***Model Regulation to Implement the Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#171)**

Suggested Revisions to Sections 1-7

**(Assuming the proposed NAIC staff working draft revisions are accepted)**

Prior Comment Deadline Comments and July 2, 2021, Comment Deadline Comments

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| **Section 1. Purpose** | |
| **The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, to facilitate public understanding and comparison of coverage, to eliminate provisions that may be misleading or confusing in connection with the purchase of the coverages or with the settlement of claims and to provide for full disclosure in the marketing and sale of supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner’s jurisdiction over limited scope dental coverage and limited scope vision coverage, and to provide for disclosure in the sale of those coverages.** | |
| **Missouri Department of Insurance (MO DOI)** | The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, to facilitate public understanding and comparison of coverage, to eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims and to provide for full disclosure in the marketing and sale of supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner’s jurisdiction over limited scope dental coverage and limited scope vision coverage, and to provide for disclosure in the sale of those coverages. |
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| **Section 2. Authority** | |
| **This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* and any other appropriate section of law regarding authority of commissioner to issue regulations].** | |
| **No comments received** |  |
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| **Section 3. Applicability and Scope** | |
| **A. This regulation applies to all individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as “supplementary health insurance,” delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation also applies to short-term, limited-duration health insurance coverage delivered or issued for delivery in this state on and after [insert effective date], which, unless otherwise specified, is included in the definition of “short-term health insurance” under the Act.** | |
| **Blue Cross and Blue Shield Association (BCBSA)**  **NEW COMMENT** | A. This regulation applies to all individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as “supplementary health insurance,” delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation also applies to short-term, limited-duration health insurance delivered or issued for delivery in this state regardless of the situs of the delivery of the contract on and after [insert effective date], which, unless otherwise specified, is included in the definition of “short-term health insurance” under the Act.  B. For purposes of this regulation, “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 of no longer than [X days or months] after the original effective date of the contract.  **\*Have two definition sections: one for policy definitions, which is currently Section 5 and one for definitions for the model regulation (include a definition of STLDPs). A policy includes “certificate.” ????** |
| **MO DOI** | A. This regulation applies to all individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as “supplementary health insurance,” delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation applies to short-term, limited-duration health insurance coverage delivered or issued for delivery in this state on and after [insert effective date], which, unless otherwise specified, is included in the definition of “short-term health insurance” under the Act. |
| **Washington Insurance Department (WA DOI)** | A. This regulation applies to all individual and group insurance policies and certificates providing ?supplementary?” hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as “supplementary health insurance,” delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation also applies to short-term, limited-duration health insurance coverage delivered or issued for delivery in this state on and after [insert effective date], which, unless otherwise specified, is included in the definition of “short-term health insurance” under the Act. |
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| **B. This regulation shall apply to limited scope dental coverage and limited scope vision coverage only as specified.** | |
| **MO DOI** | B. This regulation applies to limited scope dental coverage and limited scope vision coverage only as specified. |
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| **C. This regulation shall not apply to:**  **(1) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act];**  **(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Act]; or**  **(3) TRICARE formerly known as 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. | |
| **Health Benefits Institute (HBI)**  **NEW COMMENT** | (4) Limited long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC Limited Long-Term Care Insurance Model Act] (**okay to add**) |
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| **D. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.** | |
| ***No comments received*** |  |
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| **Section 4. Effective Date** | |
| **This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation].** | |
| ***No comments received*** |  |
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| **Section 5. Policy Definitions** | |
| **A. Except as provided in this regulation, a supplementary or short-term health insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.**  **Except as provided in this regulation, to the extent these definitions are used in a policy or certificate, all policies subject to this regulation shall use definitions as provided in this section.**  Bob language from the end of the July 26 meeting for discussion during Aug. 9 meeting: (okay)  Except as provided in this regulation, to the extent these definitions are used in a policy or certificate, definitions used in a policy or certificate may vary from the definitions in this section, but not in a manner that restricts coverage. | |
| **BCBSA** | A. Except as provided in this regulation, a supplementary policy or short-term, limited-duration insurance (add **policy or certificate)** delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.  **Note: Moving forward look at any issues with using “certificate” and regulatory review. Also can address with the definition of STLDPs.** |
| **MO DOI** | A. A supplementary health insurance policy, short-term health insurance policy, limited scope dental policy or limited scope vision policy delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth below that comply with the requirements of this section. |
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| **B. “Convalescent nursing home,” “extended care facility,” or “skilled nursing facility” shall be defined in relation to its status, facility and available services.**  **(1) A definition of the home or facility shall not be more restrictive than one requiring that it: (a) Be operated pursuant to law; (b) Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested; (c) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (d) Provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and (e) Maintain a daily medical record of each patient.**  **(2) The definition of the home or facility may provide that the term shall not be inclusive of: (a) A home, facility or part of a home or facility used primarily for rest; (b) A home or facility for the aged or for the care of drug addicts or alcoholics; or (c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.**  **Drafting Note:** The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state law may be required in structuring this definition. | |
| **MO DOI** | \*\*\*\*\*  (2) The definition of the home or facility is permitted, but not required to exclude: (a) A home, facility or part of a home or facility used primarily for rest; (b) A home or facility for the aged or for the care of drug addicts or alcoholics; or (c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.  \*\*\*\*\* |
| **NAIC Consumer representatives** | B. “Convalescent nursing home,” “extended care facility,” “skilled nursing facility,” “assisted living facility,” or “continued care retirement community” shall be defined in relation to its status, facility and available services.  (1) A definition of the home or facility shall not be more restrictive than one requiring that it: (a) Be operated pursuant to law; (b) Be approved for payment of Medicare and/or Medicaid benefits or be qualified to receive approval for payment of Medicare and/or Medicaid benefits, if so requested; (c) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (d) Provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and (e) Maintain a daily medical record of each patient.  (2) The definition of the home or facility may provide that the term shall not be inclusive of: (a) A home, facility or part of a home or facility used primarily for rest; (b) A home or facility for the aged and/or for the care of individuals with a substance-related disorder; or (c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.  **Drafting Note:** The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state or federal Medicare or Medicaid law may be required in structuring this definition. |
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| **C. “Disability” or “disabled” shall be defined as due to injury or sickness.** | |
| **WA DOI** |  |
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| **D. “Hospital” may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission.**  **(1) The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital: (a) Be an institution licensed to operate as a hospital pursuant to law; (b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and (c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.**  **(2) The definition of the term “hospital” may state that the term shall not be inclusive of: (a) Convalescent homes or, convalescent, rest or nursing facilities;**  **(b) Facilities affording primarily custodial, educational or rehabilitory care; (c) Facilities for the aged, drug addicts or alcoholics; or (d) A military or veterans’ hospital, a soldiers’ home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services.**  **Drafting Note:** The laws of the states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition. | |
| **America’s Health Insurance Plans (AHIP)** | (e) Facilities existing primarily to provide psychiatric services. (DEFERRED) WILL RESEARCH WHY IN THE MINUTES |
| **MO DOI** | ACCEPTED\*\*\*\*\*  (2) The definition of the term “hospital” is permitted, but not required to exclude: (a) Convalescent homes or, convalescent, rest or nursing facilities; (b) Facilities affording primarily custodial, educational or rehabilitory care; (c) Facilities for the aged, drug addicts or alcoholics; or (d) A military or veterans’ hospital, a soldiers’ home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services.  \*\*\*\*\* |
| **NAIC Consumer representatives** | DID NOT ACCEPT  \*\*\*\*\*  (2) The definition of the term “hospital” may state that the term shall not be inclusive of: (a) Convalescent homes or, convalescent, rest or nursing facilities; (b) Facilities affording primarily custodial or educational services; or (c) A military or veterans’ hospital, a soldiers’ home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services.  \*\*\*\*\* |
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| **E. (1) “Injury” shall be defined as bodily injury resulting from an accident, independent of disease , which occurs while the coverage is in force.**  **(3) The definition shall not use words such as “external, violent, visible wounds” or similar words of characterization or description.**  **(4) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.**  **(5) The definition may provide that “injury” shall not include an injury for which benefits are provided under workers’ compensation, employers’ liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.** | |
| **MO DOI** | \*\*\*\*\*  \*\*\*\*\* |
| **WA DOI** | ?Should this be a definition of “accidental injury”??? |
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| **F. “Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.** | |
| **Maine DOI**  **NEW COMMENT** | **COMMENT: DOES THIS DEFINITION BELOW IN SECTION 5 BECAUSE IT IS AN ACTUAL DEFINITION:** F. “Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.  This definition will be included in the new definitions section. |
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| **G. “Mental or nervous disorder” shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.** | |
| **MO DOI (fix)** | G. “Mental or nervous disorder” means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor at the time the policy is issued.  \*\*If the policy uses some other term such as “mental health condition or substance use disorder” (look at transcript) for language for substantive or DN.  Look at MO170, Section 4A(14), which uses “mental or nervous disorder.” |
| **NAIC consumer representatives** | G. “Mental disease or disorder” shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease. |
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| **H. “Nurse” may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “nurse,” “trained nurse” or “registered nurse” are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.** | |
| **NAIC consumer representatives** | H. “Nurse” may be defined so that the description of nurse is restricted to a type of nurse, such as an advance practice nurse, registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “nurse,” “advance practice nurse,” “trained nurse” or “registered nurse” are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.  DN: States may want to consider if the functions of apn fall under this definition or the definition of “physician” in K. |
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| **I. “One period of confinement” means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.** | |
| **MO DOI** | Is this term used in the proposed revised model? Does not appear to be. If not, delete. |
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| **J. “Partial disability” shall be defined to meant that, due to a disability, an individual:**  **(1) Is unable to perform one or more but not all of the “major,” “important” or “essential” duties of the individual’s employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and**  **(2) Is in fact engaged in work for wage or profit.** | |
| **NAIC consumer representatives** | J. “Partial disability” shall be defined to meant that, due to a disability, an individual:  (1) Is unable to perform one or more but not all of the “major,” “important” or “essential” duties of the individual’s employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and  (2) Is in fact engaged in work for wage or profit, including compensation in the form of goods and services. |
