

SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

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

Section 2. Applicability and Scope

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

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

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

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

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

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

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

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

Section 3. Definitions

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

Drafting Note: Where the word “commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

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

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

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

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

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

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

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

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

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

Section 4. Standards for Policy Provisions

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

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

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

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

Section 5. Minimum Standards for Benefits

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

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

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

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

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

Section 6. Disclosure Requirements

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

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

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

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

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

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

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

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

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

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

Section 7. Preexisting Conditions

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

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

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

Section 8. Administrative Procedures

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

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

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

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

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

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

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

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

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

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state’s activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC’s interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO CURRENT ACTIVITY	
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas		ARK. ADMIN. CODE § 054.00.18 (1981/2003).
California		CAL. INS. CODE §§ 10600 to 10609 (1974/2019).
Colorado	NO CURRENT ACTIVITY	
Connecticut		CONN. GEN. STAT. § 38a-505 (1976/2017) (portions of previous version of model).
Delaware		DEL. CODE ANN. tit. 18, §§ 3601 to 3613 (1983/2019) (previous version of model).
District of Columbia	NO CURRENT ACTIVITY	
Florida		FLA. STAT. § 627.643 (1982/2003) (previous version of model).
Georgia	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho		IDAHO CODE ANN. §§ 41-4201 to 41-4207 (1975/2009) (previous version of model).
Illinois		215 ILL. COMP. STAT. 5/355a (1980/2017).
Indiana	NO CURRENT ACTIVITY	
Iowa		IOWA CODE §§ 514D.1 to 514D.9 (1980/2013) (previous version of model); IOWA ADMIN. CODE r. 191-36.1 (514D) (1981/2019).
Kansas		KAN. STAT. ANN. §§ 40-2216 to 40-2220 (1976/1997) (previous version of model).
Kentucky	NO CURRENT ACTIVITY	
Louisiana	NO CURRENT ACTIVITY	
Maine		ME. REV. STAT. ANN. tit. 24-A, § 2694 (2001).
Maryland		MD. CODE ANN. INS. § 12-102 (1963/2017).
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota	NO CURRENT ACTIVITY	
Mississippi	NO CURRENT ACTIVITY	
Missouri	NO CURRENT ACTIVITY	
Montana	NO CURRENT ACTIVITY	
Nebraska	NO CURRENT ACTIVITY	
Nevada	NO CURRENT ACTIVITY	
New Hampshire		N.H. REV. STAT. ANN. §§ 415-A:1 to 415-A:7 (1975/2019) (previous version of model).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
New Jersey		N.J. STAT. ANN. § 17B:26-45 (1979); N.J. ADMIN. CODE §§ 11:22-5.1 to 11:22-5.11 (2006/2019).
New Mexico		N.M. STAT. ANN. §§ 59A-23G-1 to 59A-23G-7 (2019).
New York		N.Y. INS. LAW § 3217 (1984/2017).
North Carolina	NO CURRENT ACTIVITY	
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	NO CURRENT ACTIVITY	
Oklahoma		OKLA. STAT. tit. 36, § 3611 (1957/1993); OKLA. ADMIN. CODE §§ 365:10-5-1 to 365:10-5-9 (1991/2011).
Oregon		OR. REV. STAT. § 743.010(1) (1979/2018) (commissioner’s authority to adopt).
Pennsylvania		40 PA. STAT. ANN. §§ 776.1 to 776.7 (1976) (previous version of model).
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		R.I. GEN. LAWS §§ 27-18-1 to 27-18-84 (1956/2012).
South Carolina		S.C. CODE ANN. §§ 38-71-510 to 38-71-560 (1988/1993).
South Dakota	NO CURRENT ACTIVITY	
Tennessee	NO CURRENT ACTIVITY	
Texas		TEX. INS. CODE ANN. §§ 1201.101 to 1201.154 (2005/2015); § 1202.051 (2005).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Utah		UTAH CODE ANN. §§ 31A-22-605 to 31A-22-606 (1986/2019) (previous version of model).
Vermont		4-3 VT. CODE R. § 8 (1980).
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		VA. CODE ANN. §§ 38.2-3516 to 38.2-3520 (1986/2013) (previous version of model).
Washington		WASH. REV. CODE ANN. §§ 48.20.450 to 48.20.480 (1975) (previous version of model).
West Virginia		W. VA. CODE §§ 33-28-1 to 33-28-7 (1974/1996) (previous version of model).
Wisconsin	NO CURRENT ACTIVITY	
Wyoming	NO CURRENT ACTIVITY	

