

SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this Act is to standardize and simplify the terms and coverages, to facilitate public understanding and comparison, to eliminate provisions that may be misleading or unreasonably confusing in connection either with the purchase of these coverages or with the settlement of claims and to provide for full disclosure in the sale of supplementary and short-term health insurance, as defined in this Act.

Section 2. Applicability and Scope

- A. This Act shall apply to individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity insurance, accident only, specified accident, specified disease, limited benefit health, and disability income protection, referred to collectively in Section 1 of this Act and hereafter, as “supplementary health insurance.” This Act also applies to short-term, limited-duration health insurance coverage, which, unless otherwise specified, is included in the definition of “short-term health insurance” under this Act.

Drafting Note: Subsection A includes short-term, limited-duration health insurance within the scope of this Act. Although, short-term, limited-duration health insurance is not an “excepted benefit,” as the other listed coverages, short-term, limited-duration coverage has been included in this Act because it is not considered individual health insurance under federal law and, as such, is not subject to the individual market reforms under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the federal Affordable Care Act (ACA).

Drafting Note: The term “individual” as used in this Act corresponds to its use in the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180), thus extending the coverage of the Act to “family” policies. The term “group” as used in this Act corresponds to its use in the NAIC *Group Health Insurance Standards Model Act* (#100).

Drafting Note: States should be aware that generally, Section 1251 of the ACA exempts coverage from most reforms in Subtitles A and C of Title 1 of the ACA if the coverage was in force as of March 23, 2010, the date on which the ACA was signed into law, and the terms of coverage have not materially changed. This coverage is known as “grandfathered health plan coverage.” However, Section 1251 of the ACA specifically applies certain provisions of the ACA from which such coverage would otherwise be exempt. Some of these provisions apply to all grandfathered health plans, while other provisions apply only to grandfathered group health insurance plans. To the extent provisions of the PHSa, ERISA and the Internal Revenue Code (IRC) do not apply as amended by the ACA to a grandfathered plan, the pre-ACA versions of those provisions will continue to apply. In general, grandfathered plans must also comply with all applicable state laws; the only express preemption provision in the ACA is the prohibition against states including grandfathered plans in the rating pool for non-grandfathered plans. The standards for grandfathered plans, including the requirements for maintaining grandfathered status, are found in the final regulations on grandfathered plans (26 CFR 54.9815-1251, 29 CFR 2590.715-1251 and 45 CFR 147.140), as published in the *Federal Register* Nov. 18, 2015 (80 FR 72191).

- B. This Act shall apply to limited scope dental coverage and limited scope vision coverage only as specified.
- C. This Act shall not apply to:
 - (1) Medicare supplement policies subject to [insert reference to state law equivalent to the NAIC *Medicare Supplement Insurance Minimum Standards Model Act* (#650)];
 - (2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* (#640)]; or

Drafting Note: The NAIC *Long-Term Care Insurance Model Act* (#640) defines long-term care insurance as a policy that provides coverage for not less than twelve months. If a state allows issuance of policies that provide benefits similar to long-term care insurance for a period of less than twelve months, then those policies should be considered limited long-term care insurance plans, and should be subject to the *Limited Long-Term Care Insurance Model Act* (#642) and the *Limited Long-Term Care Insurance Model Regulation* (#643).

- (3) TRICARE formerly known as the Civilian Health and Medical Program of the Uniformed Services (Chapter 55, title 10, of the United States Code) (CHAMPUS) supplement insurance policies.

Drafting Note: TRICARE supplement insurance is not subject to federal regulation. TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to TRICARE benefits. In general, states regulate TRICARE supplement insurance policies under the state group or individual insurance laws.

Section 3. Definitions

- A. “Certificate” means a statement of the coverage and provisions of a policy of group supplementary and short-term health insurance, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.
- B. “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.

- C. “Direct response solicitation” means a communication through a sponsoring or endorsing entity or individually through mail, telephone, the internet or other mass communication media.
- D. “Form” means policies, certificates, contracts, riders, endorsements and applications as provided in [insert reference to state law regarding the filing and approval of supplementary and short-term health insurance policy forms].

Drafting Note: This definition may be unnecessary if the term “form” is appropriately defined elsewhere, but it may be helpful to include it here with an appropriate cross-reference.

