REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Nov. 17, 2024, Minutes

- Regulatory Framework (B) Task Force Nov. 4, 2024, Minutes (Attachment One)
  - *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) Adopted by the Task Force, Nov. 4, 2024 (Attachment One-A)
  - Regulatory Framework (B) Task Force 2025 Proposed Charges (Attachment One-B)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Oct. 17, 2024, Minutes (Attachment Two)
  - NAIC Staff Suggested Revisions to Limited Dental and Limited Vision Provisions (Attachment Two-A)
- Accident and Sickness Insurance Minimum Standards (B) Subgroup Sept. 9, 2024, Minutes (Attachment Three)
- Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group Aug. 14, 2024, Minutes (Attachment Four)

Draft Pending Adoption

Draft: 11/19/24

Regulatory Framework (B) Task Force
Denver, Colorado
November 17, 2024

The Regulatory Framework (B) Task Force met in Denver, CO, Nov. 17, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie, Vice Chair, represented by Chris Heisler (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Sanjeev Chaudhuri (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); Holly W. Lambert represented by Scott Shover (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Robert L. Carey represented by Marti Hooper (ME); Chlora Lyndley-Myers represented by Amy Hoyt (MO); Mike Causey represented by Charles Whitehead (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Maggie Reinert and Margaret Garrison (NE); D.J. Bettencourt represented by Michelle Heaton (NH); Scott Kipper (NV); Judith L. French represented by Kyla Dembowski (OH); Andrew R. Stolfi represented by TK Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Debra Diaz-Lara and Daniel McAdams (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek represented by Rebecca Rebholz (WI); and Allan L. McVey represented by Joylynn Fix (WV).

1. Adopted its Nov. 4 and Summer National Meeting Minutes

The Task Force met Nov. 4. During this meeting, the Task Force adopted its 2025 proposed charges and proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

Bartuska made a motion, seconded by Kosky, to adopt the Task Force's Nov. 4 (Attachment One) and Aug. 13 (*see NAIC Proceedings – Summer 2024, Regulatory Framework (B) Task Force*) minutes. The motion passed unanimously.

2. Adopted its Subgroup and Working Group Reports

Keen made a motion, seconded by Fix, to adopt the following reports: 1) the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Oct. 17 (Attachment Two) and Sept. 9 (Attachment Three) 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 Aug. 14 (Attachment Four) minutes; and 4) the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group. The motion passed unanimously.

3. Heard a Presentation from AffirmedRX on PBM Transparency

Rob Nolan (AffirmedRX) discussed pharmacy benefit management (PBM) transparency initiatives. He offered a brief overview of PBMs, emphasizing the importance of transparency in PBM operations and addressing related challenges and barriers. He described public benefit corporations (PBCs) and PBC PBMs, highlighting how PBC PBMs focus on providing transparent and ethical drug pricing while ensuring access to medications for underserved populations. Nolan said this approach: 1) enhances trust among stakeholders, partners, and the public; 2) attracts socially conscious investors; and 3) improves public image and reputation. He discussed future directions, including PBM transparency emerging trends, the potential impact of new technologies, and ongoing

legislative and regulatory efforts. He noted that AffirmedRX is an example of a PBM that uses a fully transparent, fee-based model that passes through rebates directly to consumers, avoiding hidden fees and ensuring that savings are shared.

Nolan emphasized the importance of PBM transparency for fair pricing and improved patient outcomes. He also stressed the importance of continuing efforts to promote transparency and accountability. Nolan encouraged stakeholders to support transparency initiatives and advocate for policies that ensure fair and equitable access to medications.

Fix asked about AffirmedRX's relationship with pharmacies and whether its transparency model is the same for pharmacies. Nolan said AffirmedRX operates with the same transparency in its contracts with pharmacies.

Commissioner Mulready asked Nolan to clarify what he meant about PBC PBMs' ability to attract socially conscious investors. Nolan explained that being socially conscious means investors are aligned with a PBC PBM's mission to provide transparent and ethical drug pricing while ensuring access to medications for underserved populations. Commissioner Mulready asked why AffirmedRX uses a separate company, JustifyRX, a full-service rebate collective PBC, for its rebating operations. Nolan said AffirmedRX decided to contract with JustifyRX as part of its transparency initiatives and, as such, wanted an arm's length arrangement between the two companies.

