REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Aug. 13, 2024, Minutes
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- Accident and Sickness Insurance Minimum Standards (B) Subgroup July 29, 2024, Minutes (Attachment Two)
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- Accident and Sickness Insurance Minimum Standards (B) Subgroup March 25, 2024, Minutes (Attachment Seven)
- Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group March 17, 2024, Minutes (Attachment Eight)
- Pharmacy Benefit Manager Regulatory Issues (B) Subgroup June 7, 2024, Minutes (Attachment Nine)
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  - Draft Revised 2024 Charges (Attachment Ten-A)

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Draft Pending Adoption

Draft: 8/19/24

Regulatory Framework (B) Task Force
Chicago, Illinois
August 13, 2024

The Regulatory Framework (B) Task Force met in Chicago, IL, Aug. 13, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie, Vice Chair, represented by Erica Weyhenmeyer (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by John Buono (AL); Michael Conway represented by Kate Harris and Debra Judy (CO); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Amy L. Beard represented by Scott Shover (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Shaun Orme (KY); Robert L. Carey represented by Robert Wake and Marti Hooper (ME); Chlora Lyndley-Myers represented by Amy Hoyt (MO); Mike Causey represented by John Hoomani (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Judith L. French represented by Laura Miller (OH); Michael Humphreys represented by Shannen Logue (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by R. Michael Markham, Debra Diaz-Lara, and Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup, Ryan Jubber, and Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek represented by Rebecca Rebholz and Jennifer Stegall (WI); and Allan L. McVey represented by Joylynn Fix (WV). Also participating was: Patrick Smock (RI).

1. <u>Adopted its July 1 and Spring National Meeting Minutes</u>

The Task Force met July 1 and adopted by e-vote its 2024 revised charges, which amend the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.

Swanson made a motion, seconded by VanAalst, to adopt the Task Force's July 1 (Attachment One) and March 16 (*see NAIC Proceedings – Spring 2024, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. <u>Adopted its Subgroup and Working Group Reports</u>

Gaines made a motion, seconded by Logue, to adopt the following reports: 1) the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 29 (Attachment Two), July 15 (Attachment Three), June 24 (Attachment Four), April 22 (Attachment Five), April 8 (Attachment Six), and March 25 (Attachment Seven) minutes; 2) the Employee Retirement Income Security Act (ERISA) (B) Working Group; 3) the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its March 17 (Attachment Eight) minutes; and 4) the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its June 7 (Attachment Nine) and May 2 (Attachment Ten) minutes. The motion passed unanimously.

3. <u>Heard a Presentation from CHIR on Facility Fees</u>

Rachel Swindle (Center on Health Insurance Reforms—CHIR) discussed outpatient facility fee billing reforms and options for the states to address the issue. She explained that facility fees are a second fee that hospitals charge in addition to the health care professional's bill. She said that entities charging such fees assert that the fees are to cover hospital overhead costs. Swindle described the issues involved in charging facility fees, such as consumer out-of-pocket cost exposure and the lack of transparency in billing and ownership. She also discussed potential

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solutions, including: 1) site-neutral payment; 2) billing transparency; 3) public reporting; and 4) consumer notification requirements.

Swindle provided an overview of state outpatient facility fee reforms, explaining that some states, such as Colorado, Connecticut, Maryland, and Washington, have implemented multiple strategies to address the issue. She highlighted a few of those state reforms: 1) facility fee prohibitions; 2) requiring billing transparency; and 3) public oversight. Swindle also identified states that have implemented certain outpatient facility fee reforms. She discussed additional CHIR resources and publications that have been developed on outpatient facility fees.

4. Discussed *Loper Bright* and Potential Implications on Health Insurance-Related Regulations

William G. Schiffbauer (Schiffbauer Law Office) provided an overview of *Loper Bright Enterprises v. Raimondo* and *Relentless v. Department of Commerce* (collectively referred to as *Loper Bright*) rulings, which overturned the so-called "Chevron Doctrine." He also discussed its potential implications on federal health insurance-related regulations.

Schiffbauer explained that the Chevron Doctrine stems from a ruling in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.* (*Chevron*), which required federal courts to defer to a federal agency's reasonable interpretation where statutory text is ambiguous or silent. He said the case involved a challenge to a federal agency rule under the federal Administrative Procedure Act (APA). In its ruling, the court established a two-step analysis for federal courts to follow when conducting judicial reviews of such challenges. Schiffbauer said the Chevron Doctrine adopted a presumption of an implied delegation of interpretative authority to a federal agency without reference to any provision in the APA.

Schiffbauer explained how the *Loper Bright* ruling overturned the Chevron Doctrine and its two-step analysis. He said that in overturning the Chevron Doctrine, the majority opinion stated that *Chevron* defies the command of the APA that the reviewing court, not the agency whose action it reviews, is to decide all relevant questions of law and statutory interpretation. *Chevron* requires a court to ignore, not follow, the reading the court would have reached had it exercised its independent judgment, as required by the APA.

Schiffbauer highlighted several health insurance-related regulations, including the federal Affordable Care Act's (ACA's) Section 1557 federal regulations, the ACA's cost-sharing and deductible regulations, and Medicare hospital payment rules that could be affected by the overturning of the Chevron Doctrine. He suggested that moving forward, federal agency rules upheld in prior court decisions using *Chevron* may still be challenged under the APA and de novo review by a federal court. He noted that the Supreme Court of the U.S. has already vacated several appellate court *Chevron* decisions pending review and remanded them for further consideration under *Loper Bright*. Schiffbauer suggested that state agencies might examine judicial review provisions and deference case law under their state administrative procedure acts and consider the lessons of *Loper Bright*.

5. Heard a Presentation from BPC and AHIP on the New Collaborative Multi-Stakeholder Initiative PHtP

Anand Parekh (Bipartisan Policy Center—BPC) and Kate Berry (America's Health Insurance Plans—AHIP) discussed Promoting Health Through Prevention (PHtP), a new collaborative multi-stakeholder initiative. Parekh explained that AHIP and a coalition of preeminent public and private health organizations launched PHtP to encourage people to get the recommended preventive services available with no out-of-pocket cost under the ACA because preventive services save lives. He discussed the current uptake for certain preventive services and how there is room for improvement. The lack of patient education is a major factor contributing to the low uptake of preventive services, and PHtP aims to address this issue. Parekh described how participants in the PHtP initiative are using multiple communication approaches to raise awareness about the importance of preventive services.

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Berry discussed the health organizations participating in the PHtP initiative. She described the PHtP's ongoing actions, including: 1) expanding participation; 2) identifying strategies/timing for additional communications; 3) conducting targeted outreach for different populations and/or types of screenings; and 4) exploring fundraising to support broader advertising and outreach. She also highlighted opportunities for the states and related stakeholder engagement by promoting the MyHealthfinder tool and leveraging existing social media tools.

Commissioner Mulready asked where to find the MyHealthfinder tool, which Berry explained can be accessed at *https://health.gov/myhealthfinder*. Commissioner Mulready noted that PHtP released a press release announcing the new initiative. He asked about other ways state insurance regulators and other stakeholders could promote the initiative. Berry said the PHtP has social media messages and other white-label media she would be happy to share.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 7/2/24

Regulatory Framework (B) Task Force
E-Vote
July 1, 2024

The Regulatory Framework (B) Task Force conducted an e-vote that concluded July 1, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie represented by Erica Weyhenmeyer, Vice Chair (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler (AL); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods (DC); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Amy L. Beard represented by Alex Peck (IN); Vicki Schmidt (KS); Sharon P. Clark (KY); Kevin P. Beagan (MA); Robert L. Carey represented by Robert Wake (ME); Chlora Lyndley-Myers represented by Jo LeDuc (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Scott Kipper (NV); Judith L. French represented by Laura Miller (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys represented by Jodi Frantz (PA); Larry D. Deiter (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its 2024 Revised Charges

The Task Force conducted an e-vote to consider adoption of its 2024 revised charges, which amend the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 7/2/24
Adopted by the Health Insurance and Managed Care (B) Committee, July 26, 2024
Adopted by the Regulatory Framework (B) Task Force, July 1, 2024
Adopted by the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, June 7, 2024

2024 Revised Proposed Charges

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2024.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to association health plans (AHPs).
   F. Monitor, analyze, and report, as necessary, developments related to short-term, limited-duration (STLD) coverage.

2. The **Accident and Sickness Insurance Minimum Standards (B) Subgroup** will:
   A. Review and consider revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

3. The **ERISA (B) Working Group** will:
   A. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.
   D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook) and modify it, as necessary, to reflect developments related to ERISA. Report annually.

REGULATORY FRAMEWORK (B) TASK FORCE *(continued)*

4. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
   A. Monitor, report, and analyze developments related to the MHPAEA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Develop and provide resources to the states to support a greater understanding of laws, policies, and market conditions related to the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the *Market Regulation Handbook*.
   E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

5. The ~~**Pharmacy Benefit Manager Regulatory Issues (B) Subgroup**~~**Pharmaceutical Benefit Management Regulatory Issues (B) Working Group** will:
   ~~A. Develop a white paper to: 1) analyze and assess the role pharmacy benefit managers (PBMs), pharmacy services administrative organizations (PSAOs), and other supply chain entities play in the provision of prescription drug benefits; 2) identify, examine, and describe current and emerging state regulatory approaches to PBM business practices, such as price transparency and reporting requirements, rebating, and spread pricing, including the implications of the *Rutledge v. Pharmaceutical Care Management Association (PCMA)* decision on such business practices; and 3) discuss any challenges, if any, the states have encountered in implementing such laws and/or regulations.~~
   ~~B. Consider developing a new NAIC model to establish a licensing or registration process for PBMs. Based on issues identified in the white paper, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.~~
   A. Serve as a forum to educate state insurance regulators on issues related to pharmacy benefit manager (PBM) regulation and other stakeholders in the prescription drug ecosystem.
   B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to PBM regulation, such as examinations and contracting, and pharmaceutical drug pricing and transparency.
   C. As the subject matter experts (SMEs) and to promote uniformity across the states, while remaining sensitive to variation in state approaches, develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related regulated entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group.
   D. Maintain a current listing of PBM laws and regulations and case law for reference by state insurance regulators.
   E. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   F. Monitor, facilitate, and coordinate with the states and federal agencies to ensure compliance and enforcement efforts regarding PBMs.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook

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Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 29, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 29, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Stephen Flick (DC); Carson Gaines (FL); Robert Wake (ME); Camille Anderson-Weddle (MO); Martin Swanson and Maggie Reinert (NE); Andreea Savu (SC); Heidi Clausen and Shelley Wiseman (UT); and Anna Van Fleet and Jamie Gile (VT).

1. Discussed Additional Comments Received on Draft Revisions to Model #171

Before beginning its discussion of the comments submitted by Wake on the May 3 draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force, Attachment Four-A*), the Subgroup reviewed Bowden's revisions to Section 8E(4) (Attachment Two-A). Bowden said the revisions reflect the Subgroup's discussion during its July 15 meeting. She said that in addition, she suggests that the Subgroup consider moving the language defining "home health care agency" in Section 8E(4)(k)(i) to Section 6—Policy Definitions. After discussion, the Subgroup accepted Bowden's revisions to Section 8E(4) and her suggestion to move the definition of "home health care agency" to Section 6. The Subgroup also agreed to correct a spelling error and delete the word "chux," which is a product brand name for disposable absorbent pads, and replace it with "disposable absorbent pads."

The Subgroup next discussed Wake's comments on Section 8H(8)—Short-Term, Limited-Duration Health Insurance Coverage concerning the notice requirements necessary when rescinding a policy. After discussion, the Subgroup agreed to clarify this provision by adding language separating the rescission notice requirements from the cancellation notice requirements to require a carrier to provide "a notice of rescission to an insured in writing with an appeal period of [thirty (30) days]." The Subgroup discussed Wake's comments and suggested revisions to the drafting note for Section 8H. After discussion, the Subgroup accepted Wake's suggested revision of adding a new sentence at the beginning of the drafting note. The Subgroup decided to delete the remainder of the drafting note language and requested NAIC staff add language alerting the states that they should review any relevant federal regulations establishing requirements for short-term, limited-duration (STLD) coverage that could differ from the state's requirements.

The Subgroup next discussed Wake's suggested revisions to Section 9A(1)—Required Disclosure Provisions. Wake suggested revising this provision to clearly state that the disclosures required under Section 9 may be modified as needed for accuracy and clarity "and only with the approval of the commissioner." The Subgroup accepted his suggested revision. The Subgroup also accepted Wake's non-substantive revisions to Section 9A(2). The Subgroup discussed Wake's suggested revisions to the drafting note for Section 9A(2). After discussion, the Subgroup accepted his suggested revisions but decided not to accept the suggested revisions that would have added language suggesting that the states should review "any applicable NAIC models" that may have provisions on readability and accessibility.

The Subgroup next discussed Wake's suggestions to delete the drafting note for Section 9A(3) requiring the disclosure of hospital indemnity coverage, make the phrase "fixed dollar benefits" prominent, and add the language to the substantive provision itself. The Subgroup accepted the suggested revision.

The Subgroup next discussed how the federal notice and disclosure requirements for hospital indemnity and other fixed indemnity coverage would work with state notice and disclosure requirements for such coverage. The Subgroup concluded that given the issue's complexity and other factors, such as current and future litigation related to the federal rules establishing the notice and disclosure requirements, it would not be practical to include the federal language. During the discussion, it was suggested that the Subgroup consider adding drafting notes to the relevant provisions alerting the states to the issue.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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SECTION 8E(4) SUGGESTED REVISIONS FROM JULY 15 MEETING

(4) A policy that provides coverage ~~for each insured person~~ on an expense-incurred basis for cancer-only coverage, or for cancer in combination with one or more other specified diseases, ~~on an expense incurred basis~~ shall provide coverage for each insured person for services, supplies, care and treatment of cancer, consistent with the requirements in this paragraph.