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Proceedings Citations

Cited to the Proceedings of the NAIC

Drafting on the model began with the goal of providing state insurance regulators with the authority to promulgate comprehensive minimum standards for accident and sickness insurance policies. **1974 Proc. I 414.**

A representative from a trade association argued that minimum standards legislation was neither necessary nor desirable. The reasons he gave included: 1) if the standards were too rigid, progress in product development would be restricted; 2) if benefit minimums were too high, some people might be priced out of the market altogether. Since the proposed model bill left much detail to the regulation that would accompany it, he could not determine the far-reaching effects. **1974 Proc. I 418-419.**

The first model contained provisions only applicable to individual policies. An interested party commented in support of this decision because there were already procedures and practices in place to adequately inform an employee or member of a group as to the scope and extent of group coverage. **1974 Proc. I 424.**

When a group was appointed in 1997 to review the model, the members proposed amendments in several areas. They discussed the addition of group insurance provisions to the NAIC Individual Accident and Sickness Insurance Model Act and Regulation, extension of disclosure requirements, addition of clarifying drafting notes, adjustment to the models necessitated by the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and modernization of model language. In addition, the group discussed updating minimum benefit standards. **1997 Proc. 3rd Quarter 1278.**

Section 1. Purpose

The drafting group reviewed the model act and regulation and sought to standardize the use of the word “group.” The goal was to clarify that the model act and regulation covered individual major medical and supplemental policies and group supplemental policies. The model act and regulation were not intended to govern group major medical products. A regulator had expressed concern that basic hospital and surgical coverages were being sold through associations in a way that misled consumers into thinking the products provided more benefits than they actually covered. This issue was addressed in the draft model regulation through required disclosures in the outline of coverage for group basic hospital and surgical products. **1998 Proc. 1st Quarter 807.**

Section 2. Applicability and Scope

Staff noted that these were older models and that NAIC staff will try to bring these drafts up to more modern standards. In particular, she suggested the addition of a new “Applicability and Scope” section, and suggested that the exclusion of coverage be moved from the “Purpose” section to the new section. The working group agreed with this suggestion. **1998 Proc. 1st Quarter 807.**

B. The issue of whether dental plans should be excluded from the models was considered by the drafting group. Staff said that there were no other model acts that addressed minimum standards for dental plans. A regulator said that dental plans were gaining in importance and, short of setting up a new dental plan working group, he recommended including them in these models. Another regulator observed that dental plans had not caused much concern. She felt that they fit here and they might as well be left in. **1998 Proc. 1st Quarter 807.**

The issue was discussed again prior to the next meeting, and the drafters agreed that dental and vision plans were not susceptible to the same kinds of problems as other limited benefit health plans; that is, consumers were generally aware of the scope of their coverage and did not suffer from the misconception that they had comprehensive health coverage. However, since these forms of coverage were not regulated elsewhere, the group decided to keep dental and vision plans within the scope of this model act. The group agreed that the disclosure requirements for limited benefit health plans were not appropriate for dental or vision plans and, therefore, decided to exempt these plans from the specific notice requirements of the act and regulation. However, these plans would still be required to provide outlines of coverage. **1998 Proc. 2nd Quarter II 756.**

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Proceedings Citations

Cited to the Proceedings of the NAIC

Section 2 (cont.)

C. A regulator suggested that the working group should consider specifically excluding long-term care insurance and credit insurance from the model. **1997 Proc. 4th Quarter II 836.**

At the next meeting, the group reported that the Minimum Standards Act and Regulation specifically excluded products that were regulated under the NAIC Long-Term Care Insurance Model Act and Regulation. This raised the question as to whether the Long-Term Care Insurance Model Act and Regulation included policies that covered home health care (including stand-alone home health policies) or policies that covered less than one year of benefits. Staff reported that stand-alone home health coverage was included under the Long-Term Care Insurance Model Act and Regulation as long as the duration of the coverage was at least 12 months. With respect to coverage with a duration of less than 12 months, the drafting group agreed that it would be considered limited benefit health coverage under the Minimum Standards Act and Regulation. Some members of the group indicated that a stand-alone home health benefit (or any “long-term care type coverage”) of less than 12 months would not be allowed because it did not meet the definition of long-term care insurance; others indicated that it would be regulated as limited benefit health coverage. The group agreed to include a drafting note in the Minimum Standards Act and Regulation indicating that if a state allowed a long-term care product of less than one year, then it should be considered a limited benefit health plan. **1998 Proc. 2nd Quarter II 756.**