4. Discussed Issues Related to the Implementation of ACA Section 1557 and its Final Regulation

Amy Killelea (Killelea Consulting) and Jalisa Clark (Center on Health Insurance Reforms—CHIR) provided an overview of the federal Affordable Care Act's (ACA's) Section 1557 nondiscrimination provisions, including the application of its nondiscrimination provisions to Medicare supplemental insurance (Medigap) and other excepted benefit products. They also highlighted that Section 1557's nondiscrimination provisions apply to any health program or activity, including any part of which is receiving federal financial assistance.

Killelea noted that given the recent presidential election, it is anticipated that there could be a change in direction on how the final regulations could be interpreted and implemented. She said that because of this, state insurance regulators can play an important role in ensuring that Section 1557's nondiscrimination protections are applied and enforced.

Meghan Stringer (AHIP) said AHIP supports the final regulation's protections against discrimination. She discussed the importance of excepted benefit products to consumers and the value they provide to millions of Americans. She highlighted the four categories of excepted benefit products most utilized: 1) Medigap; 2) supplemental health (hospital or other fixed indemnity, specified disease, accident-only); 3) disability income; and 4) long-term care (LTC).

Stringer noted the outstanding questions that remain, including: 1) what the rules are for using gender as a rating factor; and 2) how the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) will evaluate "unaffordability" and "fundamental alteration" as applied to plan benefit design and underwriting. She said federal guidance is needed to clarify and answer these questions, particularly with respect to Medigap plans, because neither covered entities nor state insurance regulators have the information to answer these outstanding questions.

Stringer said trying to implement the final regulations amid this level of uncertainty would cause severe and potentially unnecessary disruptions in the market and create confusion among consumers. Stringer urged state insurance regulators to wait until the OCR provides guidance to answer the questions.

Harris asked Killelea and Clark what recommendations or best practices they would suggest for state insurance regulators to use to ensure enforcement of Section 1557's nondiscrimination provisions. Killelea said the complaint process is one tool, but on a more proactive basis, state insurance regulators should use their review authority to review plan benefit designs for potential discriminatory benefit designs.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2024 Fall Meeting/RFTF 11-17-24 MtgMin.docx

Draft: 11/7/24

Regulatory Framework (B) Task Force
Virtual Meeting
November 4, 2024

The Regulatory Framework (B) Task Force met Nov. 4, 2024. The following Task Force members participated: Glen Mulready, Chair (OK); Ann Gillespie, Vice Chair (IL); Lori K. Wing-Heier represented by Sarah Bailey (AK); Mark Fowler represented by Anthony Williams and Yada Horace (AL); Ricardo Lara represented by Tyler McKinney (CA); Michael Conway represented by 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 Weston Trexler and Shannon Hohl (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Angi Raley (KY); Michael T. Caljouw represented by Kevin Beagan (MA); Robert L. Carey represented by Robert Wake (ME); Chlora Lyndley-Myers (MO); Mike Causey represented by Ted Hamby and Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); D.J. Bettencourt represented by Michelle Heaton (NH); Justin Zimmerman represented by David Wolf (NJ); Scott Kipper represented by Jeremy Christensen (NV); Judith L. French represented by Laura Miller (OH); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden and Debra Diaz-Lara (TX); Jon Pike represented by Shelley Wiseman and Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Mike Kreidler represented by Ned Gaines (WA); Nathan Houdek (WI); and Allan L. McVey (WV). Also participating was: Andy Schallhorn (OK).

1. Adopted the Revisions to Model #171

Commissioner Mulready said the Task Force's first item of business is to consider adoption of the proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). He explained that in 2013, the former Affordable Care Act Model (ACA) Review (B) Working Group identified Model #171 and its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) (formerly known as the *Accident and Sickness Insurance Minimum Standards Model Act*), as needing to be revised because of the federal Affordable Care Act (ACA). After completing revisions to other NAIC models with a higher priority, in 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup to revise Model #170 and Model #171. The Subgroup completed its work on Model #170 in late 2018. The full NAIC membership adopted those revisions in February 2019.