(a) Coverage ~~in which~~ may be limited to amounts not in excess of the usual and customary charges, with a deductible amount not in excess of $[X], ~~and~~ an overall aggregate benefit limit of not less than $[X], and a benefit period of not less than three (3) years.~~,~~ ~~shall provide~~~~including~~

(b) A policy must include at least the ~~following~~ minimum ~~provisions~~benefits specified in this subparagraph. ~~,~~Coverage under clauses (i) - (xiv) of this subparagraph ~~which~~ may be subject to cost sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis:

(i~~a~~) Treatment by, or under the direction of, a licensed physician, surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

(ii~~b~~) Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

~~(c) Hospital room and board and any other hospital furnished medical services or supplies;~~

(iii~~d~~) Blood transfusions and their administration, including expense incurred for blood donors;

(iv~~e~~) Drugs and medicines prescribed by a physician, including but not limited to, chemotherapy, including both oral and IV administered, immunotherapy, targeted therapies, and chemotherapy supportive drugs;

~~(f) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition;~~

(v~~g~~) Private duty services of a licensed nurse provided in a hospital;

~~(h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;~~

(vi~~h~~) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

(vii~~i~~) 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

(viii~~jk~~) (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. **(move to Section 6 policy definitions)** 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 licensed 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.

________(ixlk) Physical, speech, hearing and occupational therapy;

________(xml) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux**,(disposable absorbent pads**) oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

________(xinm) Prosthetic devices including wigs and artificial breasts;

________(xiion) Nursing home care for noncustodial services;

________(xiiiop) Reconstructive surgery when deemed necessary by the attending physician; and

____

________(xivpq) Hospice services, as defined in paragraph (2)(m) above; and.

________(xve) Hospital room and board and any other hospital furnished medical services or supplies;

________(xvif) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition;

(de) A policy Mmay include coverage of any other expenses necessarily incurred in the treatment of the disease.

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

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Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
July 15, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met July 15, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Carson Gaines (FL); Camille Anderson-Weddle and Amy Hoyt (MO); Martin Swanson and Maggie Reinert (NE); Shari Miles (SC); Heidi Clausen and Shelley Wiseman (UT); Mary Block and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed Additional Comments Received on Draft Revisions to Model #171

The Subgroup continued its discussion of the comments submitted by Robert Wake (ME) on the May 3 draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the comments on Section 8A(11)—Supplementary and Short-Term Health Insurance Minimum Standards for Benefits (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force, Attachment Four-A*). Jolie Matthews (NAIC) said Wake's comments on Section 8A(11) question the meaning of the language "irrespective of total disability," whether it means the policy must pay accidental death and dismemberment benefits even if the insured is NOT totally disabled or whether the policy must pay accidental death and dismemberment benefits if the insured IS totally disabled. She said the language is existing Model #171 language. The Subgroup discussed the comments. After discussion, the Subgroup decided to leave the language unchanged because it felt the language was clear. It requires a carrier to pay accidental death and dismemberment benefits regardless of whether the insured is totally disabled, and if the insured has disability income protection coverage and is totally disabled, the carrier must pay benefits in accordance with the terms of that policy because they are two separate policies and two separate provisions.

The Subgroup next discussed Wake's comments on Section 8C(1)—Disability Income Protection Coverage. The Subgroup discussed the comments noting that Wake made similar comments to Section 8A(2)(d). After discussion, the Subgroup agreed to delete the words "to receive Social Security benefits" for consistency with the revision made to Section 8A(2)(d). The Subgroup next discussed the comments on Section 8C(3). The Subgroup agreed that the suggested revisions clarified the language. The Subgroup next discussed Wake's comments on Section 8E(2)(h)—Specified Disease Coverage. The comments suggest revising the provision to clarify which NAIC model should be specifically referenced with respect to "the NAIC uniform provision." The Subgroup accepted the suggested revisions. The Subgroup also accepted clarifying revisions to Section 8E(2)(j) and Section 8E(2)(l). The Subgroup next discussed Wake's comments on Section 8E(2)(m) suggesting that the word "facility" is the wrong word to use with respect to hospice care. After discussion, the Subgroup decided to delete the word "facility" and replace it with "provider."

The Subgroup next discussed Wake's suggested revisions to Section 8E(4). Wake suggests reorganizing Section 8E(4) to clarify which types of benefits in a cancer-only policy are subject to the copayment provisions in Section 8E(4)(h). The Subgroup discussed the suggested revisions. After discussion, the Subgroup agreed to reorganize the language based on Wake's comments and the Subgroup's discussion. Bowden volunteered to provide language reflecting the Subgroup's discussion for its review during its next meeting on July 29.

The Subgroup next discussed Wake's comments on Section 8E(6)(a) suggesting that the existing Model #171 language in this provision is nonsensical. After discussion, the Subgroup agreed to correct the language by deleting the words "on behalf of insured persons." The Subgroup discussed and accepted Wake's suggested clarifying

revisions to Section 8E(6)(b). The Subgroup discussed Wake's comments on the drafting note for Section 8E(6)(b), questioning the inclusion of skin cancer as a specific example of a specified disease a commissioner can approve as an exception to requiring equal coverage for all subtypes of a specified disease. The Subgroup accepted his suggestion to delete the reference to skin cancer.

The Subgroup discussed and agreed to accept Wake's revised Section 8G(1)—Limited Benefit Health Coverage suggestion to revise the provision to use the statutory term "limited benefit health coverage." The Subgroup also accepted Wake's suggestion to use the word "policies" instead of "plans" for accuracy when referring to limited long-term care insurance in the drafting note for Section 8G(2).

The Subgroup next discussed Wake's suggested revisions to the drafting note for Section 8G. The Subgroup agreed that revisions should be made for accuracy. William Schiffbauer (Schiffbauer Law Office) agreed to send NAIC staff the suggested revisions.

The Subgroup next discussed Wake's comments on Section 8H—Short-Term Limited-Duration Health Insurance Coverage. The Subgroup accepted Wake's non-substantive, clarifying revisions to Section 8H(1), Section 8H(2), Section 8H(4)(b), Section 8H(4)(d), and Section 8H(5). The Subgroup discussed Wake's comments on Section 8H(6) that suggest the Subgroup consider deleting the last sentence which specifies the amount a carrier must refund a consumer when a plan is rescinded. The Subgroup accepted his suggested revisions. The Subgroup also accepted Wake's corresponding suggested revisions to Section 8H(6)'s drafting note.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 7/18/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
June 24, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met June 24, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Robert Wake (ME); Amy Hoyt (MO); Maggie Reinert (NE); Andreea Savu (SC); Heidi Clausen and Shelley Wiseman (UT); and Anna Van Fleet and Jamie Gile (VT).

1. Discussed Additional Comments Received on Draft Revisions to Model #171

The Subgroup discussed additional comments from Wake on the May 3 draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the comments on Section 3A—Applicability and Scope (Attachment Four-A). Wake explained that for clarity, he suggests adding the words "residents of" this state instead of "in" this state. He also suggests adding the word "offered." After discussion, the Subgroup accepted his suggested revisions. Additionally, Wake suggests deleting the words "unless otherwise specified is included in the definition of 'short-term health insurance' under the Act." The Subgroup accepted the suggested revision. Wake also suggests non-substantive revisions to Section 3C(3) to the reference to the U.S. uniformed services health care program, TRICARE. The Subgroup accepted the suggested revisions.

The Subgroup next discussed Wake's comments on whether to include a definition of "short-term, limited duration insurance" in Section 5C—Definitions. Wake expressed concern that the definition appears to be more of a minimum standard rather than a definition. After discussion, the Subgroup decided to revise Section 5C to provide a cross-reference to the definition for this term in Model #171's companion model act, *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170).

The Subgroup next agreed to accept Wake's suggestion to delete the word "rehabilitory" in Section 6C(2)—Policy Definitions in the policy definition of "hospital" and replace it with "rehabilitative." The Subgroup next discussed Wake's comments on the last sentence in the policy definition of "physician" in Section 6I(1). Wake expressed concern that the language would require insurers to recognize certain types of providers as physicians. The Subgroup discussed his comments. After discussion, the Subgroup agreed to add at the end of the first sentence the words "and may not be defined more narrowly than applicable state licensing laws" and delete the last sentence. The Subgroup also agreed to add a new subsection, which Bowden suggested, to the end of Section 7—Prohibited Policy Provisions stating: "A policy shall not limit an insured's choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider's scope of practice."

The Subgroup next discussed Wake's comments on the inconsistent use of the term "workers' compensation" throughout the model. NAIC staff agreed to review the model to ensure the references to the term are consistent.

The Subgroup next discussed Wake's comments on Section 7D suggesting that it be revised to add the words "the following permitted exclusions" for clarity. The Subgroup agreed to make the suggested revisions. The Subgroup also agreed to make the same revision to the drafting note for Section 7D(2). Additionally, the Subgroup agreed to make non-substantive revisions to Section 7D(5) and Section 7D(6). The Subgroup next discussed Wake's comments on Section 7D(7) concerning the provision on chiropractic care. Jolie Matthews (NAIC) pointed out that this provision is existing language in Model #171 except for the proposed revision clarifying that the provision

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refers to “chiropractic” care. After discussion, the Subgroup decided to leave the language unchanged. The Subgroup next discussed Wake’s comments Section 7D(12) suggesting that it be revised to include the language in the proposed drafting note to clearly state the limitations of the territorial limitation exclusion. The Subgroup accepted the suggested revisions.

The Subgroup next discussed and accepted Wake’s suggested non-substantive revisions to Section 7E and Section 7F.

The Subgroup next discussed Wake’s suggested revisions for Section 8A—Supplementary and Short-Term Health Insurance Minimum Standards for Benefits. He suggests reorganizing and revising Section 8A(2)(c) and Section 8A(2)(d) for clarity. Matthews noted that some of the language is existing language in Model #171. The Subgroup discussed the suggested revisions. After discussion, the Subgroup agreed to make the clarifying revisions, including reorganizing the provisions.

The Subgroup discussed and accepted Wake’s clarifying revisions to the drafting note for Section 8A(2) and Section 8A(3). The Subgroup also discussed and accepted Wake’s clarifying revisions to Section 8A(6), Section 8A(7), and Section 8A(8).

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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ADDITIONAL COMMENTS AND SUGGESTED REVISIONS FROM MAINE

Draft: 5/3/24
Model#171

The revisions to this draft reflect changes made from the existing model. Any comments on this draft should be sent by email only to Jolie Matthews at jmatthews@naic.org.

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

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Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC- *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, to facilitate public understanding and comparison of coverage, to eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims and to provide for full disclosure in the marketing and sale of supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner's jurisdiction over limited scope dental coverage and limited scope vision coverage, and to provide for disclosure in the sale of those coverages.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* and any other appropriate section of law regarding authority of commissioner to issue regulations].

Section 3. Applicability and Scope

A. This regulation applies to all individual and group insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as "supplementary health insurance," delivered or issued for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation applies to short-term, limited-duration insurance coverage offered, delivered or issued for delivery ~~in~~ to residents of this state regardless of the situs of the delivery of the contract on and after [insert effective date]~~, which, unless otherwise specified, is included in the definition of "short-term health insurance" under the Act~~. **Okay 6/24/24**

B. This regulation applies to limited scope dental coverage and limited scope vision coverage only as specified.

C. This regulation shall not apply to:

Commented [RAW1]: As written, it seems to be saying "if the contract situs is in the state, regardless of where the contract situs is," which is self-contradictory. Fortunately, because STLD is by definition not employment-based, we can use a simple residency test. See also 5C and 8H(1) below.

Commented [RB2R1]: Agree with this change.

Commented [RAW3]: I find this confusing.
1)"Short-term health insurance" is **not** a defined term under the Act or the Regulation, so the referenced definition does not exist. ("Short-term, limited duration" and "Supplementary and short-term" are the two defined terms in the Act.
2)The "unless otherwise specified" language suggests that there are provisions that specify that they apply to short-term products that do **not** meet the definition of short-term products. This seems self-contradictory, and I don't see any provisions that might be construed in this manner.
(3) Nevertheless, it's straight from Model # 170, so it's probably "ain't broke, don't fix it."

Commented [RB4R3]: I suggest deleting the last part of the sentence, rather than repeating what is in the model Act. The argument for keeping it in would be to correct the misstated definition. But that's probably not necessary, since the meaning is clear and states can fix it when adopting.

(1) Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC *Medicare Supplement Insurance Minimum Standards Model Act*];

(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*];

(3) TRICARE ~~formerly known as Civilian Health and Medical Program of the Uniformed Services~~ (Chapter 55, Ttitle 10 of the United States Code) ~~(CHAMPUS)~~ supplement insurance policies; or

(4) Limited long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Limited Long-Term Care Insurance Model Act*].

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

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

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation]. The amendments to this regulation shall apply to any policies [or certificates] issued on or after the effective date of the adoption of the amended regulation.

Section 5. Definitions

For purposes of this regulation:

A. "Excepted benefits" means coverage listed at section 2791(c) of the Public Health Service Act (PHSA) or subsequently added by regulation where authorized.

B. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

C. "Short-term, limited-duration insurance" means health insurance coverage offered or provided within the state pursuant to a contract by a health carrier, regardless of the situs of the delivery of the contract, that has an expiration date specified in the contract that is less than [X days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier's consent, has a duration of no longer than [X days or months] after the original effective date of the contract. **Eliminate the words in the definition and include a cross-reference to the definition in the Model Act**.

Section 6. Policy Definitions

A. (1) Except as provided in this regulation, a supplementary health insurance or a short-term limited duration insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.

Commented [RAW5]: I would say "Title 10, Chapter 55." (Or Chapter 55 of Title 10 of ..." but that's awkward. And if "Chapter" gets capitalized, so should "Title."

