

TEXAS DEPARTMENT OF INSURANCE COMMENTS

Draft: 5/31/19
Model#171

Comments are being requested on this draft. 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 ACCIDENT AND SICKNESS SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 6. Prohibited Policy Provisions

- A. Except as provided in Section 5K, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six-month exception shall not be applicable where the specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.
- B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.
- (2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.
- C. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.

Drafting Note: Where the state has enacted the NAIC Individual Accident and Sickness 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.

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Commented [TX1]: Consider limiting the permitted waiting period to plans that are guaranteed renewable. For example, it seems misleading in a STLD policy or a policy that can re-underwrite each year and renew only at the company's option. (Such policies could instead simply exclude the coverage if they choose.)

Commented [TX2]: I would be interested in better understanding this provision, its origins, and if it is still relevant.

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Commented [TX3]: Recommend clarifying that, except for STLD and limited scope dental and vision, the policies covered by this model cannot coordinate. As referenced in drafting notes to 7-B and 7-E, the coordination of benefits model excludes these types of coverage from the definition of a "plan," which is permitted to coordinate. However, since the COB model does not technically apply to policies that are not "plans," some carriers attempt to limit coverage to "excess only."

We generally do not permit this, but believe clarification is needed.

(We have, on a case by case basis, permitted some excess provisions in blanket policies. However, a uniform standard would be helpful on this topic.)

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D. A disability income protection policy may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to the Act and this regulation shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.

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

F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

- (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;
- (2) Mental or emotional disorders, alcoholism and drug ~~addition~~addiction;
- (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section ~~747C~~ of this regulation;
- (4) Illness, treatment or medical condition arising out of:
 - (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;
 - (b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
 - (c) Aviation;
 - (d) With respect to short-term nonrenewable policies, interscholastic sports; and
 - ~~1(e)~~ With respect to disability income protection policies, incarceration.

Drafting Note: What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.

- (5) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;
- (6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
- (7) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

Commented [TX4]: Why is this provision limited to these types of policies? (Note that a policy could always exclude coverage for which the insured is not liable for a bill.) Consider broadening. For example:

A policy may not require that a covered service be provided by a particular type of licensed facility or person, as long as the covered service is within the scope of the provider's license.

Commented [TX5]: Consider whether permitted exclusions for STLD should be consistent with other excepted benefits. Texas generally reviews for benefits consistent with major medical. For example, Texas mandates would not permit a STLD to exclude:
- Mental illness (including parity and any self-inflicted injury that is a result of a mental illness)
- Chemical dependency
- TMJ
- Hearing aids
- Preventive services

Commented [TX6]: Consider striking this, since the service in the armed forces covers it. (For example, are we intending to exclude victims of acts of war, such as injuries from a terrorist act?)

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Drafting Note: States should examine any existing “freedom of choice” statutes that require reimbursement of treatment provided by chiropractors, and make adjustments if needed.

- (8) Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workmen’s compensation, employers liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person’s immediate family; and services for which no charge is normally made in the absence of insurance;
- (9) Dental care or treatment;
- (10) Eye glasses, hearing aids and examination for the prescription or fitting of them;
- (11) Rest cures, custodial care, transportation and routine physical examinations; and
- (12) Territorial limitations.

Commented [TX7]: Recommend removing

Commented [TX8]: Consider whether to disallow excluding dental care pursuant to an accident.

Commented [TX9]: Consider removing. Texas only permits territorial limits in a disability income policy

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.

~~**Drafting Note:** States with specific waiver requirements that differ for group insurance should add language in Subsection G to be consistent with applicable statutes.~~

- H. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 34B of the ~~Accident and Sickness 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.

Section 7. ~~Accident and Sickness 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. ~~An individual accident and sickness insurance policy or group supplemental 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 8L8H 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 5A and B and C of the NAIC ~~Accident and Sickness Supplementary and Short-Term Health Insurance Minimum Standards Model Act~~].

- A. General Rules
 - (1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual ~~accident and sickness supplementary or short-term health~~ policy shall not provide for termination of coverage of the spouse solely because of the occurrence

Commented [TX10]: Consider clarifying that some combinations disqualify a product from being considered an excepted benefit. For example, adding sickness benefits to an accident-only policy will cause it to be reviewed as a major medical plan.

