the length of the past rating period. This could be interpreted as a prospective determination in setting the rate. However, many carriers have interpreted this as a “retrospective” determination, as noted below. This points to an ambiguity in the language. Reasonable actuaries interpret the application of this provision of the small group rating limitations differently.

Those actuaries who use a retrospective interpretation point to two key provisions of the rating law:

1. The provision in the statement above refers to the amount of increase, not to the absolute rate level. Because the amount of increase is, by definition, a comparison of the current premium rate to the prior premium rate, it follows that any restrictions would also apply to the same time period, which is retrospective.
2. The next phrase in the provision listed above usually refers to “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.” Because the rate limitation applies to the sum of three separate increases, it is reasonable to assume that the same time period should be used for all three increases.

Additionally, these actuaries maintain that a prospective interpretation, by its very nature, would be difficult, if not impossible, to certify, because many new rating periods from the prior year’s renewals are still in force (and technically still subject to change) as the certification is being prepared.

For example, if a renewal rate is set for a 12-month rating period beginning on 1/1/2008 and the prior rating period began on 7/1/2007, using a retrospective interpretation, the carrier can only include a 7.5 percent additional rate increase since the prior rating period was only six months long. Using a prospective interpretation would allow the full 15 percent increase.

However, if a group’s prior rating period began on 6/1/2006 and ended on 5/31/2007 (a 12-month period), but then was switched to a seven-month rating period ending on 12/31/2007, using a retrospective interpretation, the rate set at 6/1/2007 could include a full 15 percent additional rate increase since a 12-month rating period preceded the new rating period. A prospective interpretation would limit the rate increase to  $8\frac{3}{4}$  percent (i.e.  $7/12 * 15$  percent) since the new rating period will last only seven months.

If a prior or new rating period is longer than 12 months, the 15 percent limitation still applies. For example, if the prior rating period began on 10/1/2006 and was extended by the underwriter to 1/1/2008 (i.e., a 15 month rating period), the carrier could only increase the premium by 15 percent since the “new rating period” is only 12 months long; it could not increase it by  $15\text{ percent} * (15/12) = 18.75$  percent to make up for the extension on the prior rating period.

The key guidance offered by this practice note is that the carrier should consistently apply its interpretation (i.e., retrospective or prospective application) over successive years.

**Q16. What disclosures are included?**

**A16.** The actuary generally discloses any deviation from standard actuarial practice that was used in determining compliance, and the nature, rationale, and effect of such deviation. In addition, comments on data and reliance on others may be indicated. The actuary also indicates whether the opinion is non-qualified or qualified.

**Q17. What tests are performed to demonstrate compliance?**

**A17.** The actuary usually performs the tests necessary to prove and document compliance with the



applicable small employer laws and regulations for which the certification is being made and, if required, to determine that the rating methods are actuarially sound. The level of testing required generally will vary with both the specific certification requirements of the particular state and the complexity of the rating practices employed by the small employer carrier. For example, for a carrier that uses a pure community rating approach, a thorough review of rating and underwriting practices may constitute a sufficient level of testing. On the other hand, group specific calculations may be required of a carrier that incorporates all allowable rating parameters in its rating structure.

Generally, tests are performed that demonstrate that the underwriting methods and premium rates charged are established according to the following:

1. The rates are based on generally accepted actuarial methods and in accordance with sound actuarial principles, to the extent permitted by law;
2. Rates are calculated using allowed case characteristic factors, with the range of these factors within the limits allowed by law;
3. Rates do not use any prohibited separate policy fees or charges, similarly, they do not include any prohibited rebates, refunds, or discounts;
4. The index rate for any class of business does not exceed the index rate for another class by the prescribed percentage;
5. The premium rates for small employers with similar case characteristics within a class of business do not vary from the index rate of that class by more than the prescribed percentage; and
6. The percentage increase in renewal premium rates has not exceeded 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;
  - b. an adjustment, not to exceed a prescribed annual percentage (e.g., 15 percent) adjusted pro rata for periods of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer; and
  - c. any adjustment due to a change in coverage or changes in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

The actuary typically will wish to determine if the state has put forth testing procedures that must be followed or if specific policy data must accompany the certification. In the absence of prescribed testing procedures, the actuary usually will wish to be satisfied that the tests performed are sufficient to support the certification.

The complexity of the testing method called for generally depends upon the rating practices employed by the carrier. One approach that is generally appropriate for most small employer carriers is to base the testing on the rate manual that must be maintained for each class of business.