Commented [RB6R5]: Agree

Commented [RAW7]: "to residents of"? See previous comment on situs. If "within" does not refer to the situs of the contract, shouldn't we clarify what it does mean? Or are we being deliberately open-ended?

Commented [RAW8]: This is the Model Act definition, so we're stuck with it, but if the purpose is to regulate these products, these maximum time periods are really substantive requirements rather than defining criteria. They make sense as definitional under federal law because their purpose in that context is to **exempt** STLD from HIPAA/ACA requirements. As written, a policy exceeding one or both time limits is exempt from this regulation, so if either or both of the X's (the second one should have been a "Y") are more restrictive than federal requirement, we need to ensure that some other state law closes the gap by prohibiting the product from being offered.

Commented [RB9R8]: Good point. Should we move some of these substantive requirements to Section 8?

Commented [RAW10]: This is more like a set of minimum standards than a definition, but it's in 170 so we shouldn't adopt a different definition. Consider incorporating the statutory definition by reference rather than repeating it (which could create a conflict if the statute is amended, or if the state tweaked the Model Act language and didn't repeat the tweak when they did the regulation).

Commented [RB11R10]: Agree - no need to repeat.

(2) Except as provided in this regulation, to the extent these definitions are used in a policy [or certificate], definitions used in a policy [or certificate] may vary from the definitions in this section, but not in a manner that restricts coverage.

B. "Convalescent nursing home," "extended care facility," "skilled nursing facility," "assisted living facility" or "continued care retirement community" means in relation to its status, facility and available services.

Commented [RAW12]: Use "Keep With Next" formatting. Manually inserting a bunch of blank paragraphs makes subsequent editing difficult.

Commented [RB13R12]: I added my only pet formatting - using style Headers so rule sections show up in the navigation pane.

(1) A definition of the home or facility shall not be more restrictive than one requiring that it:

(a) Be operated pursuant to law;

(b) Be approved for payment of Medicare and/or Medicaid benefits or be qualified to receive approval for payment of Medicare and/or Medicaid benefits, if so requested;

(c) Be engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(d) Except for an "assisted living facility" or a "continued care retirement community," provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; and

(e) Maintain a daily medical record of each patient.

(2) The definition of the home or facility is permitted but is not required to exclude:

(a) A home, facility or part of a home or facility used primarily for rest;

(b) A home or facility for the aged and/or for the care of individuals with a substance use disorder; or

(c) A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

Drafting Note: The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state or federal Medicare or Medicaid law may be required in structuring this definition.

C. "Hospital" means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(a) Be an institution licensed to operate as a hospital pursuant to law;

(b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term "hospital" is permitted but is not required to exclude:

(a) Convalescent homes or, convalescent, rest or nursing facilities;

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(b) Facilities affording primarily custodial, educational or rehabilitory care;

(c) Facilities for the aged or individuals with a substance use disorder; or

(d) A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services where a legal liability for the patient exists for charges made to the individual for the services.

Drafting Note: The laws of the states relating to the type of hospital facilities recognized in health insurance policies are not uniform. References to individual state law may be required in structuring this definition.

D. (1) "Injury" means a bodily injury resulting from an accident, independent of disease, which occurs while the coverage is in force.

(2) The definition shall not use words such as "external, violent, visible wounds" or similar words of characterization or description.

(3) 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.

(4) 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.

E. "Mental or nervous disorder" means any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.

F. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as an advance practice nurse, a registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "advance practice nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

Drafting Note: States may want to consider ~~if~~ whether the functions of an advance practice nurse fall under this definition or the definition of "physician" in Subsection I.

G. "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

H. "Partial disability" means that, due to a disability, an individual:

(1) Is unable to perform one or more but not all of the "major," "important" or "essential" duties of the individual's employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and

(2) Is in fact engaged in work for wage or profit.

I. (1) "Physician" means and includes words such as "qualified physician" or "licensed physician." And may not be defined more narrowly than applicable state licensing laws. ~~The use of these terms~~

Commented [RAW14]: rehabilitative?

Commented [RB15R14]: Agree

~~requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws and .~~

Add in the Texas prohibited language to Section 7 at the end.

(2) The definition or concept may exclude the insured, the owner, the assignee, any person related to the insured, owner or assignee by blood or marriage, any person who shares a significant business interest with the insured, owner or assignee, or any person who is a partner in a legally sanctioned domestic partnership or civil union with the insured, owner or assignee.

Drafting Note: The laws of the states relating to the type of providers' services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition.

J. ~~(1)~~ "Preexisting condition" means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person."

Drafting Note: This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer's established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured's health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

K. "Residual disability" means in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.

L. "Sickness" means sickness, illness, 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 modified to exclude sickness or disease for which benefits are provided under a ~~worker's~~ workers' compensation, occupational disease, employers' liability or similar law.

M. "Total disability"

(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

Commented [RAW16]: I'm trying not to revisit decisions that were already made, but this one seems wrong. It is not uncommon for policies to distinguish between "physicians" and other health professions. I must have missed the relevant discussion, but it seems like a mistake to require carriers to recognize, for example, a CNA or an aromatherapist as a "physician."

Commented [RB17R16]: Would this fit better as a prohibited policy provision in Section 7?

For example:
A policy shall not limit an insured's choice of health care provider if the provider is licensed or otherwise qualified under state law and the services to be provided are within the health care provider's scope of practice.

Commented [RAW18]: We use this term 3 times and spell it 3 different ways. Let's use the most common one. (But this one is my second choice - at least it uses an apostrophe!)

Commented [RB19R18]: Agree

(a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or

(b) Engage in a training or rehabilitation program.

(3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

Section 7. Prohibited Policy Provisions

A. (1) Except as provided in this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which coverage under the policy is excluded or restricted.

(2) A policy, other than an accident only policy, may exclude coverage for a loss due to a preexisting condition, as defined in Section 6J, for a period not to exceed twelve (12) months following the issuance of the policy or certificate. The twelve-month limitation is not required if the condition was disclosed during the application or enrollment process and specifically excluded by the terms of the policy or certificate, or when the insured knowingly made a material misrepresentation during the application or enrollment process.

(3) A policy, other than an accident only policy or a short-term, limited duration health insurance policyplan, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the reproductive organs, varicose veins, adenoids, and tonsils, except when the specified diseases or conditions are treated on an emergency basis.

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

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

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

D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as for the followsing permitted exclusions:

Drafting Note: States should review the provisions of this subsection carefully to determine if any of the exceptions to limiting or excluding coverage by type of illness, accident, treatment or medical condition included in the subsection should apply to short-term, limited-duration health insurance coverage.

(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug addiction;

Drafting Note: This provision is optional. States should review the desirability of its usepermitting such exclusions.

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section 8C of this regulation;

Commented [RAW20]: I think it's useful to clarify that all these exclusions are optional. Some of them are universal practice, but others could vary by carrier and by type or level of coverage.

Commented [RB21R20]: Agree

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(4) Illness, treatment or medical condition arising out of:

(a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(c) Non-commercial or recreational aviation;

(d) With respect to short-term nonrenewable policies, interscholastic sports; and

(e) With respect to disability income protection policies, incarceration.

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

(5) Cosmetic surgery, except ~~that "cosmetic surgery" shall not include~~for 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 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 asymptomatic complaints of the feet;

(7) Chiropractic care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

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

(8) Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal ~~workmen's~~ workers' 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, except where the provision of dental services is medically necessary due to the underlying covered medical condition or clinical status of the covered person, including but not limited to, reconstructive surgery;

(10) Eye glasses, hearing aids and examination for the prescription or fitting of them;

(11) Rest cures, custodial care, transportation and routine physical examinations;

(12) Territorial limitations, provided that they do not exclude coverage for services rendered within the United States and its territories or possessions; and

~~**Drafting Note:** The intent of paragraph (12) above is to have this exclusion or limitation of coverage would apply to territories outside of the United States. This exclusion or limitation of coverage is not intended to apply to the U.S. territories.~~

Commented [RB22]: Agree

Commented [RAW23]: This is in existing 171, but was it a typo for "asymptomatic"? Why do we require coverage for a fracture that does not produce symptoms, but allow carriers to exclude care for a broken foot that causes weakness and/or pain?

Commented [RB24R23]: Agree

Commented [RAW25]: If we exclude chiropractic care when they're doing what one usually sees a chiropractor for, why are we requiring coverage for chiropractic care when carriers might reasonably conclude that the patient should be seeing a different type of practitioner?

Commented [RB26R25]: Not sure I understand this comment. Is this referring to the definition of "physician" above?

Commented [RAW27]: See comment to 6(L).

Commented [RB28R27]: Agree

Commented [RAW29]: I don't know if this is exactly what was intended, but we can't grant general permission for any and all "territorial limitations" and then rely on a drafting note to materially narrow that permission.

Commented [RB30R29]: Agree. This makes more sense to state clearly in the text and delete the drafting note.

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(13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.

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.

E. Notwithstanding Subsection D of this section, tThis 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.

F. The enumeration in this section of specific precluded pPolicy provisions ~~precluded in this section~~ shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 4B of the *Supplementary and Short-Term Health Insurance Minimum Standards Act*] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

Commented [RAW31]: If there's a conflict to worry about that might limit our authority, it's with the implications someone might read into what we didn't say, not with anything we did say above.

Commented [RB32R31]: Agree

G. A policy providing a type of supplementary health insurance that is not defined as a ""plan"" under the *Coordination of Benefits Model Regulation* (#120) shall not include a coordination of benefits provision or any other provision that allows it to reduce its benefits based on the existence of other coverage its insured may have.

Drafting Note: Former Subsection B in this section established provisions related to the issuance of a policy or rider for additional coverage as a dividend under specified circumstances. Subsection B was deleted because insurers rarely offer consumers policy dividends as a benefit on policies covered by this regulation. Such provisions are common in life insurance policies. If policy dividends are available on policies covered by this regulation in your state, you should look to the treatment of dividends in life insurance. Generally, consumers should be allowed to take the policy dividend as a cash payment, but insurers may offer the consumer additional policy benefits in lieu of a cash payment at the option of the consumer.

Section 8. 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. Aa 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 9H of this regulation.

Commented [RAW33]: I almost missed this typo because I'm not seeing spelling and punctuation errors display. I'm not sure why this is happening - I looked in the settings and I don't see the spellchecker disabled or hidden.

This section shall not preclude the issuance of any policy or contract combining two or more categories of excepted benefits set forth in [cite state law equivalent to Section 5B and C of the NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*].

A. General Rules

(1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual supplementary policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

Drafting Note: States should review the use of the term "spouse" in paragraph (1) above and replace it or add additional terms in accordance with state law or regulations.

(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 9A.

(b) The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual supplementary policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

~~(c) An individual supplementary 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 at least until the insured has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits, while actively and regularly employed.~~

(~~d~~c) Except as provided ~~above~~in subparagraph (d) of this paragraph, 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.

(~~e~~d) An individual supplementary 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 be designated as "guaranteed renewable if it provides that the insured has the right to continue the policy, while actively and regularly employed, at least until the insured has reached full retirement age, as defined under the federal Social Security Act~~, to receive Social Security benefits~~~~, while actively and regularly employed~~.

(3) In an individual supplementary policy covering ~~the~~ a married couple or civil union couple, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

Drafting Note: The references to "married couple" and "civil union couple" in paragraph (3) above are intended to apply to any legally recognized marital relationship or domestic partnership recognized in the state. States should revise the language in accordance with state law or regulations. In addition, states should review the use of the term "spouse" and replace it or add additional terms in accordance with state law or regulations.

Drafting Note: For Paragraphs (2) and (3) above, coverage ~~as defined under~~subject to Title XXVII of the federal Public Health Service Act (PHSA), as enacted by HIPAA and amended by the Affordable Care Act, ~~or applicable state law~~ must be guaranteed renewable except for reasons stated in ~~Part B Section~~ PHSA § 2742 (42 U.S.C. § 300gg-42)~~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~~PHSA § 2791~~2721, 2763 and 2791~~(c) (42 U.S.C. § 300gg-91(c))~~ of Title XXVII as amended by HIPAA, the ACA or~~. ~~a~~Applicable state law may impose requirements that mirror or exceed the federal requirements.

(4) When accidental death and dismemberment coverage is part of the individual supplementary insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

Commented [RAW34]: Was the exception for periodic income replacement intended to apply to "NC" as well as "GR," or was there always an intent to say policies with actively-at-work requirements could never ever be called "NC," only "GR"?

Commented [RAW35]: This paragraph becomes much clearer if it's moved up from (d) to (c). The primary difference between "NC" and "GR" is "except that the insurer may make changes in premium rates by classes. There's another exception, which was obviously **intended** as a reference to existing (c) because there isn't anything else that might trigger the exception. That second, more complicated exception ought to go at the end of the paragraph, so that it doesn't distract from the flow between the primary definitions.

Commented [RB36R35]: Agree

Commented [RAW37]: As noted above, this must have been intended as an exception to the general rule that "GR" means "NC," except that the carrier reserves the right to make class-wide premium increases. Furthermore, if we really only meant that they could issue these policies and not that they could call them "GR," this provision wouldn't belong in this paragraph at all, because this paragraph isn't about policy requirements, it's about the meaning of the terms "NC" and "GR".

Commented [RAW38]: Moving this phrase up does two things. One is to emphasize that what the exception does is to allow the carrier to include an "actively employed" clause. The other is to make the syntax clearer - the phrase refers t ...

Commented [RB39R38]: Agree

Commented [RAW40]: I can't remember the discussions anymore. Two questions: ...

Commented [RAW41]: I would remove this phrase. Not only is it redundant. it's also confusing because full retirement age isn't the age to "receive benefits," it's the a ...

Commented [RB42R41]: The group should discuss. We might also want to think about what the minimum standard for DI is, and how that relates to the GR label.