It may be useful to add product definitions that capture the excepted benefit parameters.

Add a statement:
A policy that includes two or more categories of coverage must meet the minimum standards applicable to each type of coverage included.

Commented [TX11]: Discuss expectations for renewability rights within a group policy, particularly with reference to member-only associations.

Commented [TX12]: A policy must clearly state how benefits are paid, and whether the policy provides benefits on a fixed indemnity basis or on an expenses-incurred basis.

A policy that limits benefits for medical expenses to a “usual and customary” amount must clearly state how the usual and customary amount is determined.

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of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

- (2) (a) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A(1).
 - (b) The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual ~~accident and sickness~~supplementary or short-term health policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.
 - (c) An individual ~~accident and sickness~~supplementary or short-term health policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.
 - (d) Except as provided above, the term "guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.
- (3) In an individual ~~accident and sickness~~supplementary or short-term health policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

Drafting Note: For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law, unless it is an excepted benefit as described in Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA, the ACA or applicable state law.

- (4) When accidental death and dismemberment coverage is part of the individual ~~accident and sickness~~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.
- ~~1-(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.

Commented [TX13]: Consider expanding "spouse" to similarly protect other covered dependents.

Commented [TX14]: Consider defining the rights presumed to attach to the right to continue or renew –
- No new underwriting
- Rates may increase only by class
- May not change which rating class the insured is assigned to
- Changes may only be made with signed acceptance of insured/policyholder, unless necessary to comply with state or federal law

Commented [TX15]: Consider expanding "spouse" to similarly protect other covered dependents.

Commented [TX16]: Recommend expanding to group.

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Commented [TX17]: Do servicemember protections need to be expanded, consistent with 50 USC §4024?

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- (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 ~~accident and sickness~~ supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to mental ~~retardation~~ or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.
- (9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.
- (10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.
- (11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.
- (12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.
- (13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.
- (14) Termination of the policy shall be without prejudice of toto a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.
- (15) A policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

Commented [TX18]: Recommend expanding to group.

Commented [TX19]: Should this be moved to the disability section (C) ?

Commented [TX20]: Consider expanding these time frames. Depending on the nature of an injury, a loss (like an amputation) could occur later. Likewise, a disability may take longer than 30-days to become evident.

Commented [TX21]: Discussion needed. Is this in the context of a fixed AD&D benefit or a policy that covers expenses, like accident only?

Commented [TX22]: Should (12) and (13) be moved to section (D) re. accident-only coverage?

Commented [TX23]: Consider defining terms – policy period, benefit period

Commented [TX24]: Should the provision be broadened?
A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or include unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

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~~B. Basic Hospital Expense Coverage~~

~~"Basic hospital expense coverage" is a policy of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:~~

- ~~(e) Daily hospital room and board in an amount not less than the lesser of:

 - 1. [80%] of the charges for semiprivate room accommodations or~~

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(b) — \$100 per day;

Drafting Note: The commissioner may determine the level of daily room and board benefits that he or she considers appropriate as a minimum for a basic hospital contract in his state. It should be an underlying principle for the establishment of benefits that the amounts are to be minimums, not maximums. In order to accommodate those states that have a substantial differential in hospital room and board costs between urban and rural areas within a state, the following language may be used in addition to the language in Subsection B(1) above: "except that \$[insert amount] may be reduced to \$[insert amount] outside the area." Other dollar amounts and percentages applicable to the various minimum benefits that follow are also bracketed to permit a commissioner to set the level of minimum benefits for his or her particular state.

- (2) — Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [\$3,000] or [ten] times the daily hospital room and board benefits; and
- (3) — Hospital outpatient services consisting of:
 - (a) — Hospital services on the day surgery is performed:
 - (b) — Hospital services rendered within seventy-two (72) hours after injury, in an amount not less than [\$150]; and
 - (c) — X ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than [\$100] if rendered to an in-patient of the hospital.
 - (4) — Benefits provided under Paragraphs (1) and (2) of this subsection may be provided subject to a combined deductible amount not in excess of [\$100].