The requirement to test that the rating practices are based on generally accepted actuarial methods

and are in accordance with sound actuarial principles can often be satisfied with a review of the various rating factors included in the rate manual. The actuary typically confirms that only allowable and permitted case characteristics are being used, that the factors associated with these case characteristics are within the limits allowed by law, and that such factors are uniformly applied. If not involved with the development of such factors, the actuary generally reviews the reasonableness of the range of values being used. A familiarity with the underwriting and renewability rules of the carrier and a review of the supporting data or actual experience on which the rates or most recent rate changes are based are also usually desirable to support the actuary's opinion.

A demonstration of how the rate manual(s) can be used to test compliance with the rating restrictions of the NAIC Model Acts is as follows:

1. *Within a Class*—All possible group premium rates can be expressed as a percentage of the new business premium rate (or the lowest rate that could be charged) for similar case characteristics, as calculated from the rate manual for that class. To be in compliance, none of these percentages can exceed the maximum percentage permitted in the state. The maximum allowable percentage can be calculated as the ratio of the highest permitted deviation from the index rate to that of the lowest. Alternatively, the same basic procedure can be followed using all possible group rates expressed as a percentage of the index rate.
2. *Between Classes*—Because each group is likely to have a unique set of case characteristics, one theoretically correct way to prove compliance between classes is to calculate the index rate for each set of case characteristics under the rating criteria of each and every class of business. The resulting index rate for each set of case characteristics for any given class of business should not exceed the index rate for each set of case characteristics for any other class by more than the prescribed percentage.

A comparison of the rate manuals of the various classes is often an important part of the testing process. Such a comparison may yield many areas where simplifying assumptions are possible.

3. *Rate Increases*—The method of expressing a group's premium rate as a percentage of the new business rate for that class can be used to test compliance with the renewal rate increase limits. Group rates for the prior period can be expressed as a percentage of the new business rate for the first day of the prior period, as calculated from the rate manual for that class. The same ratio can then be calculated for the renewal period. A rate increase can be deemed to be in compliance if the difference in these ratios is less than the percentage increase allowed by law for claims experience, health status, or duration of coverage. This method usually adjusts automatically for the change in the new business rate and any changes in coverage or case characteristics.
4. *Policy Fees*—if the state law does not allow separate fees or charges, the actuary should review the rate manual, as well as the actual rates of a representative sample of groups, to ensure the carrier is in compliance. Also, any policy fees charged need to be considered as part of the premiums being tested.
5. *Case Characteristic Rating Factors*—the actuary should review the rating manual to ensure that

only permitted case characteristics are used for rating. Permitted case characteristic rating factors are of two types for the purpose of testing compliance with small group rating laws: i) allowable case characteristics, and ii) other permitted case characteristics. See the discussion for Q5 regarding the distinction between these types of case characteristics.

In practice, the rating variations caused by application of “other permitted case characteristics” is included along with rating adjustments for claims experience, health status, and coverage duration as part of the range testing (e.g., as part of the  $\pm 25$  percent) and renewal rate increase testing (e.g., as part of the 15 percent experience factor increase limit).

In addition, many states explicitly limit the allowed range of one or more of these rating factors. For example, the factor based on group size may be limited such that the highest factor cannot exceed the lowest factor by a stated percentage (e.g., 20 percent).

If the limit is for each case characteristic separately, then the actuary should review the rate manual of each class to ensure the range of factors is within the limits allowed by law. The actuary may also want to review all or a representative sample of groups to ensure that their case characteristic factors are within the limits.

Some state laws do not have a separate limit on separate case characteristic factors but, instead, place a limit on the combined impact of several factors. In this situation, the actuary may want to:

- Verify that the carrier’s rate manual limits the range of the combined impact of the particular case characteristic factors specified in the law.
- Verify that the carrier’s rating system checks the combined impact of these factors and places a limit on the combined impact that is within the range allowed by law. In order to do this, the actuary may want to have the carrier run a sample of actual or hypothetical groups to test whether the system correctly limits the combined impact of the factors.

Other testing methods may be appropriate depending upon the rating practices of the carrier. Testing may be performed once per year or periodically within the year, in conjunction with forming the actuarial certification, or continuously using an automated testing system. In all situations, to form an unqualified opinion, the actuary will wish to be satisfied that rates and rate changes implemented by the small employer carrier meet all applicable rating restrictions.

**Q17a. What methods are typically used to test compliance within a class of business?**

**A17a.** When testing compliance within a class of business, an actuary is looking to answer four main questions: (1) that the factors being used to generate rates are allowed by the state; (2) that the proper information is used to determine rating factors; (3) that the rating factors being used are within the ranges deemed acceptable by the state; and (4) that the rating factors, when applied with the company’s rate formula, correctly generate the premium that was actually charged to the insured.