Commented [RAW43]: Title XXVII wasn't amended by HIPAA - back in the day, Title XXVII **was** HIPAA as far as insurance was concerned. And the citation to Part B seem ...

Commented [RB44R43]: Agree with all suggested changes to this drafting note.

Commented [RAW45]: Parallel citations might be useful to readers who look up their federal law in the USC.

Commented [RAW46]: 2721 has been renumbered as 2722 (although the USC citation still has a "21" in it just to be helpful), but is it necessary to say "as described in 2722 ...

Commented [RAW47]: I didn't understand the phrase "as amended by HIPAA or applicable state law" until I realized it was a dangling modifier. Clearer to stick to federal law ...

(6) ~~Except for non-payment of premium, in the event the insurer cancels or refuses to renew, p~~Policies providing pregnancy benefits shall provide for an extension of benefits, in the event the insurer cancels or refuses to renew for reasons other than non-payment of premium, as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization may~~shall not~~ condition the benefits upon admission to the convalescent or extended care facility within a specified time after discharge from the hospital, as long as the required admission date ~~period of~~is not less than thirty (30) days after discharge from the hospital.

(8) In individual supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to intellectual or physical disability on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days ~~of~~after the date the ~~company~~ insurer receives due proof of the disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(10) 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 and the disclosure materials required under Section 9 of this regulation 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 to the right to receive benefits for 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 certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

B. Hospital Indemnity or Other Fixed Indemnity Coverage

Commented [RAW48]: What happens in the event that the policy is cancelled or nonrenewed is an extension of benefits, not the addition of new policy language. Likewise, "except for nonpayment" modifies "cancels or refuses to renew," not 'policies shall provide."

Commented [RB49R48]: Agree

Commented [RAW50]: I find this confusing, but I'm not sure how to say it better. The obvious intent is to allow a "within 30 days" provision, but at first glance it looks like that's precisely what we've prohibited, because as a practical matter, I would expect that such a permitted provision **will** almost always have the effect of covering only those post-hospitalization admissions that occur "within a period of less than thirty (30) days after discharge from the hospital."

Commented [RB51R50]: Does this work better?

Commented [RAW52]: What does this phrase mean? Does it mean the policy must pay even if the insured is **not** totally disabled, or even if the insured **is** totally disabled? I'm guessing the latter *(i.e.,* that the benefits are cumulative if the policy provides both), but the language doesn't seem clear to me.

Commented [RB53R52]: Group should discuss.

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(1) "Hospital indemnity or other fixed indemnity coverage" provides benefits as a result of hospital confinement or other health-related events and based on a fixed dollar amount, regardless of the amount of expenses incurred, without coordination with any other health coverage.

(2) "Hospital indemnity coverage" may provide a single lump sum benefit for hospital confinement of not less than $[X], and/or daily benefit for hospital confinement on an indemnity basis in an amount not less than $[X] per day and not less than [X] days during each period of confinement for each person insured under the policy.

Drafting Note: Paragraph (2) above provides a framework for the state insurance regulators to establish minimum benefit amounts they feel are appropriate for hospital indemnity coverage. When setting these minimum benefit amounts, state insurance regulators should be mindful to not set a benefit amount so low such that the product does not provide a meaningful benefit to the consumer or set a benefit amount so high that a consumer could be led to believe the product is comprehensive major medical coverage. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or an alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary insurance.

(3) 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.

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

Drafting Note: For indemnity products that are triggered by a variety of health events and provide a variety of daily benefit dollar amounts, state insurance regulators should examine the amount payable per day and the total amount payable per year or lifetime to determine whether an indemnity product's benefits could be mistaken for comprehensive major medical coverage. Indemnity products should not be offered, marketed, or sold as an alternative to, or substitute for, or replacement for major medical coverage. It is the marketing of supplementary coverage as an alternative, substitute or replacement for comprehensive major medical coverage that presents the unfair trade practice, and not the supplementary coverage itself when it is offered and marketed as supplementary excepted benefits coverage and accurately described to the consumer.

C. Disability Income Protection Coverage

"Disability income protection coverage" is a policy that provides for periodic payments, no less frequently than monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(1) ~~Provides that a plan is prohibited from~~Does not ~~reducing~~ reduce periodic payments based on age, except ~~that a plan may reduce periodic payments provided that such reductions do not take place until~~if the individual has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits;

Drafting Note: Age 62 was removed so that retirement age would align with the federal Social Security Act full retirement age.

(2) Contains an elimination period no greater than:

(a) Fifty percent (50%) of the benefit period in the case of coverage providing a benefit of one hundred and eighty (180) days or less;

Commented [RAW54]: It's not the policy that "provides" what is or is not "prohibited" - it's the Act and the Regulation.

Commented [RB55R54]: Agree

Commented [RAW56]: See comment to 8(A)(2)(d), above.

Commented [RB57R56]: Can we clarify drafting note? I think our intent was that 100% Social Security benefits = full retirement age.

If we have this here, could we delete it above?

(b) Ninety (90) days in the case of a coverage providing a benefit of one hundred and eighty (180) days to one year;

(c) 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

(d) Three hundred and sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;

Commented [RAW58]: Seems confusing to prohibit a one-year elimination period (which has about a 25% chance of exceeding 365 days), but if that's how these policies are written, we shouldn't change it,

Commented [RB59R58]: I agree one-year would make more sense and would align with the group's intent.

(3) Has a period of time of at least three (3) months for which it is payable during disability ~~of at least three (3) months~~. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period; and

(4) Where a policy provides both total disability benefits and partial disability benefits, only one elimination period may be required.

D. Accident Only Coverage

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

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 in paragraph (2) and one of the following sets of minimum standards for benefits:

(a) Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Paragraph (4), (5) or (6) of this subsection.

(b) Insurance covering specified diseases other than cancer must meet the standards of Paragraphs (3) and (6) of this subsection.

(2) General Rules

Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this regulation. In cases of conflict between the following and other rules, the following shall govern:

(a) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

(b) Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(c) Notwithstanding any other provision of this regulation, specified disease policies shall provide benefits to any covered person not only for the specified disease or diseases, but also for any other conditions or diseases~~,~~ directly caused or aggravated by ~~the~~ a specified disease~~s~~ or the treatment of the specified disease.

(d) Individual supplementary policies containing specified disease coverage shall be at least guaranteed renewable.

(e) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.

(f) An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature.

Drafting Note: States may prohibit individuals who are covered by a Title XIX program from enrolling in a specified disease policy. However, this would not prohibit an individual who purchases a specified disease policy and later becomes eligible for coverage under a Title XIX program from utilizing the benefits of the specified disease policy to which the individual may be entitled to receive.

(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, b~~Benefits for specified disease coverage shall be paid regardless of other coverage, except as permitted by [insert reference to state law equivalent to Section 3B(3) of the NAIC *Uniform Individual Accident and Sickness Policy Provision Law*, regarding multiple policies with the same insurer].

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

(i) After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis.

(j) Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge,~~,~~" "expense," or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges~~.~~" or "actual expenses."

(k) "Preexisting condition" shall not be defined to be more restrictive than the following and shall be consistent with the provisions of Section 7B of the Act: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person."

Commented [RAW60]: Even if there were a single "uniform provision" (Model # 180 actually provides two alternatives) it still inappropriate to simply incorporate another NAIC Model Act by reference on a a "from time to time" moving target basis, especially without identifying which Model we're incorporating. Furthermore, if This State has adopted a variation on the NAIC's "uniform" language (I looked Maine's up, and we diverged from the Model in 1973), it should be the state law and not the NAIC Model that controls.

Commented [RB61R60]: Agree

Commented [RAW62]: If we're going to bring in the new synonym "charge," we don't want to imply that it's better than "expense" and somehow helps solve the problem this subparagraph is trying to address.

Commented [RB63R62]: Agree

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(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~~ a named preexisting condition is specifically excluded.

(m) Hospice Care.

(i) "Hospice" means a ~~facility~~ provider 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 $[X] per day; and

(III) A lifetime maximum benefit limit of at least $[X].

(iii) Hospice care does not cover nonterminally ill patients who may be confined in a:

(I) Convalescent home;

(II) Rest or nursing facility;

(III) Skilled nursing facility;

(IV) Rehabilitation unit; or

(V) Facility providing care or treatment for persons suffering from mental disorders-, who are aged, or who have a substance use-related disorder.

(3) The following minimum benefits standards apply to non-cancer coverages:

(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of $[X] and an overall aggregate benefit limit of no less than $[X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

(i) Hospital room and board and any other hospital--furnished medical services or supplies;

(ii) Treatment by a licensed physician, surgeon, or other health care professional acting within the scope of their license;

Commented [RAW64]: Seems like the wrong word, harking back to the days when hospice care was typically provided "in a hospice."

Commented [RB65R64]: Agree. "Facility or home health care provider"?

Commented [RAW66]: Leaving out the Oxford comma changes the meaning here. This is a 3-item list, not a subclass of "persons suffering from mental disorders."

Commented [RB67R66]: Agree

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Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

(iii) Private duty services of a licensed nurse;

(iv) Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

(v) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

(viii) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

(ix) 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

(x) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than $[X] payable at the rate of not less than $[X] a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage on an expense-incurred basis ~~for each insured person~~ for cancer-only coverage or for cancer in combination with one or more other specified diseases ~~on an expense incurred basis~~ shall provide coverage for each insured person for services, supplies, care and treatment of cancer, ~~in~~ which may be limited to amounts not in excess of the usual and customary charges, with a deductible amount not in excess of $[X], and an overall aggregate benefit limit of not less than $[X] and a benefit period of not less than three (3) years, ~~shall provide~~including at least the following minimum ~~provisions~~benefits, [which may be subject to cost sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis:]

(a) Treatment by, or under the direction of, a licensed physician, surgeon, or other health care professional acting within the scope of their license;

Drafting Note: States should review their laws and regulations to determine whether to use the word "acting" or "performing" in Paragraph (3)(a)(ii) above. Some states use the word "acting," while others use the word "performing."

(b) Tests, procedures, and other medical services and supplies 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, including but not limited to, chemotherapy, including both oral and IV administered, immunotherapy, targeted therapies, and chemotherapy supportive drugs;

Commented [RAW68]: If wee move the verb to the very end, then in addition to making the reader wonder if this is going to be a sentence, we've established a standard that only applie to the sub-class of cancer policies that provide coverage on an expense-incurred basis for at least 3 years and have deductibles below the state's cap and benefit limits above the state's threshold.

Commented [RB69R68]: I agree that adding "shall provide" seems to better align with the intent for this section.

Commented [RAW70]: Hiding the verb at the end of the paragraph doesn't just make it hard to read. It also means Subparagraphs (a) through (q) are only required when the deductibles, aggregate limits, and benefit period are all within the specified ranges.

Commented [RAW71]: We don't want to prohibit carriers from covering high-cost providers, do we?

Commented [RB72R71]: Agree

Commented [RAW73]: In modern terminology, doesn't copayment always refer to a fixed-dollar amount? (I said "cost sharing" rather than "coinsurance" because some people use "coinsurance" to mean the carrier's share of the charge, and we don't need to go down that rabbit hole.)

Commented [RB74R73]: Agree with the wording change and reorganization. Does the exclusion of hospital-based services and ambulance services mean no cost-sharing is permitted, or that there is no limit on cost-sharing? From a policy perspective, I don't understand the reason for applying different limits on cost-sharing.

Commented [RAW75]: If I read the Model correctly, the only services that can't be subject to coinsurance are (c) and (f), and those are by definition never outpatient services (or do we need to amend (f) to expressly prohibit copayments or coinsurance?). The statement that "however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included" is extremely confusing, because they already **were** included.

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(f) Professional ambulance for service to or from a hospital nearest able to appropriately treat the condition;

(g) Private duty services of a licensed nurse provided in a hospital;

~~(h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out patient basis;~~ keep language in (h) 7/15/24 except for the first clause. Leave that in (q).

(h~~i~~) Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

(~~j~~i) 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

(j~~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. 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 licensed 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~~k) Physical, speech, hearing and occupational therapy;

(~~m~~l) Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;

(~~n~~m) Prosthetic devices including wigs and artificial breasts;

(~~o~~n) Nursing home care for noncustodial services;

(o~~p~~) Reconstructive surgery when deemed necessary by the attending physician;~~ and~~

(p~~q~~) Hospice services, as defined in paragraph (2)(m) above; and~~.~~

(q) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

Commented [RAW76]: The wording and placement of existing Subparagraph (h) can be charitably described as "bizarre." I would infer that once upon a time in the distant past, the catch-all provision (which isn't even really necessary since it's optional) was at the end, and that there was some other awkward retrofitting at various stages of the drafting and amendment processes.

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

(5) (a) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:

(i) A fixed-sum payment of at least $[X] for each day of hospital confinement for at least [365] days;

(ii) A fixed-sum payment ~~equal~~of at least~~ to~~ [X%] the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and

Commented [RAW77]: "Of at least"? Or was prohibiting higher benefit levels intended for some reason?

Commented [RB78R77]: Agree

(iii) A fixed-sum payment of at least $[X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(b) Benefits tied to receipt of care in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal or exceed the following:

(i) A fixed-sum payment equal to [X%] the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

(ii) A fixed-sum payment equal to [X%] 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.

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(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~~ for a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $[X].

Commented [RAW79]: Do we really mean "on behalf of"? A lump-sum indemnity payment ought to be payable **to** the insured.

Commented [RB80R79]: Agree

Commented [RAW81]: This looks like it says "Insured persons of a specifically named disease," which would be gibberish. Even if the intent is to modify "benefits," "of" is still the wrong word. You can have "coverage of" a disease, but we're not talking about any "benefits of" that disease.

Commented [RB82R81]: Agree

Drafting Note: Policies that offer extremely high dollar benefits may induce fraud and concealment on the part of applicants for coverage. The commissioner should avoid approving these policies in light of the fact that these policies are not intended to be comprehensive coverage and are not intended to be sold as such. Policies offering extremely low dollar amounts, however, may offer illusory coverage that may not be understood by consumers. State insurance regulators can address this issue by requiring that this coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, and requiring the use of disclosures that this coverage is supplementary coverage.

