

From the NAIC Consumer Representatives

To: Accident and Sickness Insurance Minimum Standards (B) Working Group Co-Chairs
Laura Arp and Andrew Schallhorn, members of the Working Group, and Jolie Matthews

Date: July 2, 2021

Re: Comments on Model Regulation to Implement the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#171)

On behalf of the undersigned Consumer Representatives to the National Association of Insurance Commissioners (NAIC), we thank you for the opportunity to return to the important work of updating Model 171.

We note that NAIC enacted Model Act 170 in the Spring 2019 and while work began on Model 171, unfortunately the NAIC has not moved forward on Model 171 in over two years due to the pandemic and other issues. Given this significant lapse of time, we applaud the Subgroup's decision to solicit stakeholder comments pertaining to the first seven sections of the Model. In 2019, we submitted detailed comments and a redlined version of this model regulation in (these are posted on the working group's website), and we are re-submitting those comments with slight modifications. We look forward to discussing the changes we have recommended, as well as issues germane to Model 170 that have yet to be resolved including, but not limited to the definition of a "pre-existing condition", loss ratios, , and any additional matters raised by regulators and other stakeholders as this process continues.

Definition of "Pre-Existing Condition"

One issue the working group has discussed but has not resolved is the definition of "pre-existing condition." We continue to urge that Model 171 include a definition that is based on receipt of medical advice or care, shortening the "look-back" period, and modifying the drafting note to increase transparency for consumers about how an insurer plans to use information about the pre-existing conditions identified in the underwriting process. If we can arrive at a definition that appropriately identifies conditions that truly pre-date the effective date of a given plan, then people enrolling in short-term, indemnity, and other forms of insurance covered by this model can more accurately answer the health questions they are asked, thus mitigating the risk of having their coverage rescinded or cancelled after they receive expensive medical care. Neither the "prudent person" standard nor expecting people to divine what a physician or other provider wrote in their medical records is sufficient to protect consumers. To that end, we continue to recommend the following changes to the definition:

"Preexisting condition" shall not be defined more restrictively (for the insured or prospective insured person) 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~~ a specified condition for which medical advice, diagnosis, care, or treatment was recommended by a physician or received from a physician within a [two-] year month period preceding the effective date of the coverage of the insured person."

(Please see the attached redlined document for recommended changes to the related drafting note.)

Structure of the Model Regulation

Some stakeholders have recommended that the model set out different definitions, minimum standards or policy prohibitions for short-term health plans compared to other plans that this model covers. In general, the model regulation should set out definitions, standards, and prohibitions that are consistent across short-term and supplemental plans, as this will simplify the regulatory structure and make it more likely consumers will understand important terms. For example, the idea of an out-of-pocket maximum is hard enough for people to comprehend; having different definitions for different plans would make it

more difficult. We also note that a core concern raised by many plans covered by this model is that they are being marketed to consumers as if they were comprehensive coverage when they are not. This is not only the case with short-term health plans. Indemnity plans and bundled sets of so-called supplementary coverage are also being marketed as alternative to comprehensive coverage.¹ Therefore, we urge the working group not to draw an artificial line between short-term plans and all other plans covered in this model, but rather to work toward a final product that sets minimum standards and prohibits certain provisions in a consistent manner that will adequately protect consumers.

During discussion and work on the model law in prior years, many issues raised by the consumer representatives were deemed as more appropriate to discuss as part of work on the model regulation. One of these areas is the disclosures and notices. We look forward to discussing those in detail during this phase of the working group's work.

We look forward to participating in this important effort. If you have any questions about our comments, please do not hesitate to contact Sarah Lueck (lueck@cbpp.org) or Lucy Culp (lucy.culp@lls.org).

Sincerely,

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¹ Christen Linke Young and Kathleen Hannick, "Fixed indemnity health coverage is a problematic form of 'junk insurance,'" USC-Brookings Schaeffer Institute on Health Policy, August 4, 2020. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance/> and "GAO report sheds additional light on deceptive marketing practices among non-compliant health plans," September 25, 2020. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/09/25/gao-report-sheds-additional-light-on-misleading-and-deceptive-marketing-practices-among-non-compliant-health-plans/>

Comments are being requested on this draft by June 28, 2019. The revisions to this draft reflect changes made from the existing model. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.

MODEL REGULATION TO IMPLEMENT THE -SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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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.

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].

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.
- B. This regulation shall apply to limited scope dental coverage and limited scope vision coverage only as specified.
- 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.

- D. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

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].

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.

B. “Cancellation” or “cancel” means termination of a supplementary or short-term, limited-duration policy before the end of the coverage period under the plan.

CB. “Convalescent nursing home,” “extended care facility,” ~~or~~ “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~~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 or federal Medicare or Medicaid law may be required in structuring this definition.

D. C.—“Disability” or “disabled” shall be defined as due to injury or sickness.

E. “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.”

FD. “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, or educational services~~or rehabilitative care~~;
 - ~~(c) Facilities for the aged, drug addicts or alcoholics; or~~
 - (c) ~~(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.