Below are four methods that actuaries may use to test compliance. The method chosen will often depend on the limitations of how the data is stored by the company, and many actuaries will use more than one

of the methods in a single certification.

**Method 1: Full seriatim testing of factors and calculations**

For a company with a small block of business, extremely detailed premium and enrollment records, or both, it may be practical to test for compliance using a full seriatim listing of all premiums charged in the certification year. In its purest form, a seriatim test would follow steps similar to the following:

1. Data would be collected for each individual covered during the certification, by month/quarter (or however the data is collected). A commercial database or spreadsheet application (such as Microsoft Access or Excel) may be appropriate for this purpose. Each record of data would include the premium charged to the individual, the factors used to calculate the premium, and the demographic information used to determine the factors.
2. The rating factors in the database would be cross-checked against the list of allowable case characteristics for the state. If factors are used that are not allowed, the actuary may need to verify that there is no variation in the factor (this could occur if a carrier writes business in multiple states, with different allowable case characteristics by state, but uses a common rating formula in all states). If there is variation in an allowable rating factor but the actuary feels that the overall rates may still be in compliance, the actuary would need to use a variation of Method 3, shown below. An example would be a company that incorporates an industry factor as part of the Health Status Factor, and monitors the combined Industry/Health Status factor within the +/- 25 percent (varies by state) range allowed by the state.
3. The demographic information for each factor for each individual would be cross-checked against the company's rate manual, to ensure that the correct factors were assigned. If the rate manual exists in electronic form, the actuary should be able to re-create the rating factors using standard database matching techniques.
4. The rating factors in use would be tested to make sure that they are within the bounds allowed by the state. The most significant test is for the compliance of the Health Status Factor (in many states the allowable variation is +/- 25 percent around an index rate), but states will also commonly limit the variation in industry, group size, and age factors as well. Using spreadsheet or database functions, an actuary can determine the minimum and maximum factors in effect during the year, and whether the spread of the factors is within the range allowed by the state.
5. The rating formula would be applied to the (verified) rating factors, to ensure that the calculated premium is equal to the premium actually charged.

Because it tests each factor at the individual testing level, this is the strictest method. It is possible that a group's rates could be in compliance even though it fails an individual test. For companies with large blocks of business, well-established rating practices, and/or rating formulas that vary by policy form (or any other variable), the following methods may prove to be more practical.

**Method 2: Seriatim Testing of the Rating Manual, with a Sampling of Rating Formula Accuracy**

In situations with a well-established rating procedure (an automated rate engine that has been in place

for several years, for example), it is not necessary (and often impractical) for the actuary to test every factor, on every individual, in every month.

In these situations, the actuary will assume that the correct information is being passed from the rate manual to the rate calculation, and use the rating manual to test whether the factors are (a) allowable, (b) permitted, and (c) within the allowable ranges for the state.

Even with a verification of the rating factors in the rate manual, the actuary still needs to test that the factors are being passed correctly from the rate manual to the rating engine, and that the rating formula is being correctly calculated for the premium that is being charged. For this verification, sampling is appropriate. Depending on the actuary's confidence in the system, a small number of cases may be used, if those cases are a representative cross-sample of the business being tested.

### **Method 3: Aggregate Testing of the Rating Factors and Rating Formula**

Another testing methodology can be used in situations when the carrier has a system that does not lend itself to seriatim testing, either because factors are combined for limit purposes, or because the carrier does not store premium detail at the individual level. A testing method has been developed to address such a situation, provided that the carrier can provide the group's current rate and the new business rate for the group's current case characteristics and benefit plan.

Like Method 2, this method assumes that the certifying actuary has already verified that the carrier is applying reasonable rating factors in a consistent manner to all groups in the class. This can be programmed and then listings of actual and new business rates for the group's demographics can be compared and ratioed to a normalized rate from which the index rate and then index ratios can be determined. A step-by-step description follows.