(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~~unless there are clearly identifiable subtypes with significantly lower treatment~~s~~ costs, in which case lesser amounts may only be payable ~~so long as~~if the policy clearly differentiates that subtype and its reduced 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.

Commented [RAW83]: Do you need an exception to the exception in that case? A cancer policy ought to cover metastatic melanoma at a minimum.

F. Specified Accident Coverage

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

G. Limited Benefit Health Coverage

(1) "Limited benefit health coverage" is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, D, and F. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7E and shall not be offered for sale as ~~a~~ "limited benefit health coverage."

Commented [RAW84]: I think we want the statutory term of art here. There's nothing deceptive about merely sticking the word "limited" into the marketing materials, as long as they don't conceal its status as a specified-disease policy or try to avoid compliance with the specified-disease minimum standards.

Commented [RB85R84]: Agree

(2) This subsection does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act* and *Medicare Supplement Insurance Minimum Standards Model Act*].

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

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~~plans~~policies, and should be subject to the *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).

Drafting Note: This regulation permits the combining of excepted benefit-type products described in this section. However, it should be noted that ~~the combination of~~combining coverages ~~might not qualify as "excepted benefits" under HIPAA, as amended by the ACA, thus making those combination products subject to HIPAA requirements, as amended by the ACA, and ACA requirements, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. In addition, combining other types of products not~~ described in this section with other coverages, whether or not described in this section, could cause the combined product ~~not~~ to fail to meet the requirements ~~be considered an~~for excepted benefits under HIPAA, ~~as amended by the ACA~~, or for similar exemptions under state law. ~~type product and~~This would mean that major medical insurance requirements under federal and state law may apply, such as guaranteed availability, guaranteed renewability, and premium rating restrictions. State insurance regulators ~~can address this issue by~~should also requir~~inge~~ that ~~this~~ supplementary coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, ~~and~~ including enforcement of the requirements in this regulation~~ing~~ ~~the use of~~for disclosures that this coverage is supplementary coverage.

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

(1) "Short-term, limited-duration health insurance" means health insurance coverage offered or provided ~~within~~ to residents of the state pursuant to a contract with a health carrier, regardless of the situs 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.

(2) (a) ~~A s~~Short-term, limited-duration health insurance ~~plan~~ must comply with the benefit and coverage requirements of this state, including, if the state requires, providing benefits and coverage of state-mandated benefits and being subject to the state's external and internal review requirements.

(b) A short-term, limited-duration health insurance plan must have:

(i) An annual or lifetime limit of no less than [$1,000,000];

(ii) A coinsurance requirement of no more than fifty percent (50%) of covered charges; and

(iii) A family maximum out-of-pocket limit of not more than [X] per year.

Drafting Note: The annual and lifetime limit and the out-of-pocket limits should vary depending on the specific state interest. For states that have severely limited coverage time frames with limited renewals or extensions, smaller annual and lifetime limits and out-of-pocket maximums should apply.

(3) Short-term, limited-duration health insurance cannot be issued if it would result in an individual being covered by a short-term, limited duration plan for more than [X] months [in any 12-month period].

(4) Short-term, limited-duration health insurance, including individual policies and group certificates:

(a) May not be marketed as guaranteed renewable;

(b) Must be marketed as either nonrenewable, or renewable for a limited term without re-underwriting ~~at the option of the policyholder or insured person, if the insured person contributes to the premium~~;

Commented [RAW86]: Note that the phrase "limited long-term care insurance plan" does not occur in 642 or 643, so we don't need to say "plan" for conformity with those Models.

Commented [RB87R86]: Agree

Commented [RAW88]: Presumably states that have this regulation but don't have 642/643 will figure out how this regulation applies?

Commented [RAW89]: If coverages are bundled to the point that they trigger the ACA or more restrictive state laws, disclosures that the coverage is not major medical coverage will aggravate the problem, not alleviate it. And a drafting-note reminder might be helpful to regulators, carriers, and producers, but isn't prohibiting supplementary coverage from being marketed as a substitute for major medical something this regulation supposedly already does?

Commented [RB90R89]: I think this re-write accurately captures the meaning more concisely.

Commented [RAW91]: If we accept my earlier proposal to clarify what "in this state, regardless of situs" means, we should make the same change here.

Commented [RAW92]: Is there a reason for saying "plan" here in Subsection H , and below in Subsection 9(H)? We say "policy" everywhere else, except for a couple of outliers I've proposed correcting, even though all those types of coverage are also widely marketed through discretionary groups and some lines are even marketed to employer groups as workplace benefit plans..

Commented [RAW93R92]: I don't think we need to say "plan" to encompass both individual and group coverage. In either case, we're talking about the terms of the policy. When we're actually referring to the "policy or certificate" the consumer receives, we already say so.

Commented [RB94R92]: My mark-up removes the need to say policy. I'm fine with any changes to be consistent throughout. But I also don't see an issue with using "plan" to capture policy and certificate.

Commented [RAW95]: Probably too late to revisit, but what distinguishes this from guaranteed renewability is the time limit, not the other verbiage - especially the phrase about contribution, because it suggests that they might be able to nonrenew on the ground that somebody other than the insured person paid the premium. The other clarifying details are already in (e) where they belong.

Commented [RB96R95]: Agree

(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 issuance, except by signed acceptance of the policyholder or certificate holder the insured person, if the insured personpolicyholder or certificate holder contributes to the premium; and

(e) If the coverage is renewable, the individual policy or group certificate must:

(i) Include a statement that the insured 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 carrier will not increase premium rates or make changes in provisions in the policy or certificate on renewal based on individual health status; and

(iii) Include a statement that the carrier, at the time of renewal, may not deny renewal based on individual health status.

(5) A short-term, limited-duration health insurance carrier may not include a waiting period or a probationary period. The effective date of the plan when benefits and coverage under the plan are in effect.

(6) A carrier may not rescind a short-term limited duration health insurance plan during the coverage period except if the insured intentionally fails to disclose a prior diagnosis of a health condition or if the insured intentionally fails to disclose the insured was previously covered under a short-term limited duration health insurance plan. If the plan is rescinded, the carrier must refund all premium payments to the insured to the extent that they exceed all payments less claims paid up to the total premium amount made by or on behalf of the insured prior to the rescission date or the expiration date of the short-term limited duration health insuranceunder the rescinded policy or certificate.

Drafting Note: States should be aware that the language in paragraph (6) concerning an insured's failure to disclose prior coverage under a short-term, limited-duration health insurance plan will need to be tailored to the state's laws and regulations concerning such disclosures of prior coverage. Also, with respect to language in paragraph (6) concerning the amount that should be refunded to the insured in the event of a rescission, the expectation is that the carrier does not bill the insured for the difference in the amount between the claims paid and the premium paid in the situation where the amount of the claims paid exceeds the amount paid in premium.

(7) A carrier may not cancel a short-term, limited-duration health insurance plan during the coverage period except in the following circumstances:

(a) Nonpayment of premium;

(b) Violation of the carrier's published policies approved by the commissioner;

(c) An insured's commitment of fraudulent acts as to the carrier;

(d) An insured's material breach of the health planinsurance contract; or

(e) A change or implementation of a federal or a state law or regulation that no longer permits the continuing offering of the coverage.

(8) In the event of a cancellation or rescission of a short-term, limited-duration health insurance plan, the carrier must notify the insured in writing [thirty (30) days] prior to the cancellation date or in writing a notice of rescission with an appeal period of [thirty (30) days].

Commented [RAW97]: This seems like an awkward way to refer to discretionary group coverage. How about "policyholder or certificateholder"? The "contribution" test isn't intended to distinguish among the covered family members on an individual policy on the basis of whether they do in fact contribute to the premium (which the carrier wouldn't know anyway), and with employment-based coverage out of the picture, you're not going to have a group policyholder paying for the coverage. And even if you did, why is it relevant and how does the insurer know?

Commented [RB98R97]: Agree

Commented [RAW99]: The second sentence of this subparagraph is not a complete sentence, and I don't see how to complete it in a way that adds anything useful to the first sentence. My best guess was "The effective date of the [policy or certificate] **is** the first date when benefits and coverage are in effect," which is tautological.

Commented [RB100R99]: Agree

Commented [RAW101]: Here and in (7) and (8), we could either say "policy or certificate" or refer to "an individual's coverage under an STLD policy"

Commented [RAW102]: With this language, I don't think we need a drafting note clarifying that this was not intended to require a "negative refund" if the rescission was driven by a large paid claim.

Commented [RB103R102]: Agree

Commented [RAW104]: Even if we keep the "health plan" terminology, I don't think "breach of a health plan" is a thing.

Drafting Note: The timeframe for notifying the insured of a cancellation or rescission is bracketed because states may have different timeframes for such notices.

Drafting Note: States should carefully examine their health insurance markets to determine the appropriate maximum term and duration for such plans and whether additional definitions or standards may be needed. [~~Subsection H does not include a potential maximum length of coverage for short-term, limited-duration insurance.~~ Some states have prohibited the sale of such products, while others have set the maximum duration of coverage at less than 12 months, such as establishing a three-month maximum. Subsection H does not include a potential maximum length of coverage for successive, separately purchased short-term, limited-duration insurance. ~~In addition, s~~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]. Leave the Bob sentence and add language about the federal landscape.

Commented [RAW105]: It's not accurate to say we "don't include a potential maximum length of coverage" at all - Paragraph (1) sets both a maximum coverage period and a maximum total duration including renewals.

Commented [RB106R105]: Agree

Section 9. Required Disclosure Provisions

A. General Rules

(1) Any disclosures, and the documents to which they refer, shall be delivered in the written medium the applicant requests. These documents shall be provided before the applicant submits a completed application.

Commented [RAW107]: I assume this means "digital or hard copy," but it's potentially a lot more open-ended than that. Will it be understood by the intended audience? (Including judges and juries if there's a dispute.)

(2) (a) All applications, policies, and certificates for coverage of supplementary or short-term health insurance shall include a prominent disclosure statement, as required by this section, that reflects the type of coverage being provided.

(b) The disclosures required by this section may be modified only as approved by the commissioner and as needed to improve the accuracy and clarity of the disclosure.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the disclosure statement requirements in this section for such coverage to ensure it accurately reflects a state's specific requirements. States also should be aware that proposed federal regulations for short-term, limited duration insurance coverage and hospital indemnity or other fixed indemnity coverage include specific disclosure statement requirements for these coverages and recognize that the disclosure statement requirements in this section 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.

(c) The disclosure statement shall be in a ~~S~~sans-~~S~~serif font, in a font size at least equal to the size type used for headings or captions of sections of the document.

Commented [RAW108]: This is a generic term, not the name of a specific typeface.

Commented [RAW109R108]: Ironic that we adopt a sans-serif requirement in Times New Roman.

Commented [RB110R108]: Agree =)

(d) In the application, the disclosure statement shall be placed in close proximity to the applicant's signature block ~~on the application~~.

(e) In the policy and certificate, the disclosure statement shall be placed on the first page ~~of the policy or certificate~~.

(f) In this section, the term "prominent" means one or more methods are used to draw attention to the language, including using a larger font size, leading, underlining, bolding, or italics.

Commented [RAW111]: Personally I don't find italics to be as prominent when using sans-serif type.

Drafting Note: States should review their existing readability and accessibility laws and regulations and any applicable NAIC models to help to ensure the statements above are readable and accessible to potential applicants, including those with

disabilities such as blindness or macular degeneration, deafness or hearing loss, learning disabilities, cognitive limitations, limited movement, speech disabilities, photosensitivity, and combinations of these.

(3) For hospital indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "fixed dollar benefits" made prominent:

"This [policy] [certificate] pays fixed dollar benefits as a result of a covered hospitalization due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

~~**Drafting Note:** The words "fixed dollar benefits" should be prominent.~~

(4) For other fixed indemnity coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows:

"This [policy] [certificate] pays fixed dollar benefits as a result of covered events due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(5) For disability income protection coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows:

"This [policy] [certificate] provides periodic payments [weekly, bi-weekly, or monthly] for a set length of specific period of time while you are disabled from a covered sickness or injury. Read the description of benefits provided along with your [enrollment form/application] carefully."

(6) For accident only coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "from a covered accident" made prominent:

"This [policy] [certificate] pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

~~**Drafting Note:** The words "from a covered accident" in the first sentence should be prominent.~~

(7) For specified disease coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows:

"This [policy] [certificate] pays limited benefits as a result of the diagnosis or treatment of a covered disease specified in the [policy] [certificate]. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(8) For specified accident coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows:

"This [policy] [certificate] provides benefits for a specifically identified type of accident as named in the policy. It does not provide benefits resulting from sickness. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

Commented [RAW112]: If we want insurers to do this, we need to tell the insurers. Drafting notes are NAIC communications directed to regulators.

Commented [RB113R112]: Agree here and below.

(9) For limited benefit coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows:

"The [policy] [certificate] pays limited benefits as a result of a covered event as specified in the [policy] [certificate]. These limited benefits are designed to be paid to the[policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

(10) For limited scope dental coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all dental expenses." made prominent:

"The [policy] [certificate] provides dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental services it covers and any cost-sharing that may be your responsibility."

~~**Drafting Note:** The sentence "It is not intended to cover all dental expenses." should be prominent.~~

(11) For limited scope vision coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the sentence "It is not intended to cover all vision expenses." made prominent:

"The [policy] [certificate] provides vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision services are covered and any cost-sharing that may be your responsibility."