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| **K. (1) “Physician” may be defined by including words such as “qualified physician” or “licensed physician.” The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider’s licensed authority and are provided pursuant to applicable laws.**  **(2) The definition or concept may exclude the insured, the owner, the assignee, any person related to the insured, owner or assignee by blood or marriage, any person who shares a significant business interest with the insured, owner or assignee, or any person who is a partner in a legally sanctioned domestic partnership or civil union with the insured, owner or assignee.**  **Drafting Note:** The laws of the states relating to the type of providers’ services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition. | |
| **WA DOI** | K. (1) “Physician” may be defined by including words such as “qualified physician” or “licensed physician.” The use of these terms requires an insurer to recognize and to accept, [**WHAT DOES THIS MEAN?]:** to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider’s licensed authority and are provided pursuant to applicable laws.  (2) The definition [**WHAT DOES THIS MEAN?]:**or concept may exclude the insured, the owner, the assignee, any person related to the insured, owner or assignee by blood or marriage, any person who shares a significant business interest with the insured, owner or assignee, or any person who is a partner in a legally sanctioned domestic partnership or civil union with the insured, owner or assignee. |
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| **L. “Preexisting condition” shall not be defined more restrictively than the following: “Preexisting condition means the a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person.”**  For supplementary coverage, remove prudent layperson and retain two-year. **2/14/22 Meeting**  **Drafting Note:** This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer’s established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured’s health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured’s health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above. | |
| **AHIP** | Suggest separate definitions for supplementary coverage and STLDPs **(Still under discussion, but leaning towards one definition.** |
| **MO DOI** | L. “Preexisting condition” shall not be defined more restrictively than the following: “Preexisting condition means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person.”  **Drafting Note:** This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer’s established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured’s health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured’s health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above. |
| **WA DOI** | L. “Preexisting condition” shall not be defined more restrictively than the following: “Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person.”  **Drafting Note:** This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer’s established standards and in accordance with state law. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured’s health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured’s health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above. |
| **NAIC consumer representatives**  **NEW COMMENTS** | L. “Preexisting condition” shall not be defined more restrictively (for the insured or prospective insured person) than the following: “Preexisting condition means a specified condition for which medical advice, diagnosis, care or treatment was recommended by a physician or received from a physician within a [6-] month period preceding the effective date of the coverage of the insured person.”  **Drafting Note:** This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer’s established standards and in accordance with state and federal law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition and/or deny payment of a claim related to a condition, the policy or certificate will be endorsed or amended by including the specific exclusion and giving notice to the prospective insured about the condition or conditions for which related claims will not be paid. This same requirement of notice to the prospective insured of the specific exclusion or exclusions will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured’s health. |
| **Maine DOI**  **NEW COMMENT** | **Comments:** L. “Preexisting condition” shall not be defined more ?broadly? than the following: “Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person.”  **HAS OTHER COMMENTS RELATED TO THE DEFINITION.** |
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| **M. “Residual disability” shall be defined in relation to the individual’s reduction in earnings and may be related either to the inability to perform some part of the “major,” “important” or “essential duties” of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term “residual disability,” the insurer may use “proportionate disability” or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.** | |
| **MO DOI** | M. “Residual disability” shall be defined in relation to the individual’s reduction in earnings and may be related either to the inability to perform some part of the “major,” “important” or “essential duties” of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. **(MOVE TO SUBSTANTIVE PROVISION IN THE MODEL?)** In lieu of the term “residual disability,” the insurer may use “proportionate disability” or a similar term that in the opinion of the commissioner adequately and fairly describes the benefit. |
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| **N. “Sickness” shall not be defined to be more restrictive than the following: “Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.” The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker’s compensation, occupational disease, employers’ liability or similar law.** | |
| **MO DOI** | N. “Sickness” shall not be defined to be more restrictive than the following: “Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. [A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.] **MOVE TO SUBSTANTIVE PROVISION IN THE MODEL?**” [The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker’s compensation, occupational disease, employers’ liability or similar law. **REWORD THIS SECTION TO MAKE IT MORE UNDERSTANDABLE?**] |
| **NAIC consumer representatives** | N. “Sickness” shall not be defined to be more restrictive than the following: “Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.” The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker’s compensation, occupational disease, employers’ liability or similar law.  **Drafting Note**: States should ensure the probationary period, if applicable, is provided concurrent with – and not in addition to – any preexisting exclusion period that may be applicable. |
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| O. “Total disability” (AS OF OCT. 31, 2022, SUBGROUP HAS NOT DISCUSSED) **(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.**  **(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual’s inability to: (a) Perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of his occupation”; or (b) Engage in a training or rehabilitation program.**  **(3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured’s immediate family.** | |
| **WA DOI** | O. “Total disability” (1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.  (2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual’s inability to: (a) Perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of his occupation”; or (b) Engage in a training or rehabilitation program. **NEEDS TO BE CLARIFIED.**  (3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured’s immediate family. |
| **NAIC consumer representatives** | O. “Total disability” (1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience.  (2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual’s inability to: (a) Perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of his occupation”; or (b) Engage in a training or rehabilitation program.  (3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured’s immediate family. |
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| **Additional Suggested Definitions (AS OF OCT. 31, 2022, SUBGROUP HAS NOT DISCUSSED)** | |
| **BCBSA** | ?. “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. |
| **Idaho Insurance Department (ID DOI)** | ?. “Usual and customary” means ?  or  ?. Reasonable and customary” means ?  ?. “Medically necessary” shall not be defined more restrictively than health care services and supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to an insured person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms that are:  (1) In accordance with generally accepted standards of medical practice;  (2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the insured person’s illness, injury or disease;  (3) Not primarily for the convenience of the insured person, physician or other health care provider; and  (4) Not more costly than an alternative service or sequence of services or supply, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the insured person’s illness, injury or disease. |
| **UnitedHealth Group** | **Add back in the definition of “accident” and define**:  “Accident” means an unintended or unforeseeable event or occurrence, which occurs on or after the policy effective date and for which benefits are not excluded in the General Exclusions and Limitations section. |
| **NAIC consumer representatives** | ?”Cancellation” or “cancel” means termination of a supplementary or short-term, limited-duration policy before the end of the coverage period under the plan.  ?. “Health care professional” means a physician, pharmacist, mental health professional, or other health care practitioner who is licensed, accredited or certified to perform specified health care services consistent with state law.  **Drafting Note**: States may wish to specify the health care professionals to whom this definition may apply (e.g., physicians, pharmacists, psychologists, nurse practitioners, etc.). This definition applies to individual health care professionals, not corporate “persons.”  ?. “Out-of-Pocket Maximum” or “out-of-pocket limit” means the most the insured individual or individuals must pay for covered services under the plan or policy during the coverage period. It is inclusive of all deductibles, copayments, coinsurance, and other out-of-pocket charges the carrier requires under the plan or policy.  ?. “Rescission” or “rescind” means the undoing or retroactive cancellation of a supplementary or short-term, limited duration health insurance plan. Rescission returns the carrier and the insured to the same positions as if the plan had never existed. |
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| **Section 6. Prohibited Policy Provisions (AS OF OCT 31, 2022, SUBGROUP HAS NOT DISCUSSED THIS SECTION)**  **A. Except as provided in Section 5L, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six-month exception shall not be applicable where the specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.** | |
| **NAIC consumer representatives** | Section 6. Prohibited Policy Provisions and Minimum Policy Standards  A. Except as provided in Section 5N (related to the definition of “pre-existing condition”), a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy. Accident policies, as well as short-term health insurance plans, shall not contain probationary or waiting periods.  A supplementary or short-term limited duration health insurance policy (including a policy issued by an association or other “group” arrangement) may not be issued, delivered, or used in the state to any individual unless it has been filed with and approved in writing by the Commissioner. The Commissioner may disapprove any policy that fails to meet minimum standards or if the benefit provided therein is unreasonable in relation to the premium charged. The Commissioner may revoke approval for cause. |
| **Maine DOI** | Section 6. Prohibited Policy Provisions  A. Except as provided in this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which coverage under the policy is excluded or restricted  (1) A policy, other than an accident policy, may exclude coverage for a loss due to a preexisting condition, as defined in compliance with Section 5\*\*, for a period not to exceed twelve (12) months following the issuance of the policy or certificate. The twelve-month limitation is not required if the condition was disclosed during the application or enrollment process and specifically excluded by the terms of the policy or certificate, or when the insured knowingly made a material misrepresentation during the application or enrollment process.  (2) A policy, other than an accident policy, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the reproductive organs, varicose veins, adenoids, appendix and tonsils, except when the specified diseases or conditions are treated on an emergency basis. |
| **Vermont DOI** | **Comments:**  **Does the Subgroup know why these specific conditions—hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils—listed in this subsection were selected?**  **The Department sees two alternative readings of this subsection, does the Subgroup have any insight into the intent of the drafting:**  A. Except as provided in Section 5K, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not  to exceed six (6) months for: 1. Specified diseases; 2. Conditions and losses resulting from disease; and 3. Condition related to hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils.  **OR**  A. Except as provided in Section 5K, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or conditions related to: 1. hernia, 2. disorder of reproduction organs, 3. varicose veins, 4. adenoids, 5. appendix and tonsils.  **The Department seeks to hear other states’ take on whether this language establishes a 6-month waiting period for specified diseases in general, or only those listed (e.g. hernia… tonsils).** |
| **Texas DOI** | **Comments: Consider limiting the permitted waiting period to plans that are guaranteed renewable. For example, it seems misleading in a STLD policy or a policy that can re-underwrite each year and renew only at the company’s option. (Such policies could instead simply exclude the coverage if they choose.)**  Section 6. Prohibited Policy Provisions  A. Except as provided in Section 5L, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six-month exception shall not be applicable where the specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods. |
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| **B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.**  **(2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.** | |
| **NAIC consumer representatives** |  |