An interested party asked that Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS) plans be excluded from applicability from the models. He stated that these products were similar in structure to Medicare supplement insurance, and they should be treated as such. The working group recommended that the exclusion be placed in the next draft. **1997 Proc. 4th Quarter II 836.**

At its prior meeting, the drafting group had decided to exclude CHAMPUS supplement insurance from the models. However, the regulators wanted to confirm that these products were subject to some regulation. They researched the issue and discovered that CHAMPUS supplement insurance was not regulated on the federal level. In many instances, states regulated them as group products through filing requirements. An interested party stated that members of his association were of the opinion that CHAMPUS supplement plans were regulated as group plans, the products were filed with state insurance departments, and the products were primarily sold through associations of CHAMPUS-eligible individuals. Because there had been few reports of problems with CHAMPUS supplement plans, the drafters recommended excluding these products from the drafts and suggested that states be alerted to this issue through a drafting note. There were no objections to the drafting note from the working group or interested parties. **1998 Proc. 1st Quarter 807.**

Section 3. Definitions

A. The definition of accident and sickness insurance was modified during the drafting of amendments in 1998. **1998 Proc. 4th Quarter II 656.**

B-E. These definitions were added in 1998. **1998 Proc. 4th Quarter II 656.**

F. The definition was included in the original model in nearly the same form. **1974 Proc. I 415.**

G. This definition first appeared in 1998. **1998 Proc. 4th Quarter II 656.**

H. The definition was included in the original model in nearly the same form. **1974 Proc. I 415.**

I. This definition first appeared in 1998. **1998 Proc. 4th Quarter II 656.**

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Section 4. Standards for Policy Provisions

A. The group drafting amendments in 1997–1998 added a specific reference to group products to Section 4. One member remarked that he had noticed over the last several years a new marketing aspect incorporating work site marketing. Another regulator noted that these products were sold as individual products, and the purchasers enjoyed the portable aspects of the products, while still being able to receive something close to group premium rates. An insurer representative said that some of the products could be sold as group products. A regulator stated that group products used to mean that the employer made most of the decisions; but this new trend provided significant motivation to include group products in the model act and regulation. **1997 Proc. 4th Quarter II 836.**

An interested party objected to the language in Section 4A of the draft of the Accident and Sickness Insurance Minimum Standards Model Act that would allow the commissioner to “issue additional regulations to establish specific standards for the sale of dental and vision plans.” The association she represented did not want the commissioner to set standards for those products. The regulators agreed that the commissioner should have that authority and retained the language. **1998 Proc. 3rd Quarter 578.**

B. This subsection was included in the original model and remains substantially the same. **1974 Proc. I 416.**

Section 5. Minimum Standards for Benefits

A. When the model was amended in 1976, Paragraph (11) was added to require minimum benefit standards for limited benefit plans. **1977 Proc. I 51.**

B. An interested party asked about the rationale behind the grouping of types of policies together in a single policy, and more specifically, the prohibition of allowing specified disease, specified accident and limited benefit plans from being included in the grouping of policies. A regulator replied that specified disease policies were deemed to be experimental when the model originally was developed. There seemed to be a movement to split the coverages up into different contracts and the coverages were being spun out of major medical policies. On the other hand, if combinations are allowed, the consumer stood to lose due to duplication of per policy costs. He said that he would encourage combination of coverage as long as adequate disclosure was given to the policyholder. Another group member asked if some combination of coverage should be considered excepted coverage in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A federal representative replied that HIPAA was specific as to what was considered creditable coverage. She said that she was concerned as to what was considered excepted coverage in the statute, but she would not be concerned if the products were offered separately. In the areas of Medicare supplement insurance, specific disease and fixed indemnity, she was concerned with regard to the applicability of creditable coverage. **1997 Proc. 4th Quarter II 836.**