~~**Drafting Note:** The sentence "It is not intended to cover all vision expenses." should be prominent.~~

(12) For short-term health insurance, the application, policy, and certificate shall include a disclosure statement that reads as follows:

"IMPORTANT: This is short-term health insurance. This is temporary insurance. **It is not comprehensive health insurance.** Read your policy carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
  - Preexisting conditions; or
  - Essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, and substance use services, prescription drugs, or preventive care).
- You will not qualify for federal financial help to pay for premiums or out-of-pocket costs.
- You are not protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you're eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact the [State] department of insurance if you have questions or complaints about this policy."

(13) Each policy of individual supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(14) All riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage

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with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirement in this paragraph applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.

(15) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate and the combined total premium clearly identified as such.

(16) A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in a ~~S~~sans-s~~-S~~erif font on the first page of the policy or certificate or attached to it stating clearly that the policy or certificate holder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. ~~The statement may be made prominent in one or more methods to draw attention to the language, including using a larger font size, leading, underlining, bolding, or italics.~~

Drafting Note: This ~~section~~ paragraph should be included only if ~~the~~ it is consistent with applicable state ~~has~~ law~~legislation granting authority~~.

(19) If age is to be used as a determining factor to reduce the benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage. ~~The statement may be made prominent in one or more methods to draw attention to the language, including using a larger font size, leading, underlining, bolding, or italics.~~

(20) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person who may exercise the conversion privilege. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(21) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital -indemnity or other fixed indemnity (Section 8B), specified disease (Section 8E), or limited benefit health coverages (Section 8G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections D and F, the following language, which shall be printed on or attached to the first page of the outline of coverage, with the sentence "This is not a Medicare Supplement policy." made prominent:

This is not a Medicare Supplement policy. If you are eligible for Medicare, ask the company for the Guide to Health Insurance for People with Medicare.

~~**Drafting Note:** The sentence "This is not a Medicare Supplement policy." should be prominent. It may be made prominent in one or more methods, including using a larger font size, leading, underlining, bolding, or italics.~~

Commented [RAW114]: Do we need this? Isn't that why we defined "prominent" earlier?

Commented [RB115R114]: Agree

Commented [RAW116]: The legislation is more likely to be legislation expressly requiring a free-look period than legislation "granting authority" to the Commissioner to create one by regulation.

Commented [RB117R116]: I think "state law" would also capture regulations?

Commented [RAW118]: See previous comment.

Commented [RB119R118]: Agree

Drafting Note: States may want to review the disclosure language in paragraph (21)(a) above for consistency with the consumer disclosure language in Appendix C of the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

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

Drafting Note: States that permit individuals under the age of 65 with Medicare coverage to purchase Medicare supplement policies ~~to~~ should review how ~~they~~ insurers should provide the notices required under paragraph (21)(a) to these individuals.

(22) Insurers shall give a person applying for specified disease insurance a Buyer's Guide approved by the commissioner at the time of application enrollment and shall obtain all recipients' written acknowledgement of the guide's delivery.

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant prior to the sale of all applicable plans as required in Section 6 of the Act.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point ~~S~~sans~~-~~ ~~S~~serif ~~font~~ type, immediately above the company name, with the sentence "It is different from the outline of coverage you received when you [applied] [enrolled]." made prominent:

"NOTICE: Read this outline of coverage carefully. It is different from the outline of coverage you received when you [applied][enrolled]. The coverage you applied for was not issued."

~~**Drafting Note:** The sentence "It is different from the outline of coverage you received when you [applied] [enrolled]." should be prominent. It may be made prominent in one or more methods, including using a larger font size, leading, underlining, bolding, or italics.~~

(3) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval. In such instances, no policies may be sold or renewed until approved by the commissioner.

(4) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in Section 6H of the Act as well as this regulation.

C. Hospital Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed and be stated clearly and concisely:

[COMPANY NAME]

[Hospital Indemnity] [Other Fixed Indemnity] Coverage

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

Commented [RAW120]: "Other" doesn't really make sense as a stand-alone descriptor, but by now I suppose we're stuck with it.

Commented [RB121R120]: I would not be opposed to striking given the consumer-facing context.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) [Hospital indemnity] [Other fixed indemnity] coverage is designed to pay a fixed dollar benefits as a result of a -covered -[hospital stay] [event] due to a sickness or injury. The benefits may be limited in ways described in the [policy] [certificate]. -The fixed dollar benefit may be less than the [hospital stay's] [event's] cost.

(3) [A brief specific description of the benefits in the following order:

(a) When the benefits are payable;

(b) The duration of benefits described in (a); and

(c) The fixed dollar amount of the benefits.]

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

(6) [Any benefits provided in addition to the fixed dollar [hospital] [event] benefit.]

~~**Drafting Note**: The above descriptions shall be stated clearly and concisely.~~

D. Disability Income Protection Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed and be stated clearly and concisely:

[COMPANY NAME]

Disability Income Protection Coverage

OUTLINE OF COVERAGE

(1) Read your policy carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. -The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Disability income protection coverage is designed to pay a benefit for disabilities resulting from a covered sickness or injury. The benefit may be limited in the ways described in the [policy] [certificate]. The benefit might not fully replace your income.

(3) [A brief specific description of the benefits contained in this policy.]

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(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

~~**Drafting Note**: The above descriptions shall be stated clearly and concisely.~~

E. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Section 8D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed and be stated clearly and concisely:

[COMPANY NAME]

Accident-Only Coverage

The benefits in this [policy] [certificate] are limited.
They are intended to be separate from your other health insurance coverage.

They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Accident-only coverage pays benefits for covered injuries from a covered accident. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate].

(3) [A brief specific description of the benefits~~.~~ and a description of any deductible or copayment provisions applicable to the benefits described.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.~~

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above. Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~**Drafting Note**: The above descriptions shall be stated clearly and concisely.~~

F. Specified Disease or Specified Accident Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Sections 8E and F of this regulation. The coverage shall be identified by the

appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed and be stated clearly and concisely:

[COMPANY NAME]

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage

(1) Read your [policy] [certificate] and [outline of coverage] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) [Specified disease][Specified accident] coverage is designed to pay limited benefits as a result of the diagnosis or treatment of a [covered disease] or a [specifically identified type of accident]. -Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

(3) [A brief specific description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described..] Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.

G. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Sections 8B, D and G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed and be stated clearly and concisely:

[COMPANY NAME]

Limited Benefit Health Coverage

The benefits in this [policy] [certificate] are limited. They are intended to supplement your other health insurance coverage. They are not intended to cover all expenses.

OUTLINE OF COVERAGE

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Limited benefit health coverage pays limited benefits as a result of a covered benefit. This [policy] [certificate] is not major medical insurance and does not replace it.

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(3) [A brief specific description of the benefits, including dollar amounts and a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.~~

(4) [A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~**Drafting Note:** The above descriptions shall be stated clearly and concisely.~~

H. Short-Term, Limited Duration Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Section 8H of this regulation. The items included in the outline of coverage must appear in the sequence prescribed and be stated clearly and concisely:

[COMPANY NAME]

Short-Term, Limited Duration Coverage

The benefits in this [policy] [certificate] are limited. They are not intended to cover all expenses.

The [policy] [certificate] may not cover preexisting conditions.

OUTLINE OF COVERAGE

(1) Read your [policy] [certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) This is a short-term, limited duration [policy] [certificate]. This is temporary insurance. It is not comprehensive health insurance. It might not cover or might limit coverage for preexisting conditions. It might not cover essential health benefits such as pediatric, hospital, emergency, maternity, mental health, substance use services, prescription drugs, or preventive care. Read your [policy] [certificate] carefully to make sure you understand what is covered and any limitations on coverage.

(3) [A brief specific description of the benefits in the following order:

(a) Benefits covered by the plan, including required cost-sharing;

(b) Benefits that are not covered by the plan;

(c) Notice that cost-sharing limitations do not apply to benefits not covered by the plan; and

(d) Duration of benefits described above.]

Commented [RAW122]: This takes care of the deductible and copayment provisions.

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(4) [A description of provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (3) above. Proper disclosure of benefits that vary according to the type of accidental cause shall be made in accordance with Section 8A(13) of this regulation.]

(5) [A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

Drafting Note: The above descriptions, including those of benefits, shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 8A(13) of this regulation.

Commented [RAW123]: Is this relevant for STLD? I included it because it was in the drafting note, but it doesn't sound right.

Commented [RB124R123]: Agree, suggest deleting.

I. Limited Scope Dental Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with dental plan care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed and be stated clearly and concisely:

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Limited scope dental coverage pays benefits for dental benefits only. It is not intended to cover all dental expenses. Read your [policy] [certificate] carefully to understand what dental services it covers and any cost-sharing that may be your responsibility.

(3) [A brief specific description of the benefits.]

(4) [A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Drafting Note: The above descriptions shall be stated clearly and concisely.

J. Limited Scope Vision Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with vision plan care policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed and be stated clearly and concisely:

(1) Read your [policy][certificate] carefully. This outline of coverage briefly describes your coverage's important features. It is not the insurance contract. The [policy] [certificate] itself details your rights and obligations and those of your insurance company. It is important that you read your [policy] [certificate] carefully!

(2) Limited scope vision coverage pays benefits for vision benefits only. It is not intended to cover all vision expenses. Read your [policy] [certificate] carefully to understand what vision services it covers and any cost-sharing that may be your responsibility.

(3) [A brief specific description of the benefits.]

(4) [A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~**Drafting Note:** The above descriptions shall be stated clearly and concisely.~~

Section 10. Requirements for Replacement of Individual Supplementary and Short-Term Health Insurance Coverage

A. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other supplementary or short-term health insurance subject to this regulation, as provided in Section 3A of this regulation, presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice described in Subsection D below. ~~In no event, h~~However, ~~will the~~this notice ~~s be~~is not required in the solicitation of ~~the following types of policies:~~ accident-only policies or the replacement of ~~and~~ single-premium nonrenewable policies.

C. The notice required by Subsection B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have provided], you intend to lapse or otherwise end the supplementary or short-term health insurance you have now and replace it with a policy the [insert company name] Insurance Company will issue. For your own protection, you should know how replacing your policy with a new one might affect your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover health conditions that you might have now (preexisting conditions) or might not cover them right away. A new policy might cover some but not all the costs related to treating preexisting conditions.

Drafting Note: This subsection may be modified if preexisting conditions are covered under the new policy.

(2) Talk with your current insurance agent or company representative about replacing your policy. It is in your best interest to be sure you understand how replacing your policy could affect your future coverage.

(3) If you decide to buy a new policy, be sure to truthfully and completely answer all questions on the application about your medical/health history. If you do not, the company could deny any future claims and refund your premium as though your policy had never been in force. Check that the information on your application is complete and correct before you sign it.

The above "Notice to Applicant" was delivered to me on:

____
(Date)

____

(Applicant's Signature)

D. The notice required by Subsection B of this section for a direct response insurer shall be as follows:

Notice to Applicant About Replace of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have provided], you intend to lapse or otherwise end the supplementary or short-term health insurance you have now and replace it with the attached policy issued by [insert company name] Insurance Company. Your new policy gives you thirty days to decide at no cost if you want to keep the policy. For your own protection, you should know how replacing your policy with a new one might affect your coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover health conditions you have now (preexisting conditions) or might not cover them right away. A new policy might cover some but not all the costs related to preexisting conditions.

(2) Talk with your insurance agent or company representative about replacing your policy. It is in your best interest to be sure you understand how replacing your policy could affect your future coverage.

(3) [To be included only if the application is attached to the policy]. If you decide to buy a new policy, read the copy of the attached application and be sure that all questions are answered fully and correctly. If they are not, the company could refuse to pay an otherwise valid claim. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left off the application.

[COMPANY NAME]

Drafting Note: The sentence "Your new policy gives you thirty days to decide at no cost if you want to keep the policy." should only be required if the state has adopted Section 9A(18).

Section 11. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected thereby.

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Draft: 5/7/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
April 22, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met April 22, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Christina Jackson (FL); Martin Swanson (NE); Tanji J. Northrup, Heidi Clausen, and Shelley Wiseman (UT); Anna Van Fleet, Mary Block, and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed the Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

The Subgroup continued its discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), beginning with the Schiffbauer Law Office's suggestion to delete the work "available" in Section 9A(1)—Required Disclosure Provisions and replace it with "provided." William Schiffbauer (Schiffbauer Law Office) said he suggests this revision because he believes the word "available" is ambiguous and the word "provided" is clearer. He said for Section 9A(2)(d), he also suggests for clarity replacing the words "in close proximity" and replacing it with "directly above." After discussion, the Subgroup accepted the first suggested revision to replace the word "available" with "provided" in Section 9A(1). The Subgroup discussed the potential consequences of replacing "in close proximity" with "directly above" in Section 9A(2)(d). During the discussion, Subgroup members discussed how such a change would work with the recently adopted federal consumer disclosure requirements and whether it would be feasible. After additional discussion, the Subgroup decided not to accept the suggested revision because it might not be feasible to implement and would limit flexibility.

The Subgroup next discussed the Schiffbauer Law Office comments on Section 9C(2)—Hospital Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage). Schiffbauer said he suggests revising the language to match the disclosure language for this product in Section 9A(3) and (4). Jolie H. Matthews (NAIC) explained that the language in Section 9C(2) does not mirror the language in Section 9A(3) and (4) because the provisions are structured differently. The Subgroup discussed the suggested comment. After discussion, Schiffbauer withdrew his comments.

The Subgroup next discussed the Schiffbauer Law Office comment's on Section 9E(2)—Accident Only Coverage (Outline of Coverage) suggesting the Subgroup add "or injury" because it would tie this provision back to the definition of "injury" in Section 6D—Policy Definitions. The Subgroup discussed the suggested revision. After discussion, the Subgroup decided not to accept it because Section 9E(2) includes language stating that "accident only coverage pays for benefits for covered injuries." Given this, adding "or injury" is unnecessary.