Commissioner Mulready said the Model #170 revisions removed provisions for certain types of health insurance products that would not be permitted because of the requirements of the ACA leaving only those products considered to be excepted benefits and, therefore, not subject to the ACA's requirements. He said the Subgroup also added short-term, limited-duration (STLD) plans to the model because there was no other vehicle available in which to incorporate such plans, and the Subgroup did not want to create a new model for them. Commissioner Mulready said the proposed revisions to Model #171 revise the model for consistency with Model #170. The revisions also add standards for STLD plans and clarify provisions on consumer disclosure and outline of coverage requirements. He said the Subgroup adopted the revisions on Oct. 17.

Commissioner Humphreys said the NAIC consumer representatives submitted a comment letter to the Task Force just prior to the start of the meeting suggesting that they could not support the proposed revisions due to a provision in Model #171 that allows carriers to exclude coverage for "mental or emotional disorders, alcoholism, and drug addiction" and "suicide (sane or insane), attempted suicide, or intentionally self-inflected injury." He expressed concern about the provision and given this concern, he said he could not support the proposed revisions. Commissioner Humphreys suggested that the Task Force and the Health Insurance and Managed Care

(B) Committee should discuss the issue, particularly as to mental health coverage, more broadly. He said a lot has changed with respect to mental health coverage since the ACA was enacted and since the time the Subgroup began discussing the Model #171 revisions. Commissioner McVey expressed support for having a broader conversation of the issue. He also said he would vote to adopt the proposed revisions to move the model forward to the Health Insurance and Managed Care (B) Committee to hold those discussions.

Commissioner Humphreys asked if the Subgroup discussed the NAIC consumer representatives' concerns. Commissioner Mulready said the Subgroup had an extensive discussion on this provision. He also reiterated that Model #171 sets minimum standards, which means states can go further. Schallhorn, as co-chair of the Subgroup, agreed with Commissioner Mulready's comments.

Chris Petersen (Arbor Strategies LLC) noted that when the Subgroup discussed the provision, it was pointed out that the federal Mental Health Parity and Addiction Equity Act (MHPAEA) does not apply to excepted benefits coverage. He said there was also a concern expressed that mandating such coverage would require reopening Model #170. Petersen expressed support for moving the model forward for the Health Insurance and Managed Care (B) Committee's consideration and, if the Task Force decides it is appropriate, discussing the issue the NAIC consumer representatives' issue independently.

Jackson Williams (Dialysis Patient Citizens—DPC) said the proposed revisions to Model #171 represent a missed opportunity to bring greater value to consumers on products notorious for being of low value. He expressed disappointment that the Subgroup did not consider his proposals to address the issue.

J.P. Wieske (Horizon Government Affairs) said it is important to keep in mind that the products regulated under Model #170 and Model #171 are medically underwritten. As such, mandating mental health coverage could have the unintended consequence of limiting product availability. He also said Model #170 would have to be reopened.

Lucy Culp (The Leukemia & Lymphoma Society—LLS) restated the NAIC consumer representatives' comments included in its letter, including that the provision in Model #171 allowing a permitted exclusion for mental health coverage is not only out-of-step with advances in the mental health field, but also it is at odds with the NAIC's commitment to mental health parity and meaningful response to the opioid crisis. She also said that the landscape regarding mental health coverage has changed even since last year given the recently issued federal final rules implementing the ACA's Section 1557 nondiscrimination provisions. Culp said the NAIC consumer representatives believe the issue is not settled and that there needs to be further discussion. She asked about the process for reopening Model #170. Jolie H. Matthews (NAIC) said the Health Insurance and Managed Care (B) Committee would have to approve a Request for NAIC Model Law Development to reopen Model #170. She highlighted a few of the requirements necessary for such approval. Culp said the NAIC consumer representatives disagree with the comments suggesting that Model #170 would need to be reopened.

Deborah Steinberg (Legal Action Center—LAC) said that at the time the Subgroup discussed this issue, as other NAIC consumer representatives have stated, there were no mental health and substance use disorder experts included in the discussion. She said that as a mental health and substance use disorder expert, she would appreciate the opportunity to speak on the issue and include others with similar expertise as part of the discussion given the importance of recognizing these as health conditions. Amy Killelea (Killelea Consulting LLC) expressed support for Culp's and Steinberg's comments. She also said that as stated in the NAIC consumer representatives' comment letter, because the ACA's Section 1557 nondiscrimination protections apply to any excepted benefit products that receive federal assistance, directly or through a parent company, the permitted exclusion provision for mental health coverage in Model #171 is also likely illegal under federal law for a subset of these products. She urged the Task Force to take a closer look at the potential impact of the ACA's Section 1557 nondiscrimination provisions on the proposed revisions.