- E. “Hospital indemnity or other fixed indemnity insurance” refers to coverage that provides benefits on an independent, non-coordinated basis and that pays a fixed amount for specified events without regard to other insurance.

Drafting Note: “Hospital indemnity or other fixed indemnity insurance” does not include any other type or category of insurance that is listed separately as an excepted benefit in Section 2791(c) of the federal Public Health Service Act (PHSA) (e.g., disability income protection coverage, specified disease coverage, etc.) regardless of whether benefits under such coverage are paid as a fixed dollar amount.

- F. “Limited scope dental coverage” means insurance that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.
- G. “Limited scope vision coverage” means insurance that provides coverage substantially all of which is for treatment of the eye, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.
- H. “Policy” means the entire contract between the insurer and the insured, including riders, endorsements and the application, if attached.
- I. “Short-term, limited-duration insurance” means health insurance coverage offered or provided within the state pursuant to a contract by a health carrier, regardless of the situs of the delivery of the contract, that has an expiration date specified in the contract that is less than [X days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier’s consent, has a duration no longer than [X days or months] after the original effective date of the contract.

Drafting Note: Subsection I does not include a potential maximum length of coverage for short-term, limited duration insurance. States have established different terms and durations of coverage for short-term, limited-duration insurance, if such coverage can be sold. Some states have prohibited the sale of such products, while others have set the maximum duration of coverage at less than 12 months, such as establishing a three-month maximum. In addition, some states provide that such coverage may not be renewed or extended beyond the established term, or have otherwise limited total duration, while other states have no such provisions regarding renewal or extension. The current federal regulations, which were effective Oct. 2, 2018, limit short-term, limited-duration insurance contracts to less than twelve months and, taking into account renewals or extensions, to a maximum duration of no longer than 36 months in total. States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans, including whether renewability or extension of such coverage is appropriate and consistent with federal law. States should also ensure that any other definitions of

short-term limited-duration insurance that are used in statutes that provide exemptions from otherwise applicable regulatory requirements are consistent with the definition used above in order to prevent gaps in regulatory authority.

- J. (1) “Supplementary and short-term health insurance” means insurance written under [insert reference to state law authorizing supplementary and short-term health insurance].
- (2) “Supplementary and short-term health insurance” does not include credit accident and sickness insurance.

Drafting Note: The phrase “supplementary and short-term health” should be replaced by “accident and disability,” “accident and health,” or other phrase appropriate under state law.

Section 4. Standards for Policy Provisions

- A. The commissioner shall issue regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of supplementary and short-term health insurance subject to this Act. The commissioner may issue additional regulations to establish specific standards for the sale of limited scope dental and limited scope vision coverage. This Act and any regulations issued pursuant to this Act shall be in addition to and in accordance with applicable laws of this state, including the [insert reference to state law equivalent to the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180)], which may cover, but shall not be limited to:
 - (1) Terms of renewability or extension of coverage;
 - (2) Initial and subsequent conditions of eligibility;
 - (3) Nonduplication of coverage provisions;
 - (4) Coverage of dependents;
 - (5) Preexisting conditions and pre-existing condition exclusions;
 - (6) Termination of insurance;
 - (7) Probationary periods;
 - (8) Limitations;
 - (9) Exceptions;
 - (10) Reductions;
 - (11) Elimination periods;
 - (12) Requirements for replacement;
 - (13) Recurrent conditions;
 - (14) The definition of terms, including but not limited to, the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, mental or nervous disorder, guaranteed renewable and noncancelable; and
 - (15) Any maximum duration of coverage.

Drafting Note: States may want to consider reviewing issues surrounding post-claims underwriting possibly using their state unfair practices law or regulation, or other appropriate state law or regulation, to address issues, such as policy rescissions in instances of fraud and intentional misrepresentation.

Drafting Note: This section authorizes the commissioner to establish specific standards to facilitate public understanding of policy provisions. The section does not alter the requirements of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (UPPL) (#180) or other specifically applicable state laws dealing with individual policy provisions. Regulations adopted under this section should be consistent with the UPPL and other applicable state laws relating to the subject matter. The phrase “including standards of full and fair disclosure” provides the commissioner authority to establish standards that ensure policy provisions are technically accurate, in clear language and make the significance of policy provisions fully understandable.