The decision to allow specified disease and specified accident coverage to be combined with other types of coverage raised issues with respect to HIPAA as these combined coverages may no longer be considered excepted benefits under HIPAA. The working group decided to address the issue of grouping of several limited benefits coverage in one policy by adding a drafting note alerting insurers that the combination of coverages might raise HIPAA creditable coverage concerns. Concerns were raised with respect to the wording of the drafting note and at the next meeting staff reported that the language in the drafting note had been refined. **1998 Proc. 2nd Quarter II 756.**

C. As originally drafted in 1973, this subsection imposed on the commissioner the burden of finding affirmatively that each policy was in the public interest, thereby endorsing any policy he approved. An interested party opined that the commissioner would not want to be placed in that position. As a solution he suggested that the commissioner only needed to find that the policy was not contrary to the public interest. **1974 Proc. I 419.**

D. The provisions adopted in 1973 have been the subject of technical amendments, but remain substantially the same as that in the first model. **1974 Proc. I 417.**

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Section 6. Disclosure Requirements

A. The model adopted in 1973 included a requirement for delivery of the outline of coverage that did not comport with the manner of doing business utilized by nonprofit plans. They urged a broader provision. **1974 Proc. I 424.**

New language for Section 5A was included in the draft being reviewed in late 1997, requiring the delivery of an outline of coverage. The proposed language at the beginning of Section 6 stated that the outline of coverage should be delivered either at the time of application or at the deliverance of the policy. A regulator questioned the timing of delivery, suggesting that the time of policy delivery might be too late. The chair of the drafting group also stated that the language allowed for the waiver of the requirement for group supplemental health insurance if the certificate contained the same or similar information as the outline of coverage. **1997 Proc. 4th Quarter II 836.**

The entire Subsection A from the original model was deleted in 1998 and replaced with different text. **1998 Proc. 4th Quarter II 658.**

B. The drafters revised the model act so that the outline of coverage would be delivered to the enrollee at the time of application if an agent sold the coverage to a person. However, if the policy was sold through direct response advertising, the outline of coverage would be delivered at the time of delivery of the policy. The chair explained that the group had looked at Medicare supplement insurance and long-term care insurance requirements, both of which contained this timing. The group agreed that this timing made sense since an agent should have the necessary information at the time of sale, while the coverage might change between the time of response to direct mail advertising and the actual delivery of the policy. **1998 Proc. 1st Quarter 808.**

C-F. The text of Subsections A through F was all new in 1998. **1998 Proc. 4th Quarter II 658-659.**

G. Since the model regulation was changed to require delivery of the outline of coverage at policy application for coverage issued through an agent, the issue was raised as to whether advertising material that contained the same information as the outline of coverage could fulfill this requirement. The drafting group agreed that if the advertisement contained exactly the same information in the same format (order, prominence, etc.) as required in the outline of coverage, then it could be used in place of the outline of coverage. Industry representatives pointed out that this was already allowed under the current model. The model was revised to include a drafting note after the new Subsection G clarifying that point. **1998 Proc. 2nd Quarter II 757.**

H. The text of Subsection H is nearly identical to that in the first model adopted in 1973. **1974 Proc. I.**

I. In 1978 a task force was appointed to review issues related to Medicare supplement insurance. That group decided to amend the model act to add a definition of Medicare and some disclosures regarding Medicare supplement policies. **1979 Proc. I 394-396.**

In 1989 technical amendments to the model were made to delete obsolete references to Medicare supplement. A separate model on Medicare supplement policies had been adopted. **1989 Proc. II 518-519.**

Reference to the Medicare supplement regulation was added in 1998. **1998 Proc. 4th Quarter 659.**

Section 7. Preexisting Conditions

A. Subsection A remains substantially the same as when it was originally adopted in 1973. **1974 Proc. I 418.**

B. This subsection was added in 1980, without discussion. **1980 Proc. II 634.**

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Section 8. Administrative Procedures

When the first version of the model was being considered for adoption, an interested party urged regulators to include a delayed effective date of at least 180 days to allow time for the drafting, submission and approval of policies affected by the regulation, which had not yet been developed. The model as adopted did not include that wording. **1974 Proc. I 418-419.**

Chronological Summary of Action

December 1973: Model adopted.

December 1976: Some amendments were adopted.

December 1978: Added reference to Medicare supplements.

June 1980: Added Section 7C.

June 1989: Removed provisions related to Medicare supplement insurance, in recognition of the extensive models specific to that type of coverage.

March 1998: Model extensively amended. Group limited benefit plans included. Updated in response to the federal Health Insurance Portability and Accountability Act (HIPAA).