- GE. (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.
- HF. “Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.
- IG. “Mental disease 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~~.
- JH. “Nurse” may be defined so that the description of nurse is restricted to a type of nurse, such as an advanced practice nurse, registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “nurse,” “advanced 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.
- KI. “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.
- L. “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.
- LJ. “Partial disability” shall be defined -to mean that, due to a disability, an individual:
- (1) (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) (2) —Is in fact engaged in work for wage or profit, including compensation in the form of goods or services.

- MK. (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.

NK. “Preexisting condition” shall not be defined more restrictively than the following: “Preexisting condition means ~~a specified condition 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, diagnosis, care, or treatment ~~or treatment~~ was received or recommended by a physician ~~or received from a physician~~ within a ~~[two-6] year-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 to deny payment of claims 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. ~~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.~~

OL.— “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.

P. “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.

QM. “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.

RN. “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.
- (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.

Section 6. Prohibited Policy Provisions and Minimum Policy Standards

A. ~~A.~~ — Except as provided in Section 5N (related to the definition of “pre-existing condition”)K, 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, as well as– short-term health insurance plans shall not contain probationary or waiting periods.~~

A. — ~~A supplementary or short-term limited duration health insurance policy (including a policy issued by an association or other “group” arrangement) must 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.~~

B.

~~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.~~

~~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.~~

- ~~CC~~. 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.

- ~~DD~~. 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~~ 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.

- ~~EE~~. Policies providing hospital indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

- ~~FF~~. 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;~~
- ~~(23)~~ (23) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 7C of this regulation;
- ~~(34)~~ (34) 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;~~
 - ~~(be)~~ (be) Aviation; and
 - ~~(cd)~~ (cd) With respect to short-term nonrenewable policies, interscholastic sports; and
~~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.

- ~~(45)~~ (45) 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 serves some cosmetic purpose (e.g., breast prostheses for reconstruction following mastectomy due to breast cancer).

- (56) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
- (67) 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.

- (78) 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;
- (89) 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 enrollee (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 Act should be given to the plan in such situations.

- (94) Eye glasses, hearing aids and examination for the prescription or fitting of them;
- (104) Rest cures, custodial care, and transportation ~~and routine physical examinations~~; and
- (112) 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.

~~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.~~

- GH. 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 4B 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.

- 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 carrier 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 carrier or has intentionally misrepresented information pertinent to the carrier's decision to issue the plan. If a plan is rescinded, the carrier must 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 carrier must notify the insured in writing thirty (30) days prior to the rescission date.
- J. A supplementary or short-term health plan cannot be cancelled by the carrier except for the following reasons: nonpayment of premium; violation of published policies of the carrier that the Commissioner has approved; the insured person committing fraudulent acts as to the carrier or a material breach of the medical plan; or a change or implementation of federal or state laws that no longer permit the continued offering of the coverage. If a policy is to be cancelled, the carrier must 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 carrier to cancel or rescind the medical plan unless the misrepresentation or warranty is made with actual intent to deceive.

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*].

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-cancellation~~ of coverage of the spouse solely because of the occurrence of an event specified for ~~termination-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.
- (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.

~~(e) — 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.~~

(cd) 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 of a couple husband and wife, the age of the younger spouse 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 termination cancellation of coverage of the older spouse person upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse 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 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 intellectual or physical handicap 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 incapacity 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) — 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.~~

(10~~1~~) 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~~2~~) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(12~~3~~) 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 Model the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(13~~4~~) ~~Termination-Cancellation~~ 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.

(14~~5~~) A policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations.

B. Hospital Indemnity or Other Fixed Indemnity Coverage

(1) “Hospital 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 [~~\$40X~~] 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-six (612)~~ 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- indemnity or other fixed indemnity coverage is recognized as supplemental coverage. Any hospital 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 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 indemnity or other fixed indemnity coverage purchased by the insured.

C. Disability Income Protection Coverage

“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);~~
- (12) Contains an elimination period no greater than:
 - ~~(a) Ninety-Thirty (390) days in the case of a coverage providing a benefit of one year or less;~~
 - ~~(b) One hundred and eighty (180)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) Three hundred sixty five (365)One hundred eighty (180) days in all other cases during the continuance of disability resulting from sickness or injury;~~
- (23) 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~~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.

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 [~~\$1,000X~~] and a single dismemberment amount shall be at least [~~\$500X~~].

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.

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 they may be entitled.](#)

- (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 *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 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 (as that term is used to describe the benefits covered in the Medicare hospice program) 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).

- (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[X] per day; and
 - (III) A lifetime maximum benefit limit of at least [X]\$10,000.
- (iii) Hospice care does not cover nonterminally 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 diseases or disorders, who are aged or care for the aged, or substance abusers who have a substance-related disorder.