William Schiffbauer (Schiffbauer Law Office) said that adding mental health benefits to excepted benefit products could make them look more like comprehensive major medical coverage, which is what the Subgroup has been trying to avoid throughout the drafting process. He also acknowledged that the ACA's Section 1557 discrimination provisions apply to products that receive federal funds, but he said the excepted benefit products regulated under Model #170 and Model #171 do not receive federal funds. Wieske noted that if the permitted exclusion for mental or emotional disorders, alcoholism, and drug addiction was removed from Model #171, that would not result in coverage for those conditions. He said Model #170 would have to be revised to require coverage.

Commissioner McVey made a motion, seconded by Heaton, to adopt the revisions to Model #171 (Attachment One-A). The motion passed with the following states present and voting in favor of the motion: Alaska, Connecticut, Idaho, Iowa, Kansas, Kentucky, Maine, Massachusetts, Missouri, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin. The following states voted against the motion: Colorado and Pennsylvania. The following states abstained: Indiana and Ohio.

2. Adopted its 2025 Proposed Charges

Commissioner Mulready said that prior to this meeting, NAIC staff distributed the Task Force's 2025 proposed charges for comment with a public comment period ending Oct. 24. The Task Force received one comment from Virginia suggesting that the Task Force add "excepted benefit products" to charge #1F. He said that in addition to this change, the other substantive change from the 2024 charges is the deletion of the charge for the Accident and Sickness Insurance Minimum Standards (B) Subgroup because it has completed its charge.

Gaines made a motion, seconded by Commissioner McVey, to adopt the Task Force's 2025 proposed charges (Attachment One-B). The motion passed unanimously.

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

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Adopted by the Health Insurance and Managed Care (B) Committee - TBD
Adopted by the Regulatory Framework (B) Task Force – Nov. 4, 2024
Adopted by the Accident and Sickness Insurance Minimum Standards (B) Subgroup – Oct. 17, 2024

Draft: 10/17/24
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 ~~ACCIDENT AND SICKNESS~~SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

Table of Contents

Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC ~~Accident and Sickness~~ *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*] (the Act) to standardize and simplify the terms and coverages, ~~of individual accident and sickness insurance policies, and group accident and sickness policies and certificates providing hospital confinement indemnity, accident only, specified disease specified accident or limited benefit health coverage (hereafter referred to as "group supplemental health insurance"). This regulation is also intended~~ to facilitate public understanding and comparison of coverage, to eliminate provisions ~~contained in individual accident and sickness insurance policies and group supplemental health insurance~~ 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 ~~individual accident and sickness insurance policies and group supplemental health insurance~~ 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 ~~plans~~coverage, and to provide for disclosure in the sale of those ~~plans~~coverages.

~~**Drafting Note**: States should determine if the phrase "individual accident and sickness insurance policies" is broad enough or particular enough to cover the array of individual health insurance issuers in the state. States that use different terminology (e.g. "subscriber contracts" of "nonprofit hospital, medical and dental associations") to cover these plans should choose terminology conforming to state statute.~~

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [insert reference to state law equivalent to NAIC ~~Accident and Sickness~~*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 ~~accident and sickness insurance policies~~ and group ~~supplemental health~~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 to residents of this state regardless of the situs of the delivery of the contract on and after [insert effective date].

B. This ~~Act~~regulation ~~shall apply~~applies to limited scope dental ~~plans~~coverage and limited scope vision ~~plans~~coverage only as specified.

C. This regulation shall not apply to:

~~(1) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this regulation;~~

~~(2) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;~~

~~(3)~~(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*];

~~(4)~~(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*]; ~~or~~

~~(5)~~(3) TRICARE ~~Civilian Health and Medical Program of the Uniformed Services~~ (Chapter 55, ~~t~~Title 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: ~~CHAMPUS~~TRICARE supplement insurance is not subject to federal regulation. ~~CHAMPUS~~TRICARE supplement policies are sold only to eligible individuals as determined by the Department of Defense and are tied to ~~CHAMPUS~~TRICARE benefits. In general, states regulate ~~CHAMPUS~~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" has the meaning stated in Section 3I of the Act.