- B. The commissioner may issue regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to the policyholder, a person insured under the policy, or to a beneficiary of the policy.

Section 5. Minimum Standards for Benefits

- A. The commissioner shall issue regulations to establish minimum standards for benefits under specified categories of coverage of supplementary and short-term health insurance subject to this Act.
- B. The regulation shall set minimum standards for benefits for the following categories of supplementary coverage:
 - (1) Hospital indemnity or other fixed indemnity coverage;
 - (2) Disability income protection coverage;
 - (3) Accident only coverage;
 - (4) Specified disease coverage;
 - (5) Specified accident coverage; and

Drafting Note: “Specified disease coverage” or “specified accident coverage” refers to coverage that contains exclusions, limitations, reductions, or conditions that limit the payments of benefits under the policy or contract to a specified frequency and/or amounts. Examples of a specified disease or specified accident coverage would be a cancer only policy or an automobile accident only policy.

- (6) Limited benefit health coverage.
- C. The regulation shall set minimum standards for benefits for short-term coverage referred to hereafter as “short-term, limited duration health insurance coverage.”
- D. This section does not preclude the issuance of a policy or contract that combines two (2) or more of the categories of coverage enumerated in Subsection B or C.

Drafting Note: This subsection does not restrict reasonable combinations of the coverages in Subsection B and C. For example, accident only coverage may be issued in conjunction with other categories. However, the section does not permit the combination of specified disease or specified accident coverages with other categories of coverage unless specifically permitted by a regulation adopted pursuant to this Act. In addition, it should be noted that the combination of coverages might not qualify as “excepted benefits” under HIPAA, as amended by the ACA, thus making those combination policies subject to HIPAA requirements as amended by the ACA, and ACA requirements, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. States may want to consider developing regulations on combination products and the potential for such products to confuse consumers that the combination coverage is equivalent to comprehensive, major medical coverage.

- E. A policy or contract shall not be delivered or issued for delivery in this state that does not meet the prescribed minimum standards for the categories of coverage listed in Subsection B or C or does not meet the requirements set forth in [insert reference to state law authorizing the commissioner to disapprove policy forms if the benefits provided in the policy forms are unreasonable in relation to the premium charged].
- F. The commissioner shall prescribe the method of identification of policies, certificates and contracts based upon coverages provided.

Section 6. Disclosure Requirements

- A. An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of supplementary and short-term health insurance subject to this Act and limited scope dental coverage and limited scope vision coverage delivered or issued for delivery in this state.

- B. If the sale of a policy described in Subsection A occurs through an insurance producer, the outline of coverage shall be delivered to the applicant at the time of application or to the certificateholder at the time of enrollment.
- C. If the sale of a policy described in Subsection A occurs through direct response advertising, the outline of coverage shall be delivered no later than in conjunction with the issuance of the policy or delivery of the certificate.
- D. If the outline of coverage required in Subsections A and H, and any regulations issued by the commissioner pursuant to this Act, is not delivered at the time of application or enrollment, the advertising materials delivered to the applicant or enrollee shall contain all the information required in Subsection H and in any regulations issued by the commissioner pursuant to this Act.
- E. If the outline of coverage is delivered to the applicant or enrollee at the time of application or enrollment, the insurer shall collect an acknowledgment of receipt or certificate of delivery of the outline of coverage and the insurer shall maintain evidence of the delivery.
- F. If coverage is issued on a basis other than as applied for, an outline of coverage properly describing the coverage or contract actually issued shall be delivered with the policy or certificate to the applicant or enrollee.
- G. An insurer shall not be required to deliver an outline of coverage for group supplementary and short-term health insurance group limited scope dental coverage, and group limited scope vision coverage to individual members of the group if the certificate contains a brief description of:
 - (1) Benefits;
 - (2) Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits;
 - (3) Conditions under which the insurance coverage may terminate; and
 - (4) Notice requirements as provided in the regulation promulgated pursuant to this Act.

Drafting Note: Advertisements can fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage under Subsection H and in the regulation promulgated pursuant to this Act.

- H. The commissioner shall prescribe the format and content of the outline of coverage required by Subsection A. “Format” means style, arrangement and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. The outline of coverage shall include:
 - (1) A statement identifying the applicable category or categories of coverage as prescribed in Section 5 of this Act;
 - (2) A description of the principal benefits and coverage provided;
 - (3) A statement of the exceptions, reductions and limitations;
 - (4) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums; and
 - (5) A statement that the outline is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing policy provisions.