| **HBI** | **Drafting Note:** Rarely, insurers may offer consumers policy dividends as a benefit. These provisions are common in life insurance policies. If policy dividends are available on policies covered by this regulation in your state, you should look to the treatment of dividends in life insurance. Generally, consumers should be allowed to take the policy dividend as a cash payment, but insurers may offer the consumer additional policy benefits in lieu of a cash payment at the option of the consumer. |
| **Texas DOI** | **Comments: I would be interested in better understanding this provision, its origins, and if it is still relevant.**  B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.  (2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional. |
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| **C. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.**  **Drafting Note:** Where the state has enacted the NAIC Supplementary and Short-Term Health Insurance Minimum Standard Act, Subsection C is unnecessary. States that have specific preexisting condition requirements for group supplemental insurance may need to modify the preceding subsection according to applicable statutes. This regulation shall apply to limited scope dental coverage and limited scope vision coverage only as specified. | |
| **Maine DOI** |  |
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| **D. A disability income protection policy may contain a “return of premium” or “cash value benefit” so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.**  **Drafting Note:** This provision is optional and the desirability of its use should be reviewed by the individual states. | |
| **AHIP** | D. A disability income protection policy may contain a “return of premium” or “cash value benefit” option so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.  **Drafting Note:** This provision is optional and the desirability of its use should be reviewed by the individual states. |
| **NAIC consumer representatives** | D. A disability income protection policy may contain a “return of premium” or “cash value benefit” so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or cancellation of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.  **Drafting Note:** This provision is optional and the desirability of its use should be reviewed by the individual states. |
| **Texas DOI** | **Comments:**  **Recommend clarifying that, except for STLD and limited scope dental and vision, the policies covered by this model cannot coordinate. As referenced in drafting notes to 7-B and 7-E, the coordination of benefits model excludes these types of coverage from the definition of a “plan,” which is permitted to coordinate. However, since the COB model does not technically apply to policies that are not “plans,” some carriers attempt to limit coverage to “excess only.”**  D. A disability income protection policy may contain a “return of premium” or “cash value benefit” so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.  **Drafting Note:** This provision is optional and the desirability of its use should be reviewed by the individual states. |
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| **E. Policies providing hospital confinement indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.** | |
| **Texas DOI** | **Comments:**  **Why is this provision limited to these types of policies? (Note that a policy could always exclude coverage for which the insured is not liable for a bill.) Consider broadening. For example: A policy may not require that a covered service be provided by a particular type of licensed facility or person, as long as the covered service is within the scope of the provider’s license.**  E. Policies providing hospital confinement indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government. |
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| **F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:**  **(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;**  **(2) Mental or emotional disorders, alcoholism and drug addiction;**  **(3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7C of this regulation;**  **(4) Illness, treatment or medical condition arising out of: (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; (b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; (c) Aviation; (d) With respect to short-term nonrenewable policies, interscholastic sports; and (e) With respect to disability income protection policies, incarceration.**  **Drafting Note:** What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.  **(5) Cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;**  **(6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;**  **(7) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;**  **Drafting Note:** States should examine any existing “freedom of choice” statutes that require reimbursement of treatment provided by chiropractors, and make adjustments if needed.  **(8) Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workmen’s compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person’s immediate family; and services for which no charge is normally made in the absence of insurance;**  **(9) Dental care or treatment;**  **(10) Eye glasses, hearing aids and examination for the prescription or fitting of them;**  **(11) Rest cures, custodial care, transportation and routine physical examinations; and**  **(12) Territorial limitations.**  **Drafting Note:** Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted. | |
| **American Council of Life Insurers (ACLI); AHIP** | F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:  (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;  (2) Mental or emotional disorders, alcoholism and drug addiction;  (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7C of this regulation;  (4) Illness, treatment or medical condition arising out of: (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; (b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; (c) Non-commercial or recreational aviation; (d) With respect to short-term nonrenewable policies, interscholastic sports; and (e) With respect to disability income protection policies, incarceration.  **Drafting Note:** What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.  \*\*\*\*\* |
| **NAIC consumer representatives** | F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:  (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;  (2) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7C of this regulation;  (3) Illness, treatment or medical condition arising out of: (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; (b) Aviation; and (c) With respect to short-term nonrenewable policies, interscholastic sports.  **Drafting Note:** What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.  (4) Cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease, to improve the function of a malformed body part, or anomaly of a covered dependent child that has resulted in a functional defect;  **Drafting Note:** Insurers are not required to cover cosmetic surgery, which includes surgical procedures solely directed at improving appearance. These exclusions do not apply to surgery in connection with treatment of severe burns, repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also services some cosmetic purpose (e.g., breast prostheses for reconstruction following mastectomy due to breast cancer).  (5) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;  (6) Chiropractic care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;  **Drafting Note:** States should examine any existing “freedom of choice” statutes that require reimbursement of treatment provided by chiropractors, and make adjustments if needed.  (7) Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workmen’s compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person’s immediate family; and services for which no charge is normally made in the absence of insurance;  (8) Dental care or treatment, except where the provision of dental services is medically necessary due to the underlying medical condition or clinical status of the covered person, including but not limited to, reconstructive surgery;  **Drafting Note:** In some cases, dental benefits are embedded in or are integral to a health benefit plan but are separately administered from the medical benefit of the health benefit plan. State insurance regulators should review this definition of “limited scope dental plan” to determine if exceptions from certain specified provisions of this regulation should be given to the plan in such situations.  (9) Eye glasses, hearing aids and examination for the prescription or fitting of them;  (10) Rest cures, custodial care and transportation; and  (11) Territorial limitations.  **Drafting Note:** Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted. |
| **Vermont DOI** | F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:  (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;  (2) Mental or emotional disorders, alcoholism and drug addiction;  **Drafting Note:** This provision is optional, and the desirability of its use should be reviewed by the individual states.  \*\*\*\*\* |
| **Texas DOI** | F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:  **Comments: Consider whether permitted exclusions for STLD should be consistent with other excepted benefits. Texas generally reviews for benefits consistent with major medical. For example, Texas mandates would not permit a STLD to exclude:**  **- Mental illness (including parity and any self-inflicted injury that is a result of a mental illness)**  **- Chemical dependency**  **- TMJ**  **- Hearing aids**  **- Preventive services**  (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;  (2) Mental or emotional disorders, alcoholism and drug addiction;  (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7C of this regulation;  **Comments: Consider striking (4)(a), since the service in the armed forces covers it. For example, are we intending to exclude victims of acts of war, such as injuries from a terrorist act?**  (4) Illness, treatment or medical condition arising out of: (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; (b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; (c) Aviation; (d) With respect to short-term nonrenewable policies, interscholastic sports; and (e) With respect to disability income protection policies, incarceration.  **Drafting Note:** What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.  (5) Cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;  (6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;  (7) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;  Drafting Note: States should examine any existing “freedom of choice” statutes that require reimbursement of treatment provided by chiropractors, and make adjustments if needed.  **Comments: Recommend removing the highlighted language.**  (8) Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workmen’s compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person’s immediate family; and services for which no charge is normally made in the absence of insurance;  **Comments: Consider whether to revised (9) to disallow excluding dental care pursuant to an accident.**  (9) Dental care or treatment;  (10) Eye glasses, hearing aids and examination for the prescription or fitting of them;  (11) Rest cures, custodial care, transportation and routine physical examinations; and  **Comments: Consider removing (12). Texas only permits territorial limits in a disability income policy.**  (12) Territorial limitations.  **Drafting Note:** Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted. |
| **HBI** | (13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease. |
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| **G. This regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.** | |
| **NAIC consumer representatives** |  |
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| **H. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 34B of the Supplementary and Short-Term Health Insurance Minimum Standards Act] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.** | |
| ***No comments received*** |  |
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| **Additional Suggested Provisions** | |
| **NAIC consumer representatives** | H. An out-of-pocket maximum or limit, when included in a supplementary or short-term, limited-duration plan, shall be inclusive of all deductibles, copayments, coinsurance, and other out-of-pocket charges that the insurer requires the insured to pay under the plan during the coverage period.  I. A supplementary or short-term, limited-duration health insurance plan may not be rescinded except for due to the insured’s commission of fraudulent acts as to the insurer or has intentionally misrepresented information pertinent to the insurer’s decision to issue the plan. If a plan is rescinded, the insurer shall refund to the insured all payments made by or on behalf of the insured prior to the rescission date or the expiration date. If a policy is rescinded, the insurer shall notify the insured in writing thirty (30) days prior to the rescission date.  J. (1) A supplementary or short-term health plan may not be cancelled by the insurer except for the following reasons: (a) Nonpayment of premium; (b) Violation of published policies of the insurer that the commissioner has approved; (c) the insured person committing fraudulent acts as to the insurer or a material breach of the medical plan; or (d) A change or implementation of federal or state laws that no longer permit the continued offering of the coverage.  (2) If a policy is to be cancelled, the insurer shall notify the insured in writing thirty (30) days prior to the cancellation date.  K. No oral or written misrepresentations made by an individual applying for coverage or on the individual’s behalf will be deemed material that allows the insurer to cancel or rescind the medical plan unless the misrepresentation or warranty is made with actual intent to deceive. |
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| **Section 7. Supplementary and Short-Term Health Insurance Minimum Standards for Benefits** | |
| **The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section 8H of this regulation.**  **This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in [cite state law equivalent to Section 5B and C of the NAIC Supplementary and Short-Term Health Insurance Minimum Standards Model Act].** | |
| **ACLI; AHIP** | The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. Supplementary health insurance [] delete? **Discuss next meeting 2/27/23??** shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section 8H of this regulation.  This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in [cite state law equivalent to Section 5B and C of the NAIC Supplementary and Short-Term Health Insurance Minimum Standards Model Act].  **Add a DN alerting states to the in re a certificate being issued (or delivered) understand what they do in re policies and certificates delivered outside the state??? Extraterritoriality issue**  **Did not agree to suggested revisions 2/13/23** |