Section ~~5~~6. Policy Definitions

A. (1) Except as provided in this regulation, ~~an individual accident and sickness insurance policy or group supplemental health insurance policy~~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.

(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 (1) "Accident," "accidental injury," and "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.~~

~~(2) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.~~

~~(3) The definition may provide that injuries shall not include injuries 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.~~

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

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

(a) Be operated pursuant to law;

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

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

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

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

(2) The definition of the home or facility ~~may provide that the term shall not be inclusive of~~ 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 ~~drug addicts or alcoholics~~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. "Home health care agency":

(1) Is an agency approved under Medicare;

(2) Is licensed to provide home health care under applicable state law; or

(3) Meets all the following requirements:

(a) It is primarily engaged in providing home health care services;

(b) Its policies are established by a group of professional personnel, including at least one physician and one licensed nurse;

(c) A physician or a registered nurse provides supervision of home health care services;

(d) It maintains clinical records on all patients; and

(e) 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.

~~C~~D. "Hospital" ~~may be defined~~means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission ~~on Accreditation of Healthcare Organizations~~.

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

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

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

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

(2) The definition of the term "hospital" ~~may state that the term shall not be inclusive of~~ is permitted but is not required to exclude:

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

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

(c) Facilities for the aged~~, drug addicts or alcoholics~~ 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 ~~rendered on an emergency basis~~ where a legal liability for the patient exists for charges made to the individual for the services.

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

E. (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. "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.~~

F. "Mental or nervous disorder" ~~shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind~~ 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.

G. "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 whether the functions of an advance practice nurse fall under this definition or the definition of "physician" in Subsection J.

H. "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.

I. "Partial disability" ~~shall be defined in relation to~~ means that, due to a disability, an individual:

(1) ~~the individual's inability~~ 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.

J. (1) "Physician" ~~may be defined by~~means and ~~including~~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 requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.~~

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

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

K. "Preexisting condition" ~~shall not be defined more restrictively than the following: "Preexisting condition~~ means ~~the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or~~ a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person."

Drafting Note: This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer's established standards and in accordance with state law. 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.

~~States that have specific requirements with respect to waivers or exclusionary riders or evidence of insurability requirements for group insurance should modify the preceding paragraphs by deleting group references and adding a new paragraph addressing these requirements. In states which have adopted or are operating under the "federal fallback" provisions the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for major medical coverage issued to a HIPAA eligible individual, there can be no preexisting condition exclusion. In addition, states that have specific preexisting condition requirements for group insurance may need to modify section Subsection K according to applicable statutes.~~

L. "Residual disability" ~~shall be defined~~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.

M. "Sickness" ~~shall not be defined to be more restrictive than the following: "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 ~~further~~ modified to exclude sickness or disease for which benefits are provided under a ~~worker's~~workers' compensation, occupational disease, employers' liability or similar law.

N. "Total disability"

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

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

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

(b) Engage in a training or rehabilitation program.

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

Section ~~6~~7. Prohibited Policy Provisions

A. (1) Except as provided in ~~Section 5K~~this subsection, a policy shall not contain provisions establishing a probationary or waiting period during which ~~no~~ coverage ~~is provided~~ under the policy is excluded or restricted.~~, subject to the further exception that~~

(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~~A policy, other than an accident only policy or a short-term, limited duration health insurance policy, may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of the ~~reproduction~~reproductive organs, varicose veins, adenoids, ~~appendix~~ and tonsils, except when~~. However, the permissible six-month exception shall not be applicable where~~ the specified diseases or conditions are treated on an emergency basis. ~~Accident policies shall not contain probationary or waiting periods.~~

~~B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.~~

~~(2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.~~

~~C. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following the issuance of the policy or certificate where the application or enrollment form for~~

~~the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.~~

~~**Drafting Note:** Where the state has enacted the NAIC Individual Accident and *Sickness Insurance Minimum Standard Act*, Subsection C is unnecessary. States that have specific preexisting condition requirements for group supplemental insurance may need to modify the preceding subsection according to applicable statutes.~~

~~D~~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.