Drafting Note: Any possible conflict with Section 3A(1) of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180) can be avoided by enclosing and not attaching the outline at the time of policy or certificate delivery.

- I. An insurer shall deliver to persons eligible for Medicare notice required under [insert reference to state law equivalent to Section 17D of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651)].

- J. For supplementary health insurance providing hospital indemnity or other fixed indemnity coverage, an insurer shall display prominently in the application materials in connection with enrollment a notice providing information that this coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). The notice also shall provide information advising the consumer to check the policy to understand what the policy covers and does not cover (including exclusions related to pre-existing conditions and treatment limitations on health benefits outside the scope of coverage.) The notice shall also state that if coverage expires or eligibility for coverage under the policy is lost, the consumer may have to wait until an open enrollment period to obtain other health insurance coverage.

Drafting Note: States may have to alter the language in Subsection J or consider additional disclosures to reflect hybrid types of supplementary coverage subject to this Act.

- K. For short-term, limited-duration coverage, an insurer shall display prominently in the application materials provided in connection with enrollment a notice providing information that this coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). The notice also shall provide information advising the consumer to review and check the policy to understand what the policy covers and does not cover and the possibility that if coverage expires or eligibility for coverage under the policy is lost, the consumer may have to wait until an open enrollment period to obtain other health insurance coverage.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the language in Subsection K to ensure it accurately reflects a state's specific requirements. States also should be aware that federal regulations effective Oct. 2, 2018 (see *Federal Register*, Vol. 83, No. 150, p. 38243 for the changes to 45 CFR §144.103), include specific notice requirements for short-term, limited-duration coverage, and recognize that the notice also may need to contain additional information as required by applicable state law, rules, or guidance. A state also may need to require disclosure language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage. States also may have to consider including language to alert consumers to potential issues to consider prior to enrollment when the consumer is purchasing coverage under a policy using funds from a health reimbursement account (HRA).

Section 7. Preexisting Conditions

- A. Notwithstanding the provisions of [insert reference to state law equivalent to Section 3A(2)(b) of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180)], if an insurer elects to use a simplified application or enrollment form, with or without a question as to the prospective insured's health at the time of application or enrollment, but without any questions concerning the prospective insured's health history or medical treatment history, the policy shall cover any loss occurring after twelve (12) months from any preexisting condition not specifically excluded from coverage by terms of the policy, and except as so provided, the policy or certificate shall not include wording that would permit a defense based upon preexisting conditions.

Drafting Note: States that have specific requirements with respect to waivers, exclusionary riders or evidence of insurability for group insurance should modify Subsection A by deleting references to "enrollment" and adding a new subsection addressing the requirements.

- B. Notwithstanding the provisions of Subsection A and the provisions of [insert reference to state law equivalent to Section 3A(2)(b) of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law* (#180)] an insurer that issues a specified disease policy or certificate, regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form, may not deny a claim for any covered loss that begins after the policy or certificate has been in force for at least six (6) months, unless the loss results from a preexisting condition that first manifested itself within six (6) months prior to the effective date of the policy or certificate or was diagnosed by a physician at any time prior to that date. Except for rescission for misrepresentation, no other defenses based upon preexisting conditions are permitted.

Section 8. Administrative Procedures

The adoption of regulations pursuant to this Act shall be subject to the notice and hearing requirements set forth in [insert reference to state law relating to the adoption and promulgation of rules and regulations or state Administrative Procedures Act].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1974 Proc. I 12, 14, 405, 413, 414-418 (adopted).

1977 Proc. I 26, 28, 49-53, 317, 325 (amended and reprinted).

1979 Proc. I 44, 47, 373, 385, 394-396 (amended).

1980 Proc. II 22, 26, 588, 591, 594, 634 (amended).

1989 Proc. II 13, 23-24, 467-468, 518-519, 544-548 (amended to remove references to Medicare supplement insurance).

1998 Proc. 4th Quarter 16, 17, 652, 654, 655-660 (amended and reprinted).

2019 Proc. 1st Quarter (amended and title changed from Accident and Sickness Insurance Minimum Standards Model Act).