C. — Basic Medical Surgical Expense Coverage

"Basic medical surgical expense coverage" is a policy of accident and sickness insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

- (1) — Surgical services:
 - (a) — In amounts not less than those provided on a fee schedule based on the relative values contained in the [insert reference to a fee schedule based on the Current Procedure Terminology (CPT) coding or other acceptable relative value schedule], up to a maximum of at least [\$1000] for a one procedure; or
 - (b) — Not less than [80%] of the reasonable charges.
- (2) — Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services:
 - (a) — In an amount not less than [80%] of the reasonable charges; or
 - (b) — [15%] of the surgical service benefit.

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(3) ~~In hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than [80%] of the reasonable charges, or [\$50] per day for not less than twenty-one (21) days during one period of confinement.~~

~~I. Basic Hospital/Medical Surgical Expense Coverage~~

~~“Basic hospital/medical surgical expense coverage” is a combined coverage and must meet the requirements of both Subsections B and C.~~

~~EB. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage~~

- (1) ~~“Hospital ~~confinement~~ indemnity or other fixed indemnity coverage” is a policy of ~~accident and sickness~~supplementary health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [\$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy.~~
- (2) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.
- (3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.

Drafting Note: Hospital ~~confinement~~ indemnity or other fixed indemnity coverage is recognized as supplemental coverage. Any hospital ~~confinement~~ indemnity or other fixed indemnity coverage, therefore, must be payable regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of hospital ~~confinement~~ indemnity or other fixed indemnity coverage. Section 3H(4) of the Group Coordination of Benefits Model Regulation states that the definition of a plan (for the purposes of coordination of benefits)...shall not include individual or family insurance contracts....” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of hospital ~~confinement~~ indemnity or other fixed indemnity coverage purchased by the insured.

~~F. Individual Major Medical Expense Coverage~~

~~(1) “Individual major medical expense coverage” is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than [\$500,000]; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out of pocket maximum after any deductibles shall not exceed ten thousand dollars (\$10,000) per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed five percent (5%) of the aggregate maximum limit under the policy for each covered person for at least:~~

- ~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;~~
- ~~(b) Miscellaneous hospital services;~~
- ~~(c) Surgical services;~~
- ~~(d) Anesthesia services;~~
- ~~(e) In hospital medical services;~~

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Commented [TX25]: Create a separate section with minimum standards for other fixed indemnity coverage. Clarify that any policy that provides coverage on a fixed indemnity basis is also subject to minimum standards for coverage based on the nature of the benefits provided. For example, fixed indemnity accident-only or AD&D coverage, is also subject to minimum accident standards. Fixed indemnity specified disease coverage is subject to specified disease minimum standards. A policy that provides a per-service benefit for comprehensive accident and sickness may be subject to major medical coverage requirements.

Commented [TX26]: Consider clarifying that a hospital indemnity and other fixed indemnity policies provide cash benefits that are not based on the specific services delivered. Since the benefit is a daily benefit and is not based on expenses incurred, a deductible should not apply within this type of plan. Instead, a short elimination period may apply, similar to a disability policy.

Commented [TX27]: Include a provision under Section 6 addressing that excepted benefits may not be “excess only” or otherwise condition benefits on other coverage.

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~~(f) — Out of hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and~~

~~(g) — Not fewer than three (3) of the following additional benefits:~~

~~(i) — In hospital private duty registered nurse services;~~

~~(ii) — Convalescent nursing home care;~~

~~(iii) — Diagnosis and treatment by a radiologist or physiotherapist;~~

~~(iv) — Rental of special medical equipment, as defined by the insurer in the policy;~~

~~(v) — Artificial limbs or eyes, casts, splints, trusses or braces;~~

~~(vi) — Treatment for functional nervous disorders, and mental and emotional disorders; or~~

~~(vii) — Out-of-hospital prescription drugs and medications.~~

~~(2) — If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~

~~(3) — The minimum benefits required by 7F(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7F(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

~~1. — Individual Basic Medical Expense Coverage~~

~~(4) — "Individual basic medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$250,000; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed \$25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed ten percent (10%) of the aggregate maximum limit under the policy for each covered person for at least:~~

~~(a) — Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than thirty-one (31) days during continuous hospital confinement;~~