1. For each group, the carrier needs to provide the following rate data:
  - a. The current year's actual rate for the group; and
  - b. The current year's new business rate on the group's date of rate renewal.
2. Sort cases together by rate renewal month (or by whatever rating periods are used).
3. For each rating period, calculate the ratio of the actual group rate charged to the corresponding applicable new business rate. This ratio automatically normalizes each rate charged for applicable case and benefit characteristics and, therefore, puts each case on a comparable basis with all the other cases being renewed for that period. This methodology is reasonable only if the case and benefit characteristics factors of the new business rates are consistent between plans. But this consistency is a requirement of the small group laws.
4. If the lowest rate that theoretically could be charged (i.e., the base rate) can be determined directly from the new business rating manual, the index rate can be calculated as the average of the lowest and the highest allowed health status adjustment factors. For example, if the lowest allowed rate in the rating manual equals 90 percent of the standard manual new business rate and the highest allowed rate is 66 percent higher than the base rate, the index rate (ratio) will be:

$$[.90 + (.90 \times 1.66)] \div 2 = 1.197.$$

If for some reason the base rate cannot be directly determined from the rating manual (e.g., multiple rate tables are used instead of a unified rate manual), the index rate for each renewal month can be calculated as the arithmetic average of the minimum and maximum "ratios" for that renewal month calculated in Step 3.

In the latter case, if there are serious compliance problems, certain outlier case ratios could distort the calculation of the index rate and may need to be excluded from the calculation. These outlier cases are not to be excluded from the analysis of compliance, but only from the determination of the index rate.

5. Divide each group's ratio calculated in Step 3 by the Index Ratio.
6. Any case whose ratio is more than 25 percent from the index rate (i.e., ratios in step 5 greater than 1.25 or less than .75) should be tagged for possible non-compliance. For states with test criteria different than 25 percent, the appropriate percentage should be used.
7. The rates for those groups that are tagged for possible non-compliance should then be reviewed thoroughly to see if there is a plausible and acceptable explanation for the deviation.

As stated above, this methodology can easily process large blocks of business and easily identify any groups with rates out of compliance. It does have certain limitations of which the actuary needs to be aware, particularly in regarding census and benefit changes that may not immediately be reflected in the rates when composite rating methods are used.

#### **Method 4: Sampling of Cases**

In cases where a company's data is too incomplete for any of the prior methods, or there are too many rating manuals to make an adequate comparison across policy forms, an actuary may need to resort to sampling. With the improvements in data storage and computing power since the enactment of small group rating laws, it is expected that these situations would be rare.

Even when sampling is the most reasonable method of validation, the actuary may try to use some of the previously mentioned methods on sub-sets of the business being tested, to improve confidence.

Questions on the validity of sampling and the size of samples needed for validation are addressed elsewhere in this document.

#### **Community Rates**

Several states have various levels of community rating. All community rating requires that groups with the same case characteristics, benefit plan, and effective or renewal date have identical rates. Some states also restrict the case characteristics that the carrier can use in establishing rates or restrict the range in values of these case characteristic rating factors.

To test for compliance in a community rating state, the actuary can use methods similar to those described above for other states. The actuary would likely test that the allowed rating factors comply and that there are no rate differences among groups with the same benefit plan, rate effective date, and allowed case characteristics.

For example, if a community rating state allows age factors and group size factors within a maximum range, the actuary will perform the testing or sampling methods described above to check that the age and size factors are within the allowed range. The implicit assumption in using the testing methods is that all the rates of all groups must be the index rates; that is, the permitted rate tolerance around the index rate is zero percent.

### **Q17b. What methods are typically used to test compliance between classes of business?**

**A17b.** When testing compliance between classes of business, an actuary is testing to see if the index rate for any class of business does not exceed the index rate for any other class of business by more than the prescribed percentage. The prescribed percentage will be defined by state regulation. For simplicity, this section will assume the prescribed percentage is 20 percent.

This section assumes that each class of business has already demonstrated compliance within each class. It also assumes that differences in benefits must be actuarially adjusted to assure equivalency before performing these tests.

#### **Method 1**

This method can be used only if all rating factors (age/gender, area, industry, group size, benefit relativity plan factors, etc.) and rating formulas are the same between the classes except for the manual rates to which these factors get applied. In this case, the actuary only needs to test that the difference in the manual rates between the classes is 20 percent or less.

Examples:

- a) Class 1 has a rate band of 0.75 to 1.25. Its index rate is \$100. Class 2 has a rate band of 0.75 to 1.25. Its index rate is \$115. The ratio of index rates is  $\$115/\$100 = 1.15$  which is less than 1.20, so the index test is met.
- b) Class 1 has a rate band of 0.80 to 1.20. Its index rate is \$80. Class 2 has a rate band of 0.80 to 1.20. Its index rate is \$100. The ratio of index rates is  $\$100/\$80 = 1.25$  which is greater than 1.20, so the index test is not met.
- c) Class 1 has a rate band of 1.00 to 1.67. Its index rate is \$153.53. Class 2 has a rate band of .90 to 1.50. Its index rate is \$150. The ratio of index rates is  $\$153.53/\$150 = 1.02$  which is less than 1.20, so the index test is met.