The Subgroup next discussed the Schiffbauer Law Office comments on Section 9F(2)—Specified Disease or Specified Accident Coverage (Outline of Coverage). Schiffbauer said he suggests revising the language to match the disclosure language for this product in Section 9A(3) and (4). Matthews said the suggested comments on this section are like those for Section 9C(2). After discussion, the Subgroup asked NAIC staff to review the language for consistency.

Matthews said the Subgroup has discussed all the Dec. 1, 2023, comments on the proposed revisions to Model #171 and no additional comments have been received. She said she will distribute a final draft of proposed revisions to Model #171 reflecting the Subgroup's discussions to date. She said stakeholders will have at least two weeks to review the final draft prior to the Subgroup holding a meeting to consider adoption of the revised model.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 4/29/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
April 8, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met April 8, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Christina Jackson (FL); Martin Swanson and Maggie Reinert (NE); Heidi Clausen and Shelley Wiseman (UT); and Jamie Gile (VT).

1. Discussed the Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

Before continuing its discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), the Subgroup reviewed proposed revisions to Section 8A intended to reflect the Subgroup's discussion of the term "spouse" during its March 25 meeting. Jolie H. Matthews (NAIC) said that as discussed during the March 25 meeting, she added a drafting note to Section 8A(1) and Section 8(A)(3) where the term "spouse" is used directing states to review the use of the term "spouse" and replace it or add additional terms in accordance with state law or regulations. She explained that there was an existing proposed drafting note for Section 8A(3) concerning the addition of the terms "married couple" and "civil union couple." Matthews said she revised that drafting note to reflect the Subgroup's discussion of the term "spouse" in Section 8A(1). After discussion, the Subgroup accepted the suggested revisions.

The Subgroup continued its discussion of the Dec. 1, 2023, comments beginning with the Schiffbauer Law Office's suggestion to add additional language to the drafting note in Section 8B(2). William Schiffbauer (Schiffbauer Law Office) said he suggests the Subgroup adds a sentence to the drafting note explaining that state insurance regulators can address consumer confusion about the coverage excepted benefit products provide by requiring insurers to not offer, market, or sell these products as a substitute for, or an alternative to, comprehensive major medical coverage and requiring consumer disclosures that this type of coverage is supplementary insurance. After discussion, the Subgroup accepted the suggested revision.

The Subgroup next discussed the Schiffbauer Law Office's suggested clarifying revisions to the drafting notes at the end of Section 8B by: 1) deleting the word "supplemental" and replacing it with "supplementary;" 2) deleting the word "resemble" and replacing it with "could be mistaken for;" and 3) deleting the word "developed" and replacing it with "offered." After discussion, the Subgroup accepted the suggested revisions.

The Subgroup next discussed the NAIC consumer representatives' comments on Section 8C—Disability Income Protection Coverage. Lucy Culp (The Leukemia & Lymphoma Society—LLS) said the NAIC consumer representatives suggest incorporating the language in the drafting note for Section 8C(2) into the subsection's substantive provisions. She said the NAIC consumer representatives also suggest clarifying the language in Section 8C(3). The Subgroup agreed that the drafting note language should be incorporated into Section 8C(2). After discussion, the Subgroup agreed to revise Section 8C(2) to read as follows: "(2) Contains an elimination period no greater than: (a) Fifty percent (50%) of the benefit period in the case of a coverage providing a benefit of one hundred and eighty (180) days or less; (b) Ninety (90) days in the case of a coverage providing a benefit of one hundred and eighty (180) days to one year; (c) 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 (d) Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury." To clarify Section 8C(3), the Subgroup also agreed to delete the word "maximum."

The Subgroup next discussed the Schiffbauer Law Office's suggestion to add the word "injury" to Section 8D—Accident Only Coverage for consistency with other provisions in the revised model. After discussion, the Subgroup accepted the suggested revision.

The Subgroup next discussed the NAIC consumer representatives' and Schiffbauer Law Office's suggested revisions to Section 8E—Specified Disease Coverage. The NAIC consumer representatives suggest clarifying Section 8E(1) by adding a cross-reference to paragraph (2). The Subgroup accepted the suggested revision. The Schiffbauer Law Office suggests the same revisions to the drafting note for Section 8E(6)(a) as those made to the drafting note for Section 8B(2). The Subgroup accepted the suggested revisions.

The Subgroup next discussed the Schiffbauer Law Office's suggested revisions to the drafting note for Section 8G—Limited Benefit Health Coverage. The first suggested revision seeks to clarify the language in the drafting note's second sentence, which discusses situations when excepted benefit-type products may be combined with other types of products. After discussion, the Subgroup decided not to accept the suggested revision because the suggested language seemed more confusing than clarifying. The Subgroup accepted the second revision, which added the same language the Subgroup agreed to add to the drafting notes for Section 8B(2) and Section 8E(6)(a).

The Subgroup next discussed the comments received on whether it should retain the proposed language in Section H—Short-Term, Limited-Duration Health Insurance Coverage establishing requirements for canceling a short-term, limited-duration (STLD) plan. During its initial discussions of this provision, the Subgroup preliminarily added the language but requested that NAIC staff flag it for future discussion after it completed its review of all the initial comments received on the model. The Subgroup received two comments on this provision—the Health Benefits Institute (HBI) and the NAIC consumer representatives. Both the HBI and the NAIC consumer representatives suggest retaining the provision because it is an important consumer protection provision. The Subgroup agreed.

The Subgroup next discussed the NAIC consumer representatives' comments, alerting the Subgroup that the revised model does not include minimum standards for limited-scope vision coverage and limited-scope dental coverage. The Subgroup discussed the comments. During the discussion, the Subgroup noted that Section 5—Minimum Standards for Benefits of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170), which is the companion model act to Model #171, does not provide for the establishment of minimum standards for these coverages and during the revision process for Model #170, no one suggested adding language to this provision to require the establishment of such standards.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 4/4/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
March 25, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met March 25, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers and Stephen Flick (DC); Christina Jackson (FL); Camille Anderson-Weddle (MO); Maggie Reinert (NE); Heidi Clausen and Shelley Wiseman (UT); Anna Van Fleet, Mary Block, and Jamie Gile (VT); and Ned Gaines (WA).

1. Discussed the Dec. 1, 2023, Comments Received on Draft Revisions to Model #171

The Subgroup continued its discussion of the Dec. 1, 2023, comments submitted on the Oct. 12, 2023, draft of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) beginning with the NAIC consumer representatives' comments on Section 7D. Section 7D prohibits insurers from limiting or excluding coverage by type of illness, accident, treatment, or medical condition except as provided in the section. Lucy Culp (The Leukemia & Lymphoma Society—LLS) reiterated the NAIC consumer representatives' objection to the inclusion of "mental or emotional disorders, alcoholism, and drug addiction" and "suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury" as allowable limitations or exclusions from coverage for any type of supplemental or short-term policies. The Subgroup discussed the NAIC consumer representatives' comments. During the discussion, some Subgroup members noted that the removal of the permitted limitation or exclusion of coverage for "mental or emotional disorders, alcoholism, and drug addiction" or "suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury" for these products could adversely impact the availability and affordability of such products for consumers. The Subgroup discussed how Vermont does not permit these limitations or exclusions for disability products. After additional discussion, the Subgroup decided to leave Section 7D unchanged.

The Subgroup next discussed Section 7E. Section 7E allows insurers to issue waivers that exclude or limit coverage for certain preexisting conditions or extra hazardous activities. The NAIC consumer representatives suggest deleting Section 7E because they find it unnecessary and at odds with the Subgroup's purpose, which is to set minimum standards. The NAIC consumer representatives suggest the Subgroup adopt minimum standards and not permit insurers to offer waivers limiting or excluding coverage under Section 7E. The Subgroup discussed the comments submitted regarding Section 7E. The American Council of Life Insurers (ACLI) suggests retaining Section 7E because if the Subgroup removes it, then most likely, consumers with preexisting conditions will be denied coverage completely rather than the consumer obtaining coverage except for the preexisting disease, physical condition, or extra hazardous activity that is subject to the waiver. America's Health Insurance Plans (AHIP) also suggests retaining Section 7E because, without such a provision, there would be nothing in Model #171 outlining the structure or use of waivers or for the consumer disclosure and acceptance of such a waiver. After additional discussion, the Subgroup decided to retain Section 7E.

The Subgroup next discussed the use of the term "spouse" in Section 8A. During its previous discussions of this provision, the Subgroup discussed the use of the term "spouse" and possible alternative terms to use in its place, considering the varying interpretations and meanings of the term from state to state. After extensive discussion, the Subgroup decided to retain the term "spouse" and add a drafting note suggesting that the states, when reviewing the language in Section 8A, insert replacement or additional terms in accordance with the state's laws or regulations.

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The Subgroup next discussed whether to move Section 8A(10), which is a provision permitting insurers to include in a policy a provision related to recurrent disabilities, to another section in Model #171. During its previous discussions of this provision, the Subgroup had initially considered moving Section 8A(10) to another section in Model #171 related to disability policies because it seemed to be applicable only to those types of policies. The Subgroup discussed the comments received on this issue. The comments from the ACLI and AHIP suggest leaving Section 8A(10) in its current place in Model #171 because its provisions could apply to other types of policies in addition to disability policies. After additional discussion, the Subgroup decided to leave Section 8A(10) in its current place.

The Subgroup next discussed Schiffbauer Law Office's suggestion to delete "triggered by" in Section 8B(1) and replace it with "as a result of." William Schiffbauer (Schiffbauer Law Office) explained that he is suggesting this revision to be consistent with other proposed revisions in Model #171. After discussion, the Subgroup accepted his suggested revision.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.

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Draft: 3/27/24

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Phoenix, Arizona
March 17, 2024

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Phoenix, AZ, March 17, 2024. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Crystal Phelps (AR); Gio Espinosa (AZ); Cara Cheevers and Debra Judy (CO); Kurt Swan (CT); Stephen Flick (DC); Elizabeth Nunes (GA); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); T.J. Patton (MN); Teresa Kroll (MO); Robert Croom and Ted Hamby (NC); Chrystal Bartuska and Karri Morris (ND); Ralph Boeckman and Erin Porter (NJ); Viara Ianakieva (NM); Kyla Dembowski (OH); Ashley Scott and Landon Hubbart (OK); Caroline Boehm (PA); Jill Kruger (SD); Rachel Bowden (TX); Heidi Clausen and Shelley Wiseman (UT); Julie Fairbanks (VA); Rebecca Rebholz (WI); Joylynn Fix (WV), and Jill Reinking (WY).

1. <u>Heard Presentations on Opioid Use Disorder and Medication for Opioid Use Disorder</u>

Weyhenmeyer said that state insurance regulators perform detailed analysis of coverage policy and claims data, but they lack health care providers' knowledge of diseases like opioid use disorder and effective treatments for it. She said expert physician speakers would help educate the Working Group on the effects of opioid use disorder and the evidence that supports treatment for the disorder.

Dr. Jesse Ehrenfeld (American Medical Association—AMA) said the overdose epidemic is a critical issue for the nation. He said patients with mental illness and substance use disorder need the help of parity laws that are intended to protect them. He shared data on the rising numbers of overdose deaths and the large share of deaths caused by illicit fentanyl. He said more than 100,000 people die per year due to the epidemic of overdose.

Dr. Ehrenfeld described resources from the AMA on opioids, including reports on pregnant women and justice-involved individuals, a toolkit for policymakers, and a report with statistics on the epidemic. He reviewed key trends in opioid use disorder, including reduced opioid pain prescriptions, the end of barriers to prescribing like the X waiver, the success of naloxone, and remaining barriers to care like prior authorization. He said the AMA is happy to work with state insurance regulators to strengthen state or federal parity laws if regulators do not believe they grant sufficient authority. He urged states to impose significant monetary penalties on health plans for parity violations.

Dr. Ehrenfeld said that workforce challenges exist for mental health, but in comparison to medical crises like cardiac arrest, mental health treatment is not immediate and does not have appropriate follow-up. He said medical decisions are not questioned by health plans when the decisions follow the standard of care. He said that too often, health plans have no problem denying or delaying care for mental health conditions.

Dr. Marcus Bachhuber (Center for Evidence-based Policy) presented on medications for opioid use disorder. He described the effects of opioid use as doses increase and the increasing occurrence of withdrawal for patients. He said substance use disorders share many features with other chronic medical illnesses, such as periods of remission and relapse.

Dr. Bachhuber reviewed treatments for opioid use disorder. He said there was an early recognition that opioid use is different from other drug use disorders. He noted the history of treatments, including municipal morphine

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clinics, methadone clinics, and the development of buprenorphine and injectable naloxone. He showed the effects of medications on the opioid receptors in the brain.

Dr. Bacchuber said that medication treatment for opioid use disorder is effective and lifesaving and that treatment retention is similar to other chronic conditions. He said methadone and buprenorphine generally have similar outcomes and that naltrexone requires a patient to undergo withdrawal before treatment. He said the three medications are delivered to different patients in different settings depending on the clinical circumstances, and there is not one optimal treatment for everyone.

Dr. Bacchuber covered the rules for prescribing the three medications and their dose and quantity limits. He said limitations on duration of therapy can disrupt treatment and put patients at risk for overdose death.

Dr. Bacchuber said state insurance regulators have used parity exams to compare health plans' coverage of medications to opioid use disorder with coverage for opioids for treatment of pain, as well as with other medications. He said states have found differences such as excluding methadone, applying different prior authorization requirements, or placing all medications on a high tier.

Dr. Bacchuber shared additional resources on the three medications, including from the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), and the Center for Evidence-based Policy.

Beyer said state Medicaid programs often use information from the Center for Evidence-based Policy for setting coverage standards and that the same information can support the work that state insurance regulators do in mental health parity.

Seip asked whether generic equivalents exist for the drugs Dr. Bacchuber discussed. He said methadone is a generic, there are generic forms of buprenorphine, and only the brand form of naltrexone is approved for the treatment of opioid use.