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- ~~(b) — Miscellaneous hospital services;~~
- ~~(c) — Surgical services;~~
- ~~(d) — Anesthesia services;~~
- ~~(e) — In hospital medical services;~~
- ~~(f) — Out of hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and~~
- ~~(g) — Not fewer than three (3) of the following additional benefits:
 - ~~(i) — In hospital private duty graduate registered nurse services;~~
 - ~~(ii) — Convalescent nursing home care;~~
 - ~~(iii) — Diagnosis and treatment by a radiologist or physiotherapist;~~
 - ~~(iv) — Rental of special medical equipment, as defined by the insurer in the policy;~~
 - ~~(v) — Artificial limbs or eyes, casts, splints, trusses or braces;~~
 - ~~(vi) — Treatment for functional nervous disorders, and mental and emotional disorders; or~~
 - ~~(vii) — Out of hospital prescription drugs and medications.~~~~
- ~~(2) — If the policy is written to complement underlying basic hospital expense and basic medical surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.~~
- ~~(3) — The minimum benefits required by 7G(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7G(1)(g) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, an individual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

HC 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:

Commented [TX28]: Consider moving definitions of partial, residual, and total disability into this section, as many have requirements embedded into them and don't seem relevant for other types of products.

Consider aligning with IIPRC standards and noting any variations in drafting notes.

Commented [RB29]: “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.

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Commented [RB30]: Remove the sickness or injury requirement to permit disability coverage for other circumstances, including an insured’s pregnancy, as well as family leave to care for a newborn or sick, injured, or disabled family member. Consider whether a disability policy must, at a minimum, cover a disability due to sickness or injury.

Limitations embedded into the definitions of sickness and injury may unintentionally reduce the scope of circumstances covered within a disability policy. Remove limits from definitions and instead identify permissible exclusions either in Section 6-F or in product-specific paragraphs in Section 7.

Commented [RB31]: E. (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.

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- (1) Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62);
- (2) Contains an **elimination period** no greater than:
 - (a) Ninety (90) days in the case of a coverage providing a benefit of one year or less;
 - (b) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or
 - (c) Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;
- (3) Has a maximum period of time for which it is payable during disability **of at least six (6) months**, except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. ~~Section 7F does not apply to those policies providing business buy-out coverage;~~
- (4) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

Commented [TX32]: Add a definition for elimination period.

Consider modifying this provision to provide that an elimination period cannot exceed 50% of the benefit period.

Commented [TX33]: Consider defining a short-term and a long-term disability benefit duration with applicable standards. Note that IIPRC permits a 3-month short-term benefit term.

D. **Accident Only Coverage**

“Accident only coverage” is a policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least [\$1,000] and a single dismemberment amount shall be at least [\$500].

Commented [TX34]: Note that accident-only cannot include sickness (or wellness) benefits. The combination of an accident-only benefit with a sickness benefit disqualifies it from treatment as an excepted benefit and major medical standards may apply.

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.

Commented [TX35]: Consider adding a definition for disease and clarifying whether pregnancy, infertility, mental health conditions, and substance use disorders may be covered as a specified disease.

(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.

Commented [TX36]: Consider whether to limit the number of specified diseases that may be covered. Some policies appear designed to be sold alongside an accident-only policy and marketed as comprehensive coverage.

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- (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 ~~accident and sickness~~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.
- (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.

Commented [TX37]: Delete reference to STLD.

Commented [TX38]: Define waiting period, probationary period.

Clarify whether premium is paid during the period. Clarify whether a condition is considered preex if it arises during the period.
Clarify how any separate types of periods interact.

Commented [TX39]: Consider clarifying what happens if an individual later becomes eligible for Medicaid, and addressing under (A), with respect to all product types.

Commented [TX40]: Clarify the applicability of UR requirements related to determinations of medical necessity, appropriateness, experimental/investigational. In Texas, we apply to all plans using medical necessity language, but Model 73 appears to apply only to a health benefit plan, which includes STLD but excludes excepted benefits.