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

~~F~~D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except ~~as follows~~for the following 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 ~~addition~~addiction;

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

(3) Pregnancy, except for complications of pregnancy, other than for policies defined in Section ~~7H~~8C of this regulation;

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

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

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

(c) Non-commercial or recreational ~~A~~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 ~~of a covered dependent child~~ that has resulted in a functional defect;

(6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints of the feet;

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

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

(8) ~~Treatment provided in a government hospital; b~~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; ~~and~~

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

(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.

~~G~~E. Notwithstanding Subsection D of this section, ~~This~~this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

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

~~H~~F. The enumeration in this section of specific precluded ~~Policy~~policy provisions ~~precluded in this section~~ shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section ~~3~~4B of the ~~Accident and Sickness~~*Supplementary and Short-Term Health Insurance Minimum Standards Act*] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

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.

H. 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.

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 ~~7~~8. ~~Accident and Sickness~~ Supplementary and Short-Term Health Insurance Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. ~~An individual accident and sickness insurance policy or group supplemental~~A supplementary or short-term health insurance policy or certificate shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Section ~~8L~~9H of this regulation.

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 5~~A and~~ B and C of the NAIC ~~Accident and *Sickness*~~*Supplementary and Short-Term Health Insurance Minimum Standards Model Act*].

A. General Rules

(1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual ~~accident and sickness~~supplementary 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 ~~8~~9A~~(1)~~.

(b) The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in an individual ~~accident and sickness~~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 accident and sickness or individual accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to~~

~~continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.~~

~~(d)~~(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.

(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 and, as defined under the federal Social Security Act.

(3) In an individual ~~accident and sickness~~supplementary policy covering ~~both husband and wife~~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 federal Affordable Care Act (ACA), ~~or applicable state law~~ must be guaranteed renewable except for reasons stated in ~~Part B~~PHSA ~~Section~~§ 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 2721, 2763 and 2791 of Title XXVII as amended by HIPAA~~ PHSA § 2791(c) (42 U.S.C. § 300gg-91(c))~~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 ~~accident and sickness~~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.

(6) ~~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 ~~shall not~~may condition the benefits upon admission to the convalescent or extended care facility within a ~~period of~~ specified time after discharge from the hospital, as long as the required admission date is not less than ~~fourteen (14) days~~thirty (30) days after discharge from the hospital.

(8) In individual ~~accident and sickness~~supplementary or short-term health insurance policies, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to ~~mental retardation or physical handicap~~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 ~~incapacity~~disability in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

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

(10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months.

(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 ~~of to~~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. Basic Hospital Expense Coverage~~

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

~~(1) Daily hospital room and board in an amount not less than the lesser of:~~

~~(a) [80%] of the charges for semiprivate room accommodations or~~

~~(b) [$100] per day;~~

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

(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either [80%] of the charges incurred up to at least [$3,000] or [ten] times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of:

(a) Hospital services on the day surgery is performed,

(b) Hospital services rendered within seventy-two (72) hours after injury, in an amount not less than [$150]; and

(c) X-ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than [$100] if rendered to an in-patient of the hospital.

(4) Benefits provided under Paragraphs (1) and (2) of this subsection may be provided subject to a combined deductible amount not in excess of [$100].

C. Basic Medical-Surgical Expense Coverage

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

(1) Surgical services:

(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the [insert reference to a fee schedule based on the Current Procedure Terminology (CPT) coding or other acceptable relative value schedule].up to a maximum of at least [$1000] for a one procedure; or

(b) Not less than [80%] of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services:

(a) In an amount not less than [80%] of the reasonable charges; or

(b) [15%] of the surgical service benefit.

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

~~D. Basic Hospital/Medical-Surgical Expense Coverage~~

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

~~E~~B. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage

(1) "Hospital ~~confinement~~ indemnity or other fixed indemnity coverage" ~~is a policy of accident and sickness insurance that~~ provides ~~daily~~ benefits ~~for~~as a result of hospital confinement or other health-related events and based on a fixed dollar amount, ~~on an indemnity basis in an amount not less than [$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy~~ 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.

~~(2)~~(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.

~~(3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.~~

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

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 ~~a~~ 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.

~~F. Individual Major Medical Expense