| **Texas DOI** | **Comments: Consider clarifying that some combinations disqualify a product from being considered an excepted benefit. For example, adding sickness benefits to an accident-only policy will cause it to be reviewed as a major medical plan. It may be useful to add product definitions that capture the excepted benefit parameters.**  **Add a statement:**  **A policy that includes two or more categories of coverage must meet the minimum standards applicable to each type of coverage included.**  The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section 8H of this regulation.  This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in [cite state law equivalent to Section 5B and C of the NAIC Supplementary and Short-Term Health Insurance Minimum Standards Model Act]. |
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| **A. General Rules (AS OF OCT. 31, 2022, SUBGROUP HAS NOT DISCUSSED THIS SUBSECTION A)**  **(1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual supplementary or short-term health policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured’s death, the spouse of the insured, if covered under the policy, shall become the insured.**  **(2) (a) The terms “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A(1).**  **(b) The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual supplementary or short-term health policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.**  **(c) An individual supplementary or short-term health policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.**  **(d) Except as provided above, the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.**  **(3) In an individual supplementary or short-term health policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of “noncancellable” or “guaranteed renewable.” However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.**  **Drafting Note:** For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law, unless it is an excepted benefit as described in Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA, the ACA or applicable state law.  **(4) When accidental death and dismemberment coverage is part of the individual supplementary or short-term health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.**  **(5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.**  **(6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.**  **(7) Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.**  **(8) In individual supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child’s coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.**  **(9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.**  **(10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.**  **(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.**  **(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.**  **(13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.**  **(14) Termination of the policy shall be without prejudice of toto a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.**  **(15) A policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations.** | |
| **ACLI; AHIP** | A. General Rules  (1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual supplementary health policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured’s death, the spouse of the insured, if covered under the policy, shall become the insured. **Agreed to delete (1) and (2) 2/13/23**  (2) (a) The terms “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A(1).  (b) The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual supplementary health policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.  (c) An individual supplementary health policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.  (d) Except as provided above, the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.  (3) In an individual supplementary **okay to delete**health policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of “noncancellable” or “guaranteed renewable.” However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.  **Drafting Note:** For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law, unless it is an excepted benefit as described in Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA, the ACA or applicable state law.  **(**4) When accidental death and dismemberment coverage is part of the individual supplementary (**okay to delete**) health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.  (5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.  (6) Except for non-payment of premium, **(okay to delete**) in the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.  (7) Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.  (8) In individual supplementary (**keep the reference**)health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child’s coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.  (9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.  (10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.  (11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.  (12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.  (13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.  (14) Termination of the policy shall be without prejudice of toto a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.  (15) A policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations. |
| **NAIC consumer representatives**  **n** | A. General Rules  (1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual supplementary or short-term health policy shall not provide for cancellation of coverage of the spouse solely because of the occurrence of an event specified for cancellation of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured’s death, the spouse of the insured, if covered under the policy, shall become the insured. **Did not accept 2/13/23**  (2) (a) The terms “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A(1).  (b) The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual supplementary or short-term health policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.  **Continue here on Feb. 27 Meeting.**  **Eliminate the specific ages. Make similar to Subsection C – “at least until the individual has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits.”** ???  (c) Except as provided above, the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.  (3) In an individual supplementary or short-term health policy covering both adult members, the age of the younger person shall be used as the basis for meeting the age and durational requirements of the definitions of “noncancellable” or “guaranteed renewable.” However, this requirement shall not prevent cancellation of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger person to the age or for the durational period as specified in the policy.  **Drafting Note:** For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law, unless it is an excepted benefit as described in Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA, the ACA or applicable state law.  (4) When accidental death and dismemberment coverage is part of the individual supplementary or short-term health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.  (5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.  (6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.  (7) Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility after discharge from the hospital.  (8) In individual supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to intellectual or physical disability on the date that the child’s coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.  (9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.  (10) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.  (11) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.  (12) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage and in the disclosure materials required under section 8 of this regulation the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.  (13) Cancellation of the policy shall be without prejudice of toto a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.  (14) A policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations. |
| **Vermont DOI** | \*\*\*\*\*  (3) In an individual supplementary or short-term health policy covering the married couple or civil union couple, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of “noncancellable” or “guaranteed renewable.” However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.  **Drafting Note:** For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law, unless it is an excepted benefit as described in Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA, the ACA or applicable state law.  \*\*\*\*\*  (8) In individual supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to intellectual or physical disability on the date that the child’s coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.  \*\*\*\*\* |
| **Texas DOI** | **Comments:**  **1) Discuss expectations for renewability rights within a group policy, particularly with reference to member-only associations.**  **2) A policy must clearly state how benefits are paid, and whether the policy provides benefits on a fixed indemnity basis or on an expenses-incurred basis. A policy that limits benefits for medical expenses to a “usual and customary” amount must clearly state how the usual and customary amount is determined.**  **3) Consider expanding “spouse” to similarly protect other covered dependents.**  A. General Rules  (1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual supplementary or short-term health policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured’s death, the spouse of the insured, if covered under the policy, shall become the insured.  (2) (a) The terms “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A(1).  **Comments: Consider defining the rights presumed to attach to the right to continue or renew –**  **- No new underwriting**  **- Rates may increase only by class**  **- May not change which rating class the insured is assigned to**  **- Changes may only be made with signed acceptance of insured/policyholder, unless necessary to comply with state or federal law.**  (b) The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual supplementary or short-term health policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.  (c) An individual supplementary or short-term health policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.  (d) Except as provided above, the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.  **Comments: Consider expanding “spouse” to similarly protect other covered dependents.**  (3) In an individual supplementary or short-term health policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of “noncancellable” or “guaranteed renewable.” However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.  **Drafting Note:** For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law, unless it is an excepted benefit as described in Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA, the ACA or applicable state law.  **Comments: Recommend expanding to group.**  (4) When accidental death and dismemberment coverage is part of the individual supplementary or short-term health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.  **Comments: Do servicemember protections need to be expanded, consistent with 50 USC §4024?**  (5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.  (6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.  (7) Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.  **Comments: Recommend expanding to group.**  (8) In individual supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child’s coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.  (9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.  **Comments: Should (10) be moved to Subsection C, which covers disability income protection coverage?**  (10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.  **Comments: Consider expanding the time frames in (11). Depending on the nature of an injury, a loss (like an amputation) could occur later. Likewise, a disability may take longer than 30-days to become evident.**  (11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.  **Comments: Discussion needed in re (12). Is this in the context of a fixed AD&D benefit or a policy that covers expenses, like accident only?**  (12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.  **Comments: Should (12) and (13) be moved to Subsection D—accident-only coverage?**  (13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.  **Comments: Consider defining terms – policy period, benefit period in (14).**  (14) Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.  **Comments: Should (15) be broadened per the below?**  **“A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or include unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations.”**  (15) A policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations. |
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| **B. Hospital Confinement Indemnity or Other Fixed Indemnity Coverage (SEE SEPARATE DOCUMENT FOR REVISIONS TO THIS SUBSECTION B)**  **(1) “Hospital confinement indemnity or other fixed indemnity coverage” is a policy of supplementary health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy.**  **(2) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.**  **(3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.**  **Drafting Note:** Hospital confinement indemnity or other fixed indemnity coverage is recognized as supplemental coverage. Any hospital confinement indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital confinement indemnity or other fixed indemnity coverage. Section 3H(4) of the Coordination of Benefits Model Regulation states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts….” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital confinement indemnity or other fixed indemnity coverage purchased by the insured. | |
| **ACLI; AHIP** | B. Hospital Confinement Indemnity or Other Fixed Indemnity Coverage  (1) “Hospital confinement indemnity or other fixed indemnity coverage” is a policy of supplementary health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [X] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy.  \*\*\*\*\* |
| **NAIC consumer representatives** | B. Hospital Confinement Indemnity or Other Fixed Indemnity Coverage  (1) “Hospital confinement indemnity or other fixed indemnity coverage” is a policy of supplementary health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [X] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy.  (2) Coverage shall not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.  (3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.  **Drafting Note:** Hospital confinement indemnity or other fixed indemnity coverage is recognized as supplemental coverage. Any hospital confinement indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital confinement indemnity or other fixed indemnity coverage. Section 3H(4) of the Coordination of Benefits Model Regulation states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts….” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital confinement indemnity or other fixed indemnity coverage purchased by the insured. |