#### **Method 2**

If there are differences in the rating factors or rating formulas used between classes of business, then the carrier needs to test to ensure that any combination of rating factors in one class of business does not exceed that same combination of rating factors in any other class of business by more than the allowed ratio. A group-by-group test can be done to test compliance. Let's assume there are two classes of business: Class 1 and Class 2.

1. Take each group that was rated in Class 1 and rerate it using the rating factors in Class 2.
2. For each group, divide the greater premium calculated by the lower premium for the group for the two classes.
3. Now take each group in Class 2 and rerate it using the rating factors in Class 1.
4. For each group, divide the greater premium calculated by the lower premium for the group for the two classes.
5. The index test is passed as long as all the ratios for both sets of groups is less than or equal to 1.20. If technology does not allow all groups to be tested, then sampling should be considered.

**Q17c. What methods are typically used to test compliance of rate increases?**

**A17c.** The third test that the actuary is usually required to conduct in order to certify that a carrier's rates are in compliance with small group laws is the "rate increase test." This test is conducted to verify that the renewal rates charged to a small employer do not exceed the "sum of:

1. **BASE CHANGE:** The percentage change in the new business rate during the rating period. When a block is closed, this is the percentage change in the base premium rate.
2. **EXPERIENCE CHANGE:** An adjustment, generally not to exceed 15 percent, due to claim experience, health status, or duration of coverage.
3. **DEMOGRAPHIC CHANGE:** An adjustment due to change in coverage or the change in case characteristics of the small employer."

Methods for conducting this test can vary and, like the "within class" tests, are dependent upon the rating methodology used by the carrier and the data available to the actuary for testing.

**Method 1: Health Status Factor Comparison**

This method assumes that a single rate manual is used for all groups and that a "health status" factor is applied to each group in the rating formula and that all other rating factors are based upon "allowable case characteristics." It is presumed that the reasonableness of these allowable rating factors have already been verified as part of the "within class" testing process. The rate increase test is simply looking at the ratio of the health status factor used for the testing period to that of the prior year. If the difference is less than 15 percent (or the ratio is less than 1.15 if a multiplicative approach is used by the carrier) then the rate increase test has been satisfied. If it exceeds 15 percent (or 1.15), the actuary should then verify that there are no extenuating circumstances related to the group or the data before concluding the rate is out of compliance.



The actuary should also verify that the rates have been generated from the rate manual correctly by manually checking a representative sample of cases. This method is generally only valid if the actuary has a high level of confidence that the rates are accurately generated from the rating manual.

### **Method 2: NAIC Model Regulation Method**

The second method is based upon the original NAIC “Model Regulation to Implement the Small Employer Health Insurance Availability Model Act.” The rate for each group is compared to the following:

1. The base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period);
2. Multiplied by 1 + the lesser of (i) the change in the base rate or (ii) the percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new groups;
3. Multiplied by 1 + the sum of the risk load applicable to the small employer during the previous rating period and 15 percent (or the percentage for the particular state).

If the group’s rate is less than or equal to the calculated test rate, compliance is satisfied.

In many cases, this can be simplified to comparing the group’s rate to the applicable new business rate for a group with the same demographic composition and plan design multiplied by the factor in step 3 above. This method requires the carrier to track the historical risk loads for each group and to be able to calculate a corresponding new business rate (base rate) for the group being tested.

### **Method 3: Detailed Seriatim Testing**

The third method is a detailed seriatim testing procedure.

1. This method consists of adjusting the rates used for each group from the year prior to the testing period to reflect any changes in the group’s demographics and benefit design for that underlying the rates used during the testing period. This requires that the actuary has access to such data and the ability to calculate the restated rates. For groups in which there were no benefit changes or in which the demographic factors would not have changed (e.g. no one aged from one band to the next), the rates would be identical to those used in that prior period (this is likely to be rare due to the aging of the group and the high turnover rates for small employers).
2. Once the prior year rates have been adjusted, the ratio of the testing period rates to the prior year rates is calculated.
3. This ratio needs to be modified for the test by backing out the change in the new business rates that occurred from the prior period to the testing period. The change in the new business rate, if consistent for all groups, may be a known factor and can then simply be subtracted from the ratio calculated. If the new business rate change varied by any case characteristic, a new business rate would need to be calculated based upon the demographics and benefit design of each group for

both the testing period and the prior period. The ratio of these rates reflects the change in the new business rate and would be subtracted from the ratio calculated in step 2.