Drafting Note: Specified disease coverage is recognized as supplemental coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the ~~Group Coordination of Benefits Model Regulation~~ states that the definition of a "plan" (for the purpose of coordination of benefits) "shall not include individual or family insurance contracts." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

Commented [TX41]: Include a provision under Section 6 addressing that excepted benefits may not be "excess only" or otherwise condition benefits on other coverage.

- (i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.
- (j) Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge" or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges."
- (k) "Preexisting condition" shall not be defined to be more restrictive than the following: "Preexisting condition means a condition for which medical advice,

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diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person.”

- (l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded.
- (m) Hospice Care.
 - (i) “Hospice” means a facility licensed, certified or registered in accordance with state law that provides a formal program of care that is:
 - (I) For terminally ill patients whose life expectancy is less than six (6) months;
 - (II) Provided on an inpatient or outpatient basis; and
 - (III) Directed by a physician.
 - (ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:
 - (I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;
 - (II) A fixed-sum payment of at least \$50 per day; and
 - (III) A lifetime maximum benefit limit of at least \$10,000.
 - (iii) Hospice care does not cover 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 treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers.
- (3) The following minimum benefits standards apply to **non-cancer** coverages:
 - (a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of [\$250] and an overall aggregate benefit limit of no less than [\$10,000] and a benefit period of not less than [two (2) years] for at least the following **incurred expenses**:
 - (i) Hospital room and board and any other hospital furnished medical services or supplies;
 - (ii) Treatment by a legally qualified physician or surgeon;

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- (iii) Private duty services of a registered nurse (R.N.);
 - (iv) X-ray, radium and other therapy procedures used in diagnosis and treatment;
 - (v) Professional ambulance for local service to or from a local hospital;
 - (vi) Blood transfusions, including expense incurred for blood donors;
 - (vii) Drugs and medicines prescribed by a physician;
 - (viii) The rental of an iron lung or similar mechanical apparatus;
 - (ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;
 - (x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
 - (xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.
- (b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than [\$25,000] payable at the rate of not less than [\$50] a day while confined in a hospital and a benefit period of not less than 500 days.
- (4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of [\$250], and an overall aggregate benefit limit of not less than [\$10,000] and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:
- (a) Treatment by, or under the direction of, a legally qualified physician or surgeon;
 - (b) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;
 - (c) Hospital room and board and any other hospital furnished medical services or supplies;
 - (d) Blood transfusions and their administration, including expense incurred for blood donors;
 - (e) Drugs and medicines prescribed by a physician;
 - (f) Professional ambulance for local service to or from a local hospital;
 - (g) Private duty services of a registered nurse provided in a hospital;
 - (h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured

Commented [TX42]: Consider broadening to permit a daily benefit for outpatient care and for confinement in other types of facilities, as is permitted for a cancer policy under 7-E-5.

Commented [TX43]: Consider adding:
- a definition of expense incurred; and
- a general provision related to payment standards and transparency, given the evolving use of terms like usual and customary. This should be addressed in general rules under Section 7-A

Commented [TX44]: Consider whether to permit a different payment methodology, such as x% of Medicare.

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person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;

- (i) Braces, crutches and wheelchairs deemed necessary by the attending physician for the treatment of the disease;
- (j) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
- (k) (i) Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A "home health care agency" (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:
 - (I) It is primarily engaged in providing home health care services;
 - (II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse);
 - (III) A physician or a registered nurse provides supervision of home health care services;
 - (IV) It maintains clinical records on all patients; and
 - (V) It has a full time administrator.

Drafting Note: State licensing laws vary concerning the scope of "home health care" or "home health agency services" and should be consulted. In addition, a few states have mandated benefits for home health care including the definition of required services.

- (ii) Home health includes, but is not limited to:
 - (I) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;
 - (II) Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;
 - (III) Physical, occupational or speech and hearing therapy; and
 - (IV) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.
- (l) Physical, speech, hearing and occupational therapy;

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- (m) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;
- (n) Prosthetic devices including wigs and artificial breasts;
- (o) Nursing home care for noncustodial services; and
- (p) Reconstructive surgery when deemed necessary by the attending physician.