| **HBI** | B. Hospital Confinement Indemnity or Other Fixed Indemnity Coverage  (1) “Hospital confinement indemnity or other fixed indemnity coverage” is a policy of supplementary health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [$40] per day and not less than **[**thirty-one (31) days**]** during each period of confinement for each person insured under the policy.  (2) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.  (3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.  **Drafting Note:** Hospital confinement indemnity or other fixed indemnity coverage is recognized as supplemental coverage. Any hospital confinement indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital confinement indemnity or other fixed indemnity coverage. Section 3H(4) of the Coordination of Benefits Model Regulation states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts….” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital confinement indemnity or other fixed indemnity coverage purchased by the insured. |
| **Texas DOI** | **Comments: Create a separate section with minimum standards for other fixed indemnity coverage. Clarify that any policy that provides coverage on a fixed indemnity basis is also subject to minimum standards for coverage based on the nature of the benefits provided. For example, fixed indemnity accident-only or AD&D coverage, is also subject to minimum accident standards. Fixed indemnity specified disease coverage is subject to specified disease minimum standards. A policy that provides a per-service benefit for comprehensive accident and sickness may be subject to major medical coverage requirements.**  **Consider clarifying that a hospital indemnity and other fixed indemnity policies provide cash benefits that are not based on the specific services delivered. Since the benefit is a daily benefit and is not based on expenses incurred, a deductible should not apply within this type of plan. Instead, a short elimination period may apply, similar to a disability policy.**  B. Hospital Confinement Indemnity or Other Fixed Indemnity Coverage  (1) “Hospital confinement indemnity or other fixed indemnity coverage” is a policy of supplementary health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy.  (2) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.  (3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.  **Comments: Include a provision under Section 6 addressing that excepted benefits may not be “excess only” or otherwise condition benefits on other coverage.**  **Drafting Note:** Hospital confinement indemnity or other fixed indemnity coverage is recognized as supplemental coverage. Any hospital confinement indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital confinement indemnity or other fixed indemnity coverage. Section 3H(4) of the Coordination of Benefits Model Regulation states that the definition of a plan (for the purposes of coordination of benefits)…shall not include individual or family insurance contracts….” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital confinement indemnity or other fixed indemnity coverage purchased by the insured. |
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| **C. Disability Income Protection Coverage (SEE SEPARATE DOCUMENT FOR REVISIONS TO THIS SUBSECTION C)**  **“Disability income protection coverage” is a policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:**  **(1) Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62);**  **(2) Contains an elimination period no greater than: (a) Ninety (90) days in the case of a coverage providing a benefit of one year or less; (b) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or (c) Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;**  **(3) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period;**  **(4) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.** | |
| **AHIP** | \*\*\*\*\*  (3) Has a maximum period of time for which it is payable during disability of at least three (3) (ACCEPT?) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period;  \*\*\*\*\* |
| **NAIC consumer representatives** | C. Disability Income Protection Coverage (discussed 5/9/22)  “Disability income protection coverage” is a policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:  (1) Provides that periodic payments that are payable at ages after ***sixty-two (62)*** (WHAT AGE/WHY???) (when entitled to the full retirement benefit???) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62); (LEAVE UNCHANGED?) **GET COMMENTS ON THE AGE**.  (1) Contains an elimination period no greater than: (a) Thirty (30) days in the case of a coverage providing a benefit of one year or less; (b) Ninety (90) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or (c) One hundred and eighty (180) days in all other cases during the continuance of disability resulting from sickness or injury; (LEAVE UNCHANGED?) **GET COMMENTS ON THE ELIMNATION PERIOD ISSUE**  (2) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be three (3) months. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period; **(GET COMMENTS ON THIS PROPOSED CHANGE).**  (3) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required. |
| **Texas DOI** | **Comments: Consider moving definitions of partial, residual, and total disability into this section, as many have requirements embedded into them and do not seem relevant for other types of products. Consider aligning with IIPRC standards and noting any variations in drafting notes.**  C. Disability Income Protection Coverage  **Comments: “Sickness” shall not be defined to be more restrictive than the following: “Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.” The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker’s compensation, occupational disease, employers’ liability or similar law.**  **Remove the sickness or injury requirement to permit disability coverage for other circumstances, including an insured’s pregnancy, as well as family leave to care for a newborn or sick, injured, or disabled family member. Consider whether a disability policy must, at a minimum, cover a disability due to sickness or injury.**  **Limitations embedded into the definitions of sickness and injury may unintentionally reduce the scope of circumstances covered within a disability policy. Remove limits from definitions and instead identify permissible exclusions either in Section 6-F or in product-specific paragraphs in Section 7.**  **For example: (1) “Injury” shall be defined as bodily injury resulting from an accident, independent of disease or bodily injury, which occurs while the coverage is in force.**  **(2) An insurer may indicate that the “injury” shall be sustained independent of sickness.**  **(3) The definition shall not use words such as “external, violent, visible wounds” or similar words of characterization or description.**  **(4) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.**  **(5) The definition may provide that “injury” shall not include an injury for which benefits are provided under workers’ compensation, employers’ liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.**  “Disability income protection coverage” is a policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:  (1) Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62);  **Comments: In (2), add a definition for elimination period. Consider modifying this provision to provide that an elimination period cannot exceed 50% of the benefit period.**  (2) Contains an elimination period no greater than: (a) Ninety (90) days in the case of a coverage providing a benefit of one year or less; (b) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or (c) Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;  **Comments: In (3), Consider defining a short-term and a long-term disability benefit duration with applicable standards. Note that IIPRC permits a 3-month short-term benefit term.**  (3) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period;  (4) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required. |
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| **D. Accident Only Coverage**  **“Accident only coverage” is a policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least [$1,000] and a single dismemberment amount shall be at least [$500].** | |
| **ACLI; AHIP; NAIC consumer representatives** | D. Accident Only Coverage  “Accident only coverage” is a policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least [X] and a single dismemberment amount shall be at least [X]. **Okayed 8/29/22** |
| **Texas DOI** | **Comments: Note that accident-only cannot include sickness (or wellness) benefits. The combination of an accident-only benefit with a sickness benefit disqualifies it from treatment as an excepted benefit and major medical standards may apply. (Listen to 8/29/22 recording and add Chris language in the Limited Benefit Provision. Excerpt from Aug. 29, 22 minutes:**  *“Mr. Petersen suggested adding a drafting note at the end of Section 8 stating that Model #171 permits the combining of excepted benefit-type products described in this section. The drafting note could also state that combining other types of products not described in this section could cause the product not to be considered an excepted benefit-type product, and major medical insurance requirements may apply.”***)**  D. Accident Only Coverage  “Accident only coverage” is a policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least [$1,000] and a single dismemberment amount shall be at least [$500]. |
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| **E. Specified Disease Coverage**  **(1) “Specified disease coverage” pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules and one of the following sets of minimum standards for benefits:**  **(a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.**  **(b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.**  **(2) General Rules**  **Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:**  **(a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.**  **(b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.**  **(c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease.**  **(d) Individual supplementary or short-term health insurance policies containing specified disease coverage shall be at least guaranteed renewable.**  **(e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.**  **(f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant’s or enrollee’s signature.**  **(g) Payments may be conditioned upon an insured person’s receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.**  **(h) Except for the NAIC uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage.**  **Drafting Note:** Specified disease coverage is recognized as supplemental coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the Group Coordination of Benefits Model Regulation states that the definition of a “plan” (for the purpose of coordination of benefits) “shall not include individual or family insurance contracts.” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.  **(i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.**  **(j) Policies providing expense benefits shall not use the term “actual” when the policy only pays up to a limited amount of expenses. Instead, the term “charge” or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase “actual charges.”**  **(k) “Preexisting condition” shall not be defined to be more restrictive than the following: “Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person.”**  **(l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded.**  **(m) Hospice Care.**  **(i) “Hospice” means a facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: (I) For terminally ill patients whose life expectancy is less than six (6) months; (II) Provided on an inpatient or outpatient basis; and (III) Directed by a physician.**  **(ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards: (I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less; (II) A fixed-sum payment of at least $50 per day; and (III) A lifetime maximum benefit limit of at least $10,000.**  **(iii) Hospice care does not cover non-terminally ill patients who may be confined in a: (I) Convalescent home; (II) Rest or nursing facility; (III) Skilled nursing facility; (IV) Rehabilitation unit; or (V) Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers.**  **(3) The following minimum benefits standards apply to non-cancer coverages:**  **(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of [$250] and an overall aggregate benefit limit of no less than [$10,000] and a benefit period of not less than [two (2) years] for at least the following incurred expenses: (i) Hospital room and board and any other hospital furnished medical services or supplies; (ii) Treatment by a legally qualified physician or surgeon; (iii) Private duty services of a registered nurse (R.N.); (iv) X-ray, radium and other therapy procedures used in diagnosis and treatment; (v) Professional ambulance for local service to or from a local hospital; (vi) Blood transfusions, including expense incurred for blood donors; (vii) Drugs and medicines prescribed by a physician; (viii) The rental of an iron lung or similar mechanical apparatus; (ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; (x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and (xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.**  **(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than [$25,000] payable at the rate of not less than [$50] a day while confined in a hospital and a benefit period of not less than 500 days.**  **(4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of [$250], and an overall aggregate benefit limit of not less than [$10,000] and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:**  **(a) Treatment by, or under the direction of, a legally qualified physician or surgeon;**  **(b) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;**  **(c) Hospital room and board and any other hospital furnished medical services or supplies;**  **(d) Blood transfusions and their administration, including expense incurred for blood donors;**  **(e) Drugs and medicines prescribed by a physician;**  **(f) Professional ambulance for local service to or from a local hospital;**  **(g) Private duty services of a registered nurse provided in a hospital;**  **(h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;**  **(i) Braces, crutches and wheelchairs deemed necessary by the attending physician for the treatment of the disease;**  **(j) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and**  **(k) (i) Home health care that is necessary care and treatment provided at the insured person’s residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person’s attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A “home health care agency” (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements: (I) It is primarily engaged in providing home health care services; (II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse); (III) A physician or a registered nurse provides supervision of home health care services; (IV) It maintains clinical records on all patients; and (V) It has a full time administrator.