4. If the resulting ratio minus 1 is less than or equal to 15 percent, the test has been satisfied.

#### **Method 4: Seriatim Ratio Method**

Another testing methodology is analogous to Method 3 for testing “within class” compliance. If Method 3 is used for “within class” testing, this method would likely be the preferred choice for the “rate increase” test. It is also similar to the “rate increase test” Method 3 above, but uses a normalization ratio approach instead of a premium dollar comparison.

This method assumes that the certifying actuary has already verified that the carrier is applying reasonable rating factors in a consistent manner to all groups in the class.

1. For each group, the carrier needs to provide the following rate data:
  - a. The previous year’s actual rates for the group, adjusted for the testing period year’s census and plan design; and
  - b. The previous year’s new business rate for the most similar benefit design available at the group’s date of rate renewal using the group’s testing period census;
  - c. The current year’s actual rate for the group;
  - d. The current year’s new business rate on the group’s date of rate renewal for the most similar plan design.
2. Sort cases together by rate renewal month (or by whatever rating periods are used).
3. For each rating period, calculate the ratio of the actual group rate charged to the corresponding applicable new business rate [ $r_t = g_t / n_t$ ]. This ratio automatically normalizes each rate charged for applicable case and benefit characteristics and, therefore, puts each case on a comparable basis with the prior period ratio.
4. Calculate the difference  $r = r_t - r_{t-1}$  (or for a multiplicative approach a ratio of ratios  $r = r_t / r_{t-1} - 1$ ). If  $r \leq 15$  percent, the rate is in compliance with the rate increase test. The 15 percent would be replaced by the appropriate percentage for states using different maximums.

This methodology can easily process large blocks of business and easily identify any groups with rates out of compliance. It does have certain limitations of which the actuary needs to be aware, particularly regarding census and benefit changes that may not immediately be reflected in the rates when composite rating methods are used.

As discussed earlier, small group laws use “additive” language to describe the requirements of complying with this test, but some actuaries use a “multiplicative” approach to do their testing. For Methods 3 and 4, this description assumes a combination of the additive and multiplicative interpretation. It can be easily adapted to an all multiplicative approach, but not to a pure additive

approach since the handling of the change in group demographics and benefit design is intrinsically multiplicative.

**Q18. May a sample be tested to demonstrate compliance? If so, how may the sample be determined?**

**A18.** Sampling is not the preferred method of testing if the actuary is able to test all small groups using a seriatim method and high speed information technology. However, in situations where a seriatim review is not practical or where the actuary believes that sampling would yield a nearly equivalent result, a sample may be tested to demonstrate compliance.

When a sample is used to demonstrate compliance, the actuary should first determine if the particular state's certification requirements mandate a specific sample size or sampling method. If so, the actuary should use this method. In any event, the actuary should choose a method that is unbiased and fairly represents the range of rating and business practices employed by and the groups insured by the carrier.

Both random and non-random sampling techniques may be appropriate to use. When choosing a sampling technique, the actuary should consider the rating and business practices of the carrier. A random sample generally produces a better representation of the entire population, but a nonrandom sample may be more appropriate if the actuary can determine specific groupings of cases that are more likely to represent problems.

The appropriate sample size will vary, depending on the size of the class of business and the rating practices of the small employer carrier. The actuary usually attempts to determine a sample size that fairly represents the total book of business of the carrier in the state and that adequately demonstrates complete compliance with the state's small group rating regulations.

Advanced statistical sampling techniques may be employed to determine the minimum sample size necessary to represent the block of business for a given set of criteria. However, the actuary may find that a more subjective determination, based on an analysis of the rating practices of the carrier, may yield a more meaningful sample size for the demonstration.

The actuary will generally document the methods used to select the samples, along with an appropriate statement describing the rationale for choosing the method. The actuary generally should also keep detailed records of the samples chosen.

**Q19. What should the actuary do if the sample yields groups that are non-compliant?**

**A19.** If a sample yields one or more groups that are non-compliant, then the actuary would usually note the non-compliant groups and review with the carrier the reasons that the groups were non-compliant. If there are only a few such groups, and if, upon review with the carrier, the non-compliance was only the result of random and unintended calculation errors, rather than the rating methods, factors, and practices themselves being out of compliance, then the actuary should still be able to render a qualified opinion of compliance. In that case, the actuary would typically note in the report the non-compliant groups found, the results of the review of the problems with the carrier, and the actions planned or taken by the carrier

to remedy the errors. The actuary may want to test a second sample of groups before rendering a qualified opinion of compliance.