2. Discussed Other Matters

Joe Feldman (Cover My Mental Health) said he is working to learn more about consumer complaints to state insurance regulators. He asked members of the Working Group to share how consumers can use the services their state departments of insurance (DOIs) provide. He said he will present at the Summer National Meeting on obstacles that consumers face in accessing mental health services.

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

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Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Virtual Meeting
June 7, 2024

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met June 7, 2024. The following Subgroup members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Kayla Erickson and Jeanne Murray (AK); Willard Smith (AL); Amy Seale (AR); Paul Lombardo (CT); Stephen Flick (DC); Sheryl Parker (FL); Andria Seip (IA); Erica Weyhenmeyer (IL); Vicki Schmidt (KS); Sharon P. Clark (KY); Chad Arnold and Joe Stoddard (MI); Norman Barrett Wiik (MN); Cynthia Amman and Amy Hoyt (MO); Robert Croom (NC); Cheryl Wolff (NE); Tim Stroud (NJ); Renee Blechner (NM); Jennifer Boyle, Kristina Magne, and Krista Porter (NY); TK Keen (OR); Jodi Frantz (PA); Elliott G. Webb (TN); Tanji J. Northrup (UT); Jennifer Kreitler and Ned Gaines (WA); Jennifer Stegall (WI); and Jill Reinking (WY).

1. Adopted its Revised 2024 Charges

Fix said that following the Subgroup's May 2 meeting during which the Subgroup discussed the comments received on its draft 2024 revised charges, the Subgroup met in regulator-to-regulator session to have an open and honest discussion, particularly on the draft 2024 revised charge 5C to review and consider revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22). She said that during this discussion Subgroup members and interested regulators indicated a more urgent need to have the Subgroup develop standardized market conduct examination standards for pharmacy benefit managers (PBMs) rather than reviewing Model #22. Fix explained that many state insurance departments now have the authority to conduct PBM market conduct examinations, but there currently is no guidance to assist state insurance regulators in conducting such examinations. She noted that such examination standards would have to include flexibility to reflect differences in state law. She also noted that in developing these examination standards, the Subgroup will rely on its expertise as the subject matter experts on PBMs and the prescription drug ecosystem, but it would also rely on the market conduct examination expertise of some of its members as well as industry and other stakeholder input, which will be essential to the Subgroup's work.

Fix said that prior to this meeting, NAIC staff distributed the revised draft 2024 revised charges, deleting the proposed 2024 revised charge 5C, which was to review and consider revisions to Model #22, and adding a new proposed 2024 revised charge in its place to "develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group." She said the Subgroup received comments from America's Health Insurance Plans (AHIP) and the Pharmaceutical Care Management Association (PCMA).

Kris Hathaway (AHIP) said that as noted in its comment letter, AHIP had questions about the process and how the Subgroup envisioned working with the Market Conduct Examination Guidelines (D) Working Group as it develops the proposed new PBM market conduct examination standards chapter for the *Market Regulation Handbook*. She said that in addition, AHIP has concerns about standardizing the PBM examination standards given the different approaches states have taken. To address this concern, AHIP suggests adding the words "while remaining sensitive to variation in state approaches" to the draft 2024 revised charge 5C. In response to AHIP's first question about the process, Fix said she envisions the Subgroup developing the new chapter and referring it to the Market Conduct Examination Guidelines (D) Working Group for its consideration. She anticipates the Market Conduct Examination Guidelines (D) Working Group will accept the referral and the Subgroup's draft PBM market conduct examination standard chapter for its consideration, and after receipt, the Working Group will follow its normal process of exposing the document for comment and discussing any comments and suggested revisions during

open meetings prior to considering its adoption. Fix said she supported adding AHIP's suggested language to the revised draft 2024 revised charge 5C to reflect the different approaches states have taken.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the PCMA, said the PCMA appreciates the revisions to the draft 2024 revised charges. He said the PCMA welcomes the opportunity to work with the Subgroup as it moves forward with the charge 5C to develop PBM market conduct examination standards for inclusion in the *Market Regulation Handbook*. He noted the PCMA's experience in this area, particularly on what works and what does not work in the various states from a national perspective. Randi Chapman (Blue Cross and Blue Shield Association—BCBSA) said that although it did not submit written comments, the BCBSA wanted to provide comments during this meeting expressing its appreciation for the work the Subgroup has done to develop the draft 2024 revised charges. She said the BCBSA also looks forward to working with the Subgroup as it works to develop a PBM market conduct examination standards chapter.

After discussion, the Subgroup agreed to revise the draft 2024 revised charge 5C to add the language suggested by AHIP, which would have the charge read as follows: "As the subject matter experts and to promote uniformity across the states, while remaining sensitive to variation in state approaches, develop a chapter for inclusion in the *Market Regulation Handbook* establishing examination standards for PBMs and related entities for referral and consideration by the Market Conduct Examination Guidelines (D) Working Group."

Weyhenmeyer made a motion, seconded by Northrup, to adopt the draft 2024 revised charges (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force, Attachment One-A*). The motion passed unanimously.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Pharmacy Benefit Manager Regulatory Issues (B) Subgroup
Virtual Meeting
May 2, 2024

The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met May 2, 2024. The following Subgroup members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Kayla Erickson and Sarah Bailey (AK); Anthony Williams and Yada Horace (AL); Amy Seale (AR); Paul Lombardo and Michael Shanahan (CT); Sheryl Parker and Samantha Heyn (FL); Andria Seip (IA); Erica Weyhenmeyer (IL); Craig VanAalst (KS); Daniel McIlwain (KY); Nina Hunter (LA); Chad Arnold, Tina Nacy, and Joe Stoddard (MI); Norman Barrett Wiik (MN); Chlora Lindley-Myers and Amy Hoyt (MO); Cheryl Wolff (NE); Renee Blechner (NM); Alice McKenney (NY); Ted Hamby (NC); TK Keen (OR); Shannen Logue and Sandy Ykema (PA); Elliott G. Webb (TN); Tanji J. Northrup, Heidi Clausen, and Shelley Wiseman (UT); Jennifer Kreitler (WA); Nathan Houdek and Jennifer Stegall (WI); and Jill Reinking (WY). Also participating was: Chrystal Bartuska (ND).

1. Discussed the April 19 Comments Received on its Draft Proposed Revised 2024 Charges

Fix said the purpose of this meeting is for the Subgroup to hear from stakeholders who submitted comments on the Subgroup's draft proposed 2024 revised charges (Attachment Ten-A). She said the Subgroup received comments from America's Health Insurance Plans (AHIP), the NAIC consumer representatives, the Healthcare Distribution Alliance (HDA), the National Association of Chain Drug Stores (NACDS), the National Community Pharmacists Association (NCPA); the North Dakota Insurance Department, and the Pharmaceutical Care Management Association (PCMA).

Samatha Burns (AHIP) said that, as discussed in its comment letter, AHIP recommends that the Subgroup remain a subgroup and not change to a working group. She said the term "working group" implies this will be a long-term commitment instead of gathering relevant information, completing the task, and ending within the next few years. Burns said AHIP also recommends specifically listing the supply chain entities—drug manufacturers and pharmacy services assistance organizations (PSAOs)—rather than the less prescriptive "stakeholders." She said this more descriptive listing will prompt Subgroup members to consider the various entities and potential topics to discuss for further education. Burns said AHIP recommends the proposed charge to review and consider revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) be eliminated given the history related to the development and the NAIC membership's failure to adopt the proposed [State] Pharmacy Benefit Manager Licensure and Regulation Model Act. She noted that removing the charge does not preclude the Subgroup from discussing it. Deleting the charge merely eliminates the requirement for the Subgroup to review the model.

Will Dane (HDA) said the HDA believes the Subgroup's proposed 2024 revised charges provide a thoughtful approach to further the Subgroup's work as it transitions to the Pharmacy Benefit Management Regulatory Issues (B) Working Group and supports their adoption. He said the HDA stands ready to be a resource to the Working Group, as necessary, as it moves forward with its work.

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives submitted a comment letter to the Regulatory Framework (B) Task Force for its consideration during its meeting at the Spring National Meeting expressing strong support for the draft revised 2024 proposed charges. He said that because Model #22 failed to include provisions directly regulating pharmacy benefit managers (PBMs) or specifically address the significant role that PBMs play in prescription drug benefit plan design and delivery, the NAIC consumer representatives strongly support its review and update to reflect the changing times since it was adopted. Schmid noted that although the states have taken differing steps in regulating

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PBMs, consumers can benefit from and need an agreed-upon minimum level of protection by state insurance regulators.

Joel Kurzman (NCPA) said the NCPA is generally supportive of the proposed 2024 revised charges; however, based on its priorities, the NCPA suggests the Subgroup remain focused on PBMs rather than including other stakeholders in the prescription drug ecosystem and prioritize all its activities on the enforcement of existing PBM state insurance laws. He said the NCPA believes a focus on enforcement of existing PBM state laws is a topic most stakeholders can appreciate and brings practical value to state insurance regulators. Kurzman also said that if the Subgroup decides to revisit Model #22, the NCPA believes the most relevant possible addition would be a section establishing enforcement provisions. He noted that given the Subgroup's previous discussions related to the proposed [State] Pharmacy Benefit Manager Licensure and Regulation Model Act and the PBM white paper, the NCPA prefers the Subgroup focus on the other proposed 2024 revised charges, especially those pertaining to best practices, to assist state insurance regulators in overseeing and enforcing state PBM laws.

Sandra Guckian (NACDS) reiterated the NACDS's belief about the importance of PBM licensure and the state insurance regulatory environment. She said that while the emergence of greater regulation of PBM actions is essential, so too is a regulatory structure that adequately equips the states to respond to potential law violations, whether through fines or other civil penalties, license revocation, or both. Guckian said the Subgroup can establish such a regulatory structure by adding such provisions to Model #22. She said the NACDS also supports the NCPA's comments and urges the Subgroup to maintain its focus on PBMs, particularly enforcement of current PBM state insurance laws, to continue to help protect patients and patient access to pharmacies in communities nationwide.

Bartuska said the North Dakota Insurance Department suggests the Subgroup consider revising the proposed 2024 revised charge concerning its potential review of Model #22 to remove the words "and consider any necessary updates to" and "out of" and substitute the words "due to." She said that with these suggested revisions, the proposed 2024 revised charge would read: "Review the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) due to the emergence of greater regulation in the prescription drug ecosystem." She said the North Dakota Insurance Department believes these suggested revisions remove the pressure on the Subgroup to feel compelled to offer updates to Model #22 when its focus should be on a thorough review of the model during the remainder of the year.

Chris Petersen (Arbor Strategies LLC), speaking on behalf of the PCMA, said the PCMA believes it is important for the Subgroup to expand its focus to look at all the stakeholders in the prescription drug supply chain and their relationship with each other to identify all the factors possibly affecting the cost of prescription drugs. He said that as stated in its comment letter, the PCMA does not believe it is appropriate to include a charge suggesting the Subgroup's successor working group review and consider updates to Model #22 because it would be premature, and, as already discussed, no state has adopted it in its entirety. Petersen also said Model #22 does not contemplate regulating PBMs. He said given these concerns, the proposed 2024 revised charge concerning the potential review of Model #22 should be deleted.

Seip asked Petersen why the PCMA believes the Subgroup's focus should be expanded to include all stakeholders in the prescription drug supply chain. Petersen said the PCMA believes expanding the Subgroup's focus to include all the stakeholders would allow it to better understand all the factors that go into the cost of prescription drugs. He said the PCMA believes PBMs reduce the cost of drugs, while other stakeholders in the prescription drug supply chain suggest PBMs increase the cost. Petersen said that if the Subgroup focuses its work on all the parties to the transaction, it will be able to see what portion of costs are attributed to each party. He said the Subgroup needs to understand how the entire prescription drug supply chain works and how each part impacts prescription drug costs. Seip asked Petersen for the source of the graphic included in the PCMA's April 18 comment letter stating

that prescription drug manufacturers and pharmacies retain 90% of each dollar that enters the prescription drug ecosystem. Petersen said he did not have that information but would follow up with the Subgroup.

Charise Richard (Pharmaceutical Research and Manufacturers of America—PhRMA) said that although PhRMA did not submit written comments on the Subgroup's proposed revised 2024 charges, she wants the Subgroup to know that PhRMA supports the Subgroup's efforts to better understand PBM practices and their central role in the prescription drug supply chain. She noted PhRMA's disappointment that the PBM white paper omitted several patient-centered solutions to the issues being discussed. She said that, despite this, PhRMA hopes that over time, the Subgroup will find solutions that better help patients to afford their prescriptions.

Weyhenmeyer expressed support for redesignating the Subgroup as a working group. She explained that in assisting to develop the Subgroup's proposed 2024 revised charges, the Subgroup would mirror the work of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group and have ongoing work on a complex issue of interest to all the states for which it will serve as a forum and provide an opportunity for state insurance regulator and stakeholder discussion and ongoing education. Wolff expressed support for the North Dakota Insurance Department comments about reviewing Model #22. She said Nebraska's PBM laws were a carefully crafted compromise among all the parties. Given this, she does not foresee Nebraska changing its PBM laws based on revisions to an NAIC model.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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Pharmacy Benefit Manager Regulatory Issues (B) Subgroup Draft Revised 2024 Charges

The Pharmaceutical Benefit Management Regulatory Issues (B) Working Group will:

A. Serve as a forum to educate state insurance regulators on issues related to pharmacy benefit manager (PBM) regulation and other stakeholders in the prescription drug ecosystem.
B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to PBM regulation, such as examinations and contracting, and pharmaceutical drug pricing and transparency.
C. Review and consider any necessary updates to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22) out of the emergence of greater regulation in the prescription drug ecosystem.
D. Maintain a current listing of PBM laws and regulations and case law for reference by state insurance regulators.
E. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
F. Monitor, facilitate, and coordinate with the states and federal agencies regarding compliance and enforcement efforts regarding PBMs.

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