**  **Drafting Note:** State licensing laws vary concerning the scope of “home health care” or “home health agency services” and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.  **(ii) Home health includes, but is not limited to: (I) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; (II) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists; (III) Physical, occupational or speech and hearing therapy; and (IV) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.**  **(l) Physical, speech, hearing and occupational therapy;**  **(m) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;**  **(n) Prosthetic devices including wigs and artificial breasts;**  **(o) Nursing home care for noncustodial services; and**  **(p) Reconstructive surgery when deemed necessary by the attending physician.**  **Drafting Note:** Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.  **(5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons: (i) A fixed-sum payment of at least [$100] for each day of hospital confinement for at least [365] days; (ii) A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and (iii) A fixed-sum payment of at least $50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.**  **(b) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following:**  **(i) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.**  **(ii) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days.**  **(iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.**  **(iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.**  (**6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:**  **(a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $1,000.**  **Drafting Note:** Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should be sensitive to this possibility in approving policies.  **(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.**  **Drafting Note:** The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving skin cancer or other exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease. | |
| **ACLI; AHIP** | (3) The following minimum benefits standards apply to non-cancer coverages: **Okay with this theme of the X.**  (a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of [X] and an overall aggregate benefit limit of no less than [X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses: (i) Hospital room and board and any other hospital furnished medical services or supplies; (ii) Treatment by a legally qualified physician or surgeon; (iii) Private duty services of a registered nurse (R.N.); (iv) X-ray, radium andother therapy procedures used in diagnosis and treatment; (v) Professional ambulance for local service to or from a local hospital; (vi) Blood transfusions, including expense incurred for blood donors; (vii) Drugs and medicines prescribed by a physician; (viii) The rental of an iron lung or similar mechanical apparatus; (ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; (x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and (xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.  (b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than [X] payable at the rate of not less than [X] a day while confined in a hospital and a benefit period of not less than 500 days.  (4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of [X], and an overall aggregate benefit limit of not less than [X] and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:  (a) Treatment by, or under the direction of, a legally qualified physician or surgeon;  (b) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;  (c) Hospital room and board and any other hospital furnished medical services or supplies;  (d) Blood transfusions and their administration, including expense incurred for blood donors;  (e) Drugs and medicines prescribed by a physician;  (f) Professional ambulance for local service to or from a local hospital;  (g) Private duty services of a registered nurse provided in a hospital;  (h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;  (i) Braces, crutches and wheelchairs deemed necessary by the attending physician for the treatment of the disease;  (j) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and  (k) (i) Home health care that is necessary care and treatment provided at the insured person’s residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person’s attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A “home health care agency” (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements: (I) It is primarily engaged in providing home health care services; (II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse); (III) A physician or a registered nurse provides supervision of home health care services; (IV) It maintains clinical records on all patients; and (V) It has a full time administrator.  **Drafting Note:** State licensing laws vary concerning the scope of “home health care” or “home health agency services” and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.  (ii) Home health includes, but is not limited to: (I) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; (II) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists; (III) Physical, occupational or speech and hearing therapy; and (IV) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.  (l) Physical, speech, hearing and occupational therapy;  (m) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;  (n) Prosthetic devices including wigs and artificial breasts;  (o) Nursing home care for noncustodial services; and  (p) Reconstructive surgery when deemed necessary by the attending physician.  **Drafting Note:** Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.  (5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons: (i) A fixed-sum payment of at least [X] for each day of hospital confinement for at least [365] days; (ii) A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and (iii) A fixed-sum payment of at least [X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.  (b) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following:  (i) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.  (ii) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days.  (iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.  (iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.  (6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:  (a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of [X].  **Drafting Note:** Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should be sensitive to this possibility in approving policies.  (b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.  **Drafting Note:** The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving skin cancer or other exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease. |
| **NAIC consumer representatives** | E. Specified Disease Coverage  (1) “Specified disease coverage” pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules and one of the following sets of minimum standards for benefits:  (a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.  (b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.  (2) General Rules  Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:  (a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.  (b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.  (c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease.  (d) Individual supplementary (**Okay to delete 8/29/22)** policies containing specified disease coverage shall be at least guaranteed renewable.  (e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue **(do not accept 9/12/22)** date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.  (f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant’s or enrollee’s signature.  **Drafting Note:** States may prohibit individuals who are covered by a Title XIX program from enrolling in a specified disease policy. However, this would not prohibit an individual who purchases a specified disease policy and later becomes eligible for coverage under a Title XIX program from utilizing the benefits of the specified disease policy to which the individual may be entitled. **(Okay to add 8/29/22)**  (g) Payments may be conditioned upon an insured person’s receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.  (h) Except for the NAIC uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage.  **Drafting Note:** Specified disease coverage is recognized as supplemental coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the Group Coordination of Benefits Model Regulation states that the definition of a “plan” (for the purpose of coordination of benefits) “shall not include individual or family insurance contracts.” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.  (i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.  (j) Policies providing expense benefits shall not use the term “actual” when the policy only pays up to a limited amount of expenses. Instead, the term “charge” or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase “actual charges.”  (k) “Preexisting condition” shall not be defined to be more restrictive than the following: “Preexisting condition means a specified (**did not accept 8/29/22)** condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the [six (6)] month period preceding the effective date of coverage of an insured person.” **(cross reference to the Model Act definition of the term)**  (l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded.  (m) Hospice Care.  (i) “Hospice” means a facility licensed, certified or registered in accordance with state law that provides a formal program of care (as that term is used to describe the benefits covered in the Medicare hospice program) **(did not accept 9/12/22)** that is: (I) For terminally ill patients whose life expectancy is less than six (6) months; (II) Provided on an inpatient or outpatient basis; and (III) Directed by a physician.  **Drafting Note:** For reference, “formal program of care” in the Medicare hospice program includes: physician services; nursing care; medical equipment (including wheelchairs or walkers); medical supplies (such as bandages and catheters), prescription drugs; hospice aid and homemaker services; physical and occupational therapy; speech language pathology services; social worker services; dietary counseling; grief and loss counseling for the beneficiary and family members; short-term inpatient care (for pain and symptom management; short-term respite care; and other medically necessary care recommended by the enrollee’s treating physician. (did not accept 9/12/22)  (ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards: (I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less; (II) A fixed-sum payment of at least [X] per day; and (III) A lifetime maximum benefit limit of at least [X].  (iii) Hospice care does not cover non-terminally ill patients who may be confined in a: (I) Convalescent home; (II) Rest or nursing facility; (III) Skilled nursing facility; (IV) Rehabilitation unit; or (V) Facility providing care or treatment for persons suffering from mental disorders, who are aged or who have a substance-related disorder (okay 9/12/22).  (3) The following minimum benefits standards apply to non-cancer coverages:  (a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of [X] and an overall aggregate benefit limit of no less than [X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses: (i) Hospital room and board and any other hospital furnished medical services or supplies; (ii) Treatment by a licensed physician, surgeon, or other health care professional acting within the scope of their license;  Add drafting note: in re acting versus performing.  (iii) Private duty services of a licensednurse; (iv) tests, procedures and other medical services and supplies used in diagnosis and treatment; (v) Professional ambulance for service to or from a hospital; (vi) Blood transfusions, including expense incurred for blood donors; (vii) Drugs and medicines prescribed by a physician; (viii) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease; (x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and (xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.  (b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than [X] payable at the rate of not less than [X] a day while confined in a hospital and a benefit period of not less than 500 days.  (4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of [$250], and an overall aggregate benefit limit of not less than [X] and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:  (a) Treatment by, or under the direction of, a legally qualified physician or surgeon or other health care professional (make same change as (3)(a)(ii) above);  (b) tests, procedures and other medical services and supplies used in diagnosis and treatment (make same change as above)  (e) Hospital room and board and any other hospital furnished medical services or supplies;  (f) Blood transfusions and their administration, including expense incurred for blood donors;  (g) Drugs and medicines prescribed by a physician, including but not limited to (see (c) above to add) 9/12/22;  (h) Professional ambulance for service to or from a hospital (nearest hospital able to appropriately treat the condition) 9/29/22 ;  (i) Private duty services of a licensed nurse provided in a hospital  (9/29/22)  (j) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis; (decided to leave unchanged 9/29/22)  (k) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease; (make consistent with above)  (l) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; **decided to leave unchanged 9/29/22** and  (m) (i) Home health care that is necessary care and treatment provided at the insured person’s residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person’s attending physician, who shall approve the program prior to its start. (**agreed to accept/delete 9/29/22).** A “home health care agency” (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements: (I) It is primarily engaged in providing home health care services; (II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse); (III) A physician or a registered nurse provides supervision of home health care services; (IV) It maintains clinical records on all patients; and (V) It has a full time administrator.  **Drafting Note:** State licensing laws vary concerning the scope of “home health care” or “home health agency services” and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.  (ii) Home health includes, but is not limited to: (I) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; (II) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists; (III) Physical, occupational or speech and hearing therapy; and (IV) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.  (l) Physical, speech, hearing and occupational therapy;  (m) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;  (n) Prosthetic devices including wigs and artificial breasts;  (o) Nursing home care for noncustodial services;  (p) Reconstructive surgery when deemed necessary by the attending physician;  (q) Hospice services, as defined paragraph (2)(m) above, for cancer coverage; (accepted 10-18-22) and  I Coverage for identifying and maintaining bone marrow donations (decided not to accept because of other agreed changes).  **Drafting Note:** Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.  (5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons: (i) A fixed-sum payment of at least [X] for each day of hospital confinement for at least [365] days; (ii) A fixed-sum payment equal to [X%] the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and (iii) A fixed-sum payment of at least [X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.  (b) Benefits tied to receipt of care in a skilled nursing home or to receipt of home health care **(did not accept 9/29/22)** must equal the following:  (i) A fixed-sum payment equal to [X%]one-fourth] the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.  (ii) A fixed-sum payment equal to [x%]one-fourth] the hospital in-patient benefit for each day of home health care for at least 100 days.  (iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.  (iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare. **(left unchanged 9/29/22)**  (6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:  (a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $1,000.  **Drafting Note:** Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should avoid approving these policies in light of the fact that these policies are not intended to be comprehensive coverage and are not intended to be sold as such . Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers. **(accepted 9/29/22)**  (b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease. (leave as is/unchanged, yes, 9/29/22, and drafting note too)  **Drafting Note:** The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. |
| **Texas DOI** | E. Specified Disease Coverage  **Comments: Consider adding a definition for disease and clarifying whether pregnancy, infertility, mental health conditions, and substance use disorders may be covered as a specified disease.**  (1) “Specified disease coverage” pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules and one of the following sets of minimum standards for benefits:  (a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.  (b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.  (2) General Rules  Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:  **Comments: Consider whether to limit the number of specified diseases that may be covered. Some policies appear designed to be sold alongside an accident-only policy and marketed as comprehensive coverage. (Maybe put in notice section sometime in notice/disclosure section about combining policies and beware)**  (a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.  (b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.  (c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease.  **Comments: Delete reference to STLD.**  (d) Individual supplementary **(already agreed to delete)** policies containing specified disease coverage shall be at least guaranteed renewable.  **Comments: Define waiting period, probationary period. Clarify whether premium is paid during the period. Clarify whether a condition is considered preex if it arises during the period.**  **Clarify how any separate types of periods interact. (See prohibited policy provision section and consider definitions??? 10/18/22)**  (e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.  **Comments: Consider clarifying what happens if an individual later becomes eligible for Medicaid, and addressing under Subsection A, with respect to all product types.**  (f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant’s or enrollee’s signature.  **Comments: In (g), clarify the applicability of UR requirements related to determinations of medical necessity, appropriateness, experimental/investigational. In Texas, we apply to all plans using medical necessity language, but Model 73 appears to apply only to a health benefit plan, which includes STLD but excludes excepted benefits.**  (g) Payments may be conditioned upon an insured person’s receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment. Discussed 10/18/22 Add in something about no prior authorization unless follow the requirements of a state’s utilization review laws and regulations???. If you use managed care principles, then must have an appeals process??? Will revisit next meeting.  Add a drafting note to alert states to the issue (Subgrp may revisit if new language is developed) (Agreed Oct 31 meeting)  **Comments: Include a provision under Section 6 addressing that excepted benefits may not be “excess only” or otherwise condition benefits on other coverage. Current language addresses (Decided Oct 31)**  (h) Except for the NAIC uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage.  **Drafting Note:** Specified disease coverage is recognized as supplemental coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the Group Coordination of Benefits Model Regulation states that the definition of a “plan” (for the purpose of coordination of benefits) “shall not include individual or family insurance contracts.” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.  (i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.  (j) Policies providing expense benefits shall not use the term “actual” when the policy only pays up to a limited amount of expenses. Instead, the term “charge” or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase “actual charges.”  (k) “Preexisting condition” shall not be defined to be more restrictive than the following: “Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person.”  (l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded.  (m) Hospice Care.  (i) “Hospice” means a facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: (I) For terminally ill patients whose life expectancy is less than six (6) months; (II) Provided on an inpatient or outpatient basis; and (III) Directed by a physician.  (ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards: (I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less; (II) A fixed-sum payment of at least $50 per day; and (III) A lifetime maximum benefit limit of at least $10,000.  (iii) Hospice care does not cover non-terminally ill patients who may be confined in a: (I) Convalescent home; (II) Rest or nursing facility; (III) Skilled nursing facility; (IV) Rehabilitation unit; or (V) Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers.  (3) The following minimum benefits standards apply to non-cancer coverages:  (a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of [$250] and an overall aggregate benefit limit of no less than [$10,000] and a benefit period of not less than [two (2) years] for at least the following incurred expenses: (i) Hospital room and board and any other hospital furnished medical services or supplies; (ii) Treatment by a legally qualified physician or surgeon; (iii) Private duty services of a registered nurse (R.N.); (iv) X-ray, radium and other therapy procedures used in diagnosis and treatment; (v) Professional ambulance for local service to or from a local hospital; (vi) Blood transfusions, including expense incurred for blood donors; (vii) Drugs and medicines prescribed by a physician; (viii) The rental of an iron lung or similar mechanical apparatus; (ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; (x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and (xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.  **Comments: Consider broadening to permit a daily benefit for outpatient care and for confinement in other types of facilities, as is permitted for a cancer policy under Subsection E(5). (Agreed change not needed Oct 31 meeting.)**  (b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than [$25,000] payable at the rate of not less than [$50] a day while confined in a hospital and a benefit period of not less than 500 days.  **Comments: Consider adding a definition of “expense incurred”; and a general provision related to payment standards and transparency, given the evolving use of terms like usual and customary. This should be addressed in general rules under Subsection A. Consider whether to permit a different payment methodology, such as x% of Medicare. (Decided to leave as is Oct. 31 meeting)**    (4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of [X], and an overall aggregate benefit limit of not less than [X] and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:  (a) Treatment by, or under the direction of, a legally qualified physician or surgeon;  (b) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;  (c) Hospital room and board and any other hospital furnished medical services or supplies;  (d) Blood transfusions and their administration, including expense incurred for blood donors;  (e) Drugs and medicines prescribed by a physician;  (f) Professional ambulance for local service to or from a local hospital;  (g) Private duty services of a registered nurse provided in a hospital;  (h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;  (i) Braces, crutches and wheelchairs deemed necessary by the attending physician for the treatment of the disease;  (j) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and  (k) (i) Home health care that is necessary care and treatment provided at the insured person’s residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person’s attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A “home health care agency” (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements: (I) It is primarily engaged in providing home health care services; (II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse); (III) A physician or a registered nurse provides supervision of home health care services; (IV) It maintains clinical records on all patients; and (V) It has a full time administrator.  **Drafting Note:** State licensing laws vary concerning the scope of “home health care” or “home health agency services” and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.  (ii) Home health includes, but is not limited to: (I) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; (II) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists; (III) Physical, occupational or speech and hearing therapy; and (IV) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.  (l) Physical, speech, hearing and occupational therapy;  (m) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;  (n) Prosthetic devices including wigs and artificial breasts;  (o) Nursing home care for noncustodial services; and  (p) Reconstructive surgery when deemed necessary by the attending physician.  **Drafting Note:** Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.  (5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons: (i) A fixed-sum payment of at least [$100] for each day of hospital confinement for at least [365] days; (ii) A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and (iii) A fixed-sum payment of at least $50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.  (b) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following:  (i) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.  (ii) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days.  (iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.  (iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.  (6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:  (a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $1,000.  Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should be sensitive to this possibility in approving policies.  (b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.  **Drafting Note:** The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving skin cancer or other exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease. |
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| **F. Specified Accident Coverage**  **“Specified accident coverage” is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than [$1,000] for accidental death, [$1,000] for double dismemberment [$500] for single dismemberment.** | |
| **ACLI; AHIP; NAIC consumer representatives** | F. Specified Accident Coverage  “Specified accident coverage” is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than [X] for accidental death, [X] for double dismemberment [X] for single dismemberment.  **Agreed to change given past discussion about the “x”. 10/31/22** |
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| **G. Limited Benefit Health Coverage**  **(1) “Limited benefit health coverage” is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, D, E, and F. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7E and shall not be offered for sale as a “limited coverage.”**  **(2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].**  **Drafting Note:** The NAIC *Long-Term Care Insurance Model Act* 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 its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643). | |
| **NAIC consumer representatives** |  |
| **Texas DOI** | **Comments: Is this category still relevant with the removal of major medical from the model? Specified disease is the only product left with substantive requirements and cannot be offered as a limited benefit plan. Leave as is Oct 31**  G. Limited Benefit Health Coverage  (1) “Limited benefit health coverage” is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, D, E, and F. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7E and shall not be offered for sale as a “limited coverage.”  (2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].  **Drafting Note:** The NAIC *Long-Term Care Insurance Model Act* 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 its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643). |
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| **H. Short-Term, Limited-Duration Health Insurance Coverage** | |