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

- (5) (a) The following minimum benefits standards apply to **cancer** coverages written on a **per diem indemnity basis**. These coverages shall offer insured persons:
 - (i) A fixed-sum payment of at least [\$100] for each day of hospital confinement for at least [365] days;
 - (ii) A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and
 - (iii) A fixed-sum payment of at least \$50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.
- (b) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following:
 - (i) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.
 - (ii) A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days.
 - (iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.
 - (iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.
- (6) The following minimum benefits standards apply to **lump-sum indemnity coverage** of any specified disease:
 - (a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of \$1,000.

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Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should be sensitive to this possibility in approving policies.

- (b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving skin cancer or other exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

~~K~~F. Specified Accident Coverage

“Specified accident coverage” is a policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than [\$1,000] for accidental death, [\$1,000] for double dismemberment [\$500] for single dismemberment.

~~L~~G. Limited Benefit Health Coverage

~~1~~(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, ~~C~~, D, E, and ~~F, G, I and K~~. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section ~~8L8H~~ 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 ~~77E~~ and shall not be offered for sale as a “limited coverage.”

~~2~~(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 benefit healthlong-term care insurance plans, and should be subject to the ~~NAIC Accident and Sickness Insurance Minimum Standards Model Act and implementing regulation Limited Long-Term Care Insurance Model Act (#642) and its implementing regulation, the Limited Long-Term Care Insurance Model Regulation (#643).~~

~~H~~. Short-Term, Limited-Duration Health Insurance Coverage

(1) An individual policy or group certificate of short-term limited-duration insurance must provide benefits consistent with the minimum standards for the type of coverage offered.

(2) Short-term limited-duration coverage, including individual policies and group certificates:

- (a) may not be marketed as guaranteed renewable;

Commented [TX45]: Is this category still relevant with the removal of major medical from the model? Specified disease is the only product left with substantive requirements and cannot be offered as a limited benefit plan.

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Commented [TX46]: The content below reflects Texas rules for STLD plans at [28 TAC §3.6302](#), which [implement Insurance Code Chapter 1509](#).

These rules are primarily focused on disclosure, moreso than minimum standards. See also the [disclosure form](#) adopted as part of the rules.

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- (b) must be marketed either as nonrenewable, or renewable (without new underwriting) at the option of the policyholder or enrollee, if the enrollee contributes to the premium;
 - (c) must clearly state the duration of the initial term and the total maximum duration including any renewal options;
 - (d) may not be modified after the date of issue, except by signed acceptance of the policyholder or the enrollee, if the enrollee contributes to the premium; and
 - (e) if coverage is renewable, a short-term limited-duration individual policy or group certificate must:
 - (i) include a statement that the enrollee has a right to continue the coverage in force by timely payment of premiums for the number of terms listed;
 - (ii) include a statement that the issuer will not increase premium rates or make changes in provisions in the policy, or certificate, on renewal based on individual health status;
 - (iii) if applicable, include a statement that the issuer retains the right, at the time of policy renewal, to make changes to premium rates by class; and
 - (iv) include a statement that the issuer, at the time of renewal, may not deny renewal based on individual health status.
- (3) An issuer offering short-term limited-duration insurance must include an accurate written disclosure form that is consistent with the form and instructions prescribed in [disclosure form] and the requirements of this section.
- (4) In creating a disclosure form, issuers must follow all instructions provided in this subsection:
- (a) The disclosure must be produced for each plan option that the issuer makes available and reflect the specific terms of the plan.
 - (b) The disclosure form must accurately represent the short-term limited-duration coverage being provided.
 - (c) If the disclosure form does not accurately represent the plan being offered, the issuer may modify the form as necessary. When filing the form with the department, the issuer must clearly identify any changes made and explain the reason for modifying the form.
 - (d) The chart under disclosure form paragraph (9) may be supplemented to include cost-sharing information for each benefit.
- (5) A disclosure form under this section must be:
- (a) filed with the department for review before use, consistent with filing procedures in Subchapter A of this chapter;
 - (b) provided in writing to a prospective enrollee:
 - (i) before the individual completes an application or makes an initial premium payment, application fee, or other fee; and
 - (ii) at the time the policy or certificate is issued; and
 - (c) signed by the enrollee to acknowledge receipt at the time of application. An electronic signature is acceptable if the issuer's procedures comply with [electronic transaction requirements].