If the actuary finds a statistically significant number of non-compliant groups in the sample, due to calculation errors rather than the rating methods, factors, and practices themselves being out of compliance, the non-compliance may be indicative of the carrier's systematic problems. In this case, the actuary should consider whether rendering an opinion of non-compliance, rather than simply a qualified opinion, is warranted. The actuary should consider testing a second sample of groups, either random or targeted to situations where the actuary found a particular concentration of non-compliant groups in the first sample. If problems are still evident in the second sample, the actuary should consider conducting a seriatim review of all or parts of the carrier's block of business. Factors that the actuary may consider are the frequency and magnitude of the errors and whether the carrier has controls in place to check for errors. The actuary's report should include the results of the review of the problems with the carrier and the actions planned or taken by the carrier to remedy the errors.

**Q20. What happens when you find a group out of compliance?**

**A20.** When an actuary finds that a group or a number of groups are out of compliance, the actuary should qualify their certification to disclose that fact. It might be stated that the "small employer carrier is in compliance with the rating requirements contained in the code except for the following exceptions:" The exceptions would then be listed with details of the non-compliance and the plan to correct the problem.

If the actuary finds groups that are non-compliant as a result of non-compliant rating methods, factors, or practices, then the actuary will typically render an opinion of non-compliance or a write a qualified report.

**Q21. What statements does the certification include if rates, rating factors, or rating methodologies are not in compliance?**

**A21.** If the actuary determines that the company's rates, rating factors, or rating methodologies do not comply with a state's statutory requirements, the actuary should report the noncompliance in a qualified opinion report. The actuary would usually describe the area of noncompliance, the number of policies affected, and any actions that are being taken to bring the carrier into compliance.

A statement such as the following might be used to provide this disclosure:

In the course of my review of the compliance of the rates and rating methodology of [insert company name], I discovered that [insert company name]'s rates (or rating factors) do not appear to comply with the statutory requirements of [name of state] in the following ways:

(An explanation of the areas in which the rates and/or rating factors do not comply with statutory requirements would follow.)

**Q22. What statements are made by the actuary about corrections of rates or factors not in compliance?**

**A22.** When writing a qualified certification, the actuary would typically include any actions that have

been or will be taken to bring the carrier into compliance. If such remedial actions were already implemented during the testing period, they may not need to be reported, subject to the judgment of the certifying actuary. If the remedial actions took place after the close of the testing period, but before the testing was done, these would likely be noted in the report with the statement that the corrections had already been implemented before testing began.

A statement such as the following might be used:

\_\_\_\_\_ has already taken corrective actions to remedy the noncompliance of its rates as described above. Such actions include the refund of premiums to policyholders whose rates exceeded the maximum allowable rates under [identify statutory requirement]. In addition, rates (or rating factors) have been adjusted as of (date) so that they now comply with the statutory requirements.

**Q23. What testing should be done if the actuary is required to attest to the rates being actuarially sound?**

**A23.** Some states require the actuary to attest to the soundness of the rates charged. This should be relatively straight forward if the actuary attesting is the same actuary who derived the rates. In that case, the methods and assumptions used would be known. But if the actuary signing the certification is required to certify to the soundness of the rates when he/she did not participate in their determination, a review of the pricing methods and assumptions and plan experience may be in order. Rates should be such that they are not inadequate or excessive, and premiums should be reasonable in relationship to the benefits covered. If the actuary relies on the certification made as part of a recent rate filing, that fact should be disclosed.

**Q24. To what period does the certification apply?**

**A24.** The certification should apply to the time period specified in the applicable regulatory requirements. In the absence of any specification in such regulatory requirements, the actuary generally certifies to the prior calendar year. In any event, the actuary should explicitly state the time period to which the certification applies.

**Q25. What documentation is retained to substantiate the certification?**

**A25.** The actuary should consider retaining all materials reviewed to determine compliance. Documentation should match the certifications requirements of the particular state. Materials typically retained may include:

1. A description of classes of business.
2. A description of benefit plans currently available and/or in force for each class.
3. A listing or description of the groups in each class.
4. A description of the methods used to develop rate manuals.

5. A description of the method used to develop rates for any specific group, including case characteristics used (both allowable and non-allowable) and methods used to adjust rates due to claims experience, health status, or duration of coverage. This should include both new business and renewal rates.
6. Actual rate manuals and rating factors. Documentation generally is sufficiently complete to calculate the rates for any group whose case characteristics and other rating variables are known.
7. Descriptions, for each class of business, of the rating periods used, the new business rates, the base premium rates, and the corresponding highest premium rates.
8. A written demonstration of compliance.
9. Demonstration of compliance for all groups tested.
10. Copies of relevant statutes and regulations on which compliance is based.
11. Calculation and evidence of any policyholder refunds or corrective actions.
12. Evidence of communication of changes to correct any systemic instances of noncompliance (such as system requests or underwriting training).