| **HBI** | **Comments:**  **Definition.**  The model law does not define the standards for short term, limited duration health insurance and does not take a position on limiting the time frame of coverage. To be perfectly clear, the Institute supports a model standard based on the federal rule which permits contracts of up to 364 days and renewals of up to three years. However, we have all agreed with the principle that settled issues should not be relitigated. To that end, we suggest the following definition:  “Short Term, Limited Duration Health Insurance Plan” means a policy of health insurance that provides hospital, medical and surgical expense coverage for a fixed period of time defined in [state law].  **Covered services.**  As the subgroup has discussed in the past, short term plans do not typically provide coverage for all of the ACA’s 10 categories. The intent of the plans is to provide flexible coverage tailored to what individuals need during a gap, and given the nature of the coverage, it is unlikely the additional services would meet underwriting standards. The Institute supports the proposed NCOIL model definition of mandatory coverage categories:  (1) Ambulatory patient services;  (2) Hospitalization;  (3) Emergency services; and  (4) Laboratory services  These services are already covered by the typical short-term plans and are what a consumer should expect from a short-term plan.  **Benefits.**  Consumers should be able to expect a minimum standard of benefits for short-term plans that differentiate them from fixed indemnity coverage. We would propose that the requirements below as minimum standards for short term health insurance and that are meet by most insurers are providing in the market:  1. Annual or lifetime limit of no less than [$1,000,000] Liked 11/14/22  2. Coinsurance of no more than 50% of covered charges. **Liked 11/14/22**  3. Family out-of-pocket maximum of not more than [x] per year. Liked 11/14/22  **Drafting Note:** The annual and lifetime limit and out-of-pocket limits should vary depending on the specific state interests. For states that have severely limited coverage time frames with limited renewals/extensions, smaller annual and out-of-pocket maximums should apply. For states allowing coverage up to the federal maximum of three years, states may want to consider different limits. Okay 11/14/22  **Pre-existing conditions / Underwriting**  The group has had extensive discussions on the use of pre-existing condition exclusions. We would suggest the proposed model adopt the following standards for short-term plan:  Short term health insurance plans may provide a look back period for underwriting purposes of not more than 2 years.  After issuance of a short-term insurance plan, the insurer may not require underwriting until all renewal periods elected for that policy have ended. [Put in the disclosure sections info on renewability and underwriting.] Okay 11/14/22  **Network Standards**  Some short-term health insurance plans offer coverage through preferred provider plans, and in some areas the short term health insurers provide access to broader networks than the individual market plans. While it makes little sense to require ACA standards to these plans, regulators need an appropriate standard. HBI would suggest inclusion of the following language:  Any preferred provider plan is sufficient in number and types of providers to assure covered individuals’ access to all covered health care services without unreasonable delay.  *Discussed 11/14/22 the possibility of adding language in re network benefits and possibly something about the surprise billing/no balance billing provisions apply to short-term. Include statement that state balance billing laws apply to these products?? If an insurer makes available network, or includes info about network, need to make clear that there could be balance billing. Offers a network benefit, must be able to access.* |
| **Texas DOI** | H. Short-Term, Limited-Duration Health Insurance Coverage  (1) An individual policy or group certificate of short-term limited-duration insurance must provide benefits consistent with the minimum standards for the type of coverage offered.  (2) Short-term limited-duration coverage, including individual policies and group certificates:  (a) May not be marketed as guaranteed renewable;  (b) Must be marketed either as nonrenewable, or renewable (without new underwriting) at the option of the policyholder or insured person, if the insured person contributes to the premium;  (c) Must clearly state the duration of the initial term and the total maximum duration including any renewal options;  (d) May not be modified after the date of issue, except by signed acceptance of the policyholder or the insured person, if the insured person contributes to the premium; and  (e) If coverage is renewable, a short-term limited-duration individual policy or group certificate must: (i) include a statement that the enrollee has a right to continue the coverage in force by timely payment of premiums for the number of terms listed; (ii) include a statement that the issuer will not increase premium rates or make changes in provisions in the policy, or certificate, on renewal  based on individual health status; (iii) if applicable, include a statement that the issuer retains the right, at the time of policy renewal, to make changes to premium rates by class; and (iv) include a statement that the carrier, at the time of renewal, may not deny  renewal based on individual health status. Subgroup supports 11/28/22 (Make a note on how pre-ex applies or not applies with respect to disclosures) contract requirements vs disclosure language  (3) A carrier offering short-term limited-duration insurance must include an accurate written disclosure form that is consistent with the form and instructions prescribed in [disclosure form] and the requirements of this section.  (4) In creating a disclosure form, issuers must follow all instructions provided in this subsection:  (a) The disclosure must be produced for each plan option that the carrier makes available and reflect the specific terms of the plan.  (b) The disclosure form must accurately represent the short-term limited-duration coverage being provided.  (c) If the disclosure form does not accurately represent the plan being offered, the carrier may modify the form, as necessary. When filing the form with the commissioner, the carrier must clearly identify any changes made and explain the reason for modifying the form.  (d) The chart under disclosure form paragraph (9) may be supplemented to include cost-sharing information for each benefit.  (5) A disclosure form under this section must be:  (a) Filed with the commissioner for review before use, consistent with filing procedures in Subchapter A of this chapter;  (b) provided in writing to a prospective insured: (i) before the individual completes an application or makes an initial premium payment, application fee, or other fee; and (ii) at the time the policy or certificate is issued; and  (c) signed by the enrollee to acknowledge receipt at the time of application. An electronic signature is acceptable if the carrier's procedures comply with [electronic transaction requirements]. |
| **NAIC consumer representatives** | H. Short-Term, Limited-Duration Health Insurance Coverage  (1) “Short-term, limited-duration health insurance” means health insurance coverage offered or provided within the state pursuant to a contract with 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] months after the original effective date. Support 11/28/22  (2) Short-term limited duration health insurance cannot be issued if it would result in a person being covered by a short-term limited duration medical plan for more than [X] months [in any 12-month period]. (Make optional by including brackets to address where states have shorter periods or something else) Discussed 11/28/22.  (3) A carrier may not issue a short-term limited duration health insurance plan during the annual open enrollment periods for individual-market health insurance and individual Marketplace plans as established in the state. Discussed 11/28/22 whether to include this and/or have a prohibition on eff. date of Jan 1 or Jan 15. Also discuss requiring language in disclosures to address this issue. Reached no solution.  (4) A short-term limited duration health insurance plan form, application form, or disclosure form may not be issued, delivered, or used unless it has been filed with and approved in writing by the commissioner. The commissioner may disapprove any forms or rates if the benefit provided therein is unreasonable in relation to the premium charged. This sort of language is the more general standard provisions. No need to have a separate provision for STLDPs. Subgroup agreed not needed 11/28/22  (5) Short-term, limited-duration health insurance must provide comprehensive major medical coverage that includes, at a minimum, the following benefits:  (a) Hospital, surgical and medical expense coverage to an aggregate maximum of not less than one million dollars ($1,000,000) and copayment or co-insurance by the covered person not to exceed twenty percent (20%) of covered charges;  (b) Coverage of inpatient services and other miscellaneous services associated with admission to a hospital for diagnosis and treatment of a covered condition. "Miscellaneous services" includes medically necessary services delivered in a hospital setting, including professional services, anesthesia, facility fees, supplies, imaging, laboratory, pharmacy services and prescription drugs, treatments,  therapy, or other services delivered on an inpatient basis;  (c) Outpatient services, including medically necessary services ordered by the member's attending health care professional and rendered on an ambulatory basis for diagnosis and treatment of a covered condition, including office and clinic visits, diagnostic imaging, laboratory services, prescription drugs administered by a physician or health care professional, radiation therapy,  physical/speech/occupational therapy, and hemodialysis; and  (d) An extension of the medical plan term while hospitalized. If a member is hospitalized as an inpatient on the expiration date of the medical plan, the member's coverage under the medical plan will continue for purposes of that covered medical condition without payment of additional premium. The coverage will continue until the date the member is discharged from the hospital or until the date on which the applicable benefit maximums are reached, whichever occurs first. Thoughts??? Can reference state extension of benefits provisions in lieu of this provision? Look for model provision in re state extension of benefits language. Subgrp decided that important to research this issue. 11/28/22  (e) The coverage for surgical services for diagnosis and treatment of a covered condition must include inpatient and outpatient surgical services at a hospital, ambulatory surgical facility, surgical suite or provider’s office.  (f) “Surgical services” includes medically necessary services delivered in a hospital, ambulatory surgical facility, surgical suite or provider’s office related to provision of a surgical service, including professional services, anesthesiology, facility fees, supplies, laboratory, pharmacy services and prescription drugs related to, or required as a result of, the surgical procedure.  (g) The coverage for medical services for diagnosis and treatment of a covered condition must include office visits.  (h) The coverage of medically necessary prescription drugs.  (i) Any out-of-pocket maximum or limit shall be inclusive of all deductibles, copayments, coinsurance, and other out-of-pocket charges that the carrier requires the insured to pay under the plan during the coverage period.  (j) A short-term, limited duration policy shall not exclude coverage of medically necessary treatment for illnesses or injuries that are not pre-existing conditions.  (6) The commissioner may withdraw any approval of a short-term, limited-duration health insurance plan at any time for cause. The commissioner’s withdrawal of a previous approval shall state the grounds for the withdrawal. Not necessary, see above (4). 11/28/22  (7) A short-term, limited-duration health insurance plan must limit the look-back period for any preexisting medical condition, illness, or injury to no more than [6] months prior to the date of application for the medical plan, if coverage of pre-existing conditions is excluded. For purposes of this subsection, “preexisting condition” means a condition for which medical advice, diagnosis, care, or treatment was received or recommended by a physician within a [6] month period preceding the effective date of the coverage of the insured person.” Looked at this issue previously to have one definition for other products and have a different definition for STLDPs. Need to discuss separate definition for STLDPs for inclusion in definition section, subsection L. 11/28/22  (8) A short-term, limited-duration health insurance issuer shall not include a waiting period or a probationary period; the effective date of the plan is the date when benefits and coverage are in effect. Okay with change to “issuer” 11/28/22  **START HERE DEC 5, 2022**  (9) A short-term limited duration health insurance plan cannot be rescinded by the carrier during the coverage period except if the insured fails to disclose a prior diagnosis of a health condition or if the insured intentionally fails to disclose the insured was covered under a short-term limited duration health insurance plan []. If the plan is rescinded, the carrier must refund to the insured all payments (less claims paid up to the total premium amount (listen to recording) made by or on behalf of the insured prior to the rescission date or the expiration date of the short-term limited duration health insurance.  DN: Expectation not billing the insured, etc (listen to recording)  DN: in re consumer not disclosing prior STLD plans if it matters based on state law in re maximum duration of coverage discuss the 12-month issue. (listen to recording).  (10) A short-term limited-duration health insurance plan cannot be canceled by the carrier during the coverage period except in the following circumstances: nonpayment of premium; violation of published policies of the carrier approved by the Commissioner; an  insured’s committing fraudulent acts as to the carrier; an insured’s material breach of the medical plan; or change or implementation of federal or state laws that no longer permit the continued offering of the coverage.  Not needed 12/5/22  (12) In the event of cancellation or rescission of a short-term, limited-duration health insurance plan, the carrier must notify the insured in writing [twenty (20) days] prior to the cancellation or rescission date.  Add DN explaining the bracketed days?? States may have statutes that are more generous (listen to recording).  (not needed)  **Drafting Note:** Subsection H does not include a potential maximum length of coverage for short-term, limited-duration insurance. 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 and 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. Federal regulations limit short-term, limited-duration insurance contracts to less than 12 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 and whether additional definitions  or standards may be needed. Okay 12/5/22 |

G:\GOVTREL\DATA\Health and Life\B Committee admin only\Regulatory Framework Task Force\Accident and Health Minimum Stds\Accident and Sickness Ins Min Stds Subgrp\Model #171 Suggested Revisions Chart - July 2 Comments - Sections 1-7.docx