(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 [~~\$250x~~] and an overall aggregate benefit limit of no less than [~~\$10,000X~~] 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 or under the direction of a legally qualified physician or surgeon or other health care professional;
 - (iii) Private duty services of a registered nurse (R.N.);
 - (iv) Laboratory tests, procedures, and other medical services~~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;~~
 - ~~(xviii)~~ Durable medical equipment~~Braces, crutches and wheel chairs as are~~ deemed necessary by the attending physician for the treatment or amelioration of symptoms or disease-related disability~~of the disease~~;
 - (ix) Costs associated with a transplant, including pre-transplant evaluation and testing and procurement of organs and tissues from a living or decedent donor;
 - (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, included but not limited to palliative care, rehabilitative or habilitative services or devices, mental health care, hospice services, or other services provided for under subsection (4) when deemed medically necessary.
- (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 [~~\$25,000X~~] payable at the rate of not less than [~~\$50X~~] 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~~\$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 or other health care professional;
- (b) Laboratory tests, procedures, and all? other medical services~~X-ray, radium chemotherapy and other therapy procedures~~ used in diagnosis and treatment;
- (c) Chemotherapy (including both oral- and/or IV-administered), immunotherapy, targeted therapies, and chemotherapy supportive drugs;
- (d) Palliative care services;

Drafting Note: The term “palliative care” means specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain and stress of serious illness. Palliative care is provided by a team of physicians, nurses and other specialists who work with a patient’s other health care providers to provide an extra layer of support. Unless otherwise indicated, the term “palliative care” is synonymous with the terms “comfort care,” “supportive care,” and similar designations.

- (~~e~~e) Hospital room and board and any other hospital furnished medical services or supplies;
- (~~f~~d) Blood transfusions and their administration, including expense incurred for blood donors;
- (~~g~~e) Drugs and medicines prescribed by a physician;
- (~~h~~f) Professional ambulance for ~~local~~ service to or from a ~~local~~ hospital;
- (~~i~~g) Private duty services of a registered nurse provided in a hospital~~All medically necessary services that are consistent with the most recent National Comprehensive Cancer Network (NCCN) guidelines~~;

Drafting Note: The National Comprehensive Cancer Network (NCCN) issues clinical practice guidelines that are a recognized standard for clinical policy in oncology

- (~~j~~h) Must 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~~;
- (~~k~~i) Durable medical equipment~~Braces, crutches and wheelchairs~~ deemed necessary by the attending physician for the treatment or amelioration of symptoms or disease-related disabilities~~of the disease~~;
- (~~l~~j) Emergency transportation and medically necessary transportation services including transportation to and from chemotherapy administration; ~~if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and~~

Drafting Note: Policies that offer transportation and/or lodging benefits for an insured person should not condition those benefits on transportation

- (mk) (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.

~~(q) Hospice services, defined in subsection (E)(2)(m) above; and~~

~~(r) Coverage for identifying and maintaining bone marrow donations.~~

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~~~~\$X~~] for each day of hospital confinement for at least [365] days;

(ii) A fixed-sum payment equal to [~~X~~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~~~~\$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~~~~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 ~~avoid approving these policies in light of the fact that these policies are intended to supplement an individual's minimum essential coverage policy. Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers.~~ ~~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.~~

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~~X] for accidental death, [~~\$1,000~~X] for double dismemberment [~~\$500~~X] for single dismemberment.

~~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).

~~GH. 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.~~

- (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.
- (3) A carrier must 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.
- (4) A short-term limited duration health insurance plan form, application form, or disclosure form must 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.
- (5) Short-term, limited-duration health insurance must provide comprehensive major medical coverage that includes, at a minimum, the following benefits:

 - (i) 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;
 - (ii) 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;
 - (iii) 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
 - (iv) 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.
 - (v) 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.
 - (vi) "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.
 - (vii) The coverage for medical services for diagnosis and treatment of a covered condition must include office visits.
 - (viii) The coverage of medically necessary prescription drugs.
 - (ix) 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.
 - (x) 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.
- (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."
- (8) A short-term, limited-duration health insurance plan 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.
- (9) A short-term limited duration health insurance plan cannot be rescinded by the carrier during the coverage period except if the insured commits fraudulent acts as to the carrier or if the insured intentionally fails to disclose they were covered under a short-term limited duration health insurance plan during the 12-month period prior to the date of application. If the plan is rescinded, the carrier must refund to the insured all payments 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.
- (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.
- (11) In any application for a short-term, limited duration health insurance plan, made in writing by the person or on the person's behalf, the falsity of any statement (in the absence of fraud) shall not bar the right to recover under the contract unless the false statement was made with actual intent to deceive.
- (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.
- (13) All carriers offering or providing a short-term, limited-duration health insurance plan must issue a standard disclosure form for each short-term plan in the same format and with the same content as specified in this Model Regulation. The form, and all other written communications related to the short-term, limited-duration plan must be written in simply language that is readily understood by prospective applicants or insured individuals.

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 limits 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.