**Q26. What disclosures may be made when business practices not directly related to premium rates are likely to result in noncompliance?**

**A26.** This practice note has addressed certification considerations related to premium rates. The small group laws in some states require a certification broader than just opining on premium rates. There are two general situations that may be applicable to this question:

1. The small group law of the state requires the actuary to opine on more than just the compliance of the premium rates used by the carrier, and the review uncovers compliance issues related to other areas (e.g., underwriting or fair marketing issues) to be addressed by the certification.

In this case the actuary is required by the law to review compliance for these non-rating areas and address the findings in the certification. If the actuary does not feel competent to make such judgments regarding non-actuarial issues, a qualifying statement regarding the limited scope of the certification will need to be clearly made in the certification. Section 4.1 of ASOP No. 26 regarding the content of the certification requires a listing of the practices that are covered by the certification. Precept 8 of the American Academy of Actuaries Code of Professional Conduct and ASOP No. 41 require clear communication that will not mislead the reader to conclude that the actuary is certifying to all requirements of the law.

In those situations in which the actuary limits the scope of the review to a premium rate certification, he or she might require an affidavit or reliance letter from the carrier's appropriate officer regarding

compliance with the law in those areas that the actuary is not addressing.

2. The small group law does not explicitly require that the actuary opine on the compliance of a specific area governed by the state's small group law (e.g., underwriting or fair marketing requirements), but during the course of the review the actuary identifies that there are compliance deficiencies.

In this situation the actuary needs to use judgment as to the course of action to take. The actuary does not need to disclose the findings in the certification if they are beyond the scope of the review and the requirements of the law for the certification. The requirements of confidentiality (Precept 9 of the Academy's Code of Professional Conduct) need to be weighed against any legal requirement that may require disclosure, perhaps outside of the certification. In any case, the actuary should bring the finding of non-compliance to the attention of appropriate company management and properly document such communication.

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

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Section 1. Short Title

This Act shall be known and may be cited as the Small Employer Health 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.
  - (1) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, [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.
  - (2) "Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:
    - (a) The carrier files on or before March 1 of each year a certification with the commissioner that contains the statement and information described in Subparagraph (b).
    - (b) The certification required in Subparagraph (a) shall contain the following:
      - (i) A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital

or medical expense insurance or major medical expense insurance.

- (ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this state.
  - (c) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after the effective date of the Act, the carrier files with the commissioner the information and statement required in Subparagraph (b) at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state.
- 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.

- E.
  - (1) A Taft Hartley trust, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Section 6A with respect to a health benefit plan provided to the trust.
  - (2) The commissioner may grant such a waiver if the commissioner finds that application of Section 6A with respect to the trust would:
    - (a) Have a substantial adverse effect on the participants and beneficiaries of such trust; and
    - (b) Require significant modifications to one or more collective bargaining arrangement under which the trust is established or maintained.
  - (3) A waiver granted under this section shall not apply to an individual if the person participates in such a trust as an associate member of an employee organization.

#### 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 1E 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 contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision,



provided that the restriction of benefits to network providers results in substantial differences in claim 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 small employer carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan 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 more than ninety (90) days prior to the effective date of new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. 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) Except as permitted under Paragraphs (1) and (3), a small employer carrier shall not modify a 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 or benefits for specific diseases, medical conditions or services otherwise covered by the 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) Within thirty (30) days after the plan of operation is approved by the commissioner under Section 11, each small employer carrier shall notify the commissioner 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 as application process for small employer carrier seeking to change their status under this subsection. In the case of a small employer carrier that has been acquired by another such carrier, the commissioner may waive or modify the time periods established in Paragraph (2).

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) members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the commissioner.

Drafting Note: The commissioner should consider the appropriateness of appointing risk-assuming carriers



to the board of the reinsurance program. The potential for conflict of interest as well as the type and scope of powers given to the board should be considered.

- (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;
  - (5) Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers through capitation or salary; and
  - (6) 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.
- (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 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 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. Restoration of Terminated Coverage

The commissioner may promulgate regulations to require small employer carriers, as a condition of transacting business with small employers in this state after the effective date of this Act, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after [insert date 6 months prior to the date of enactment]. The commissioner may prescribe such terms for the reissue of coverage as the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

#### Section 19. Effective Date

The Act shall be effective on [insert date].

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

1992 Proc. I 86, 94-95, 912-913, 921, 937-951 (adopted).

1993 Proc. I 8, 136, 819, 909, 912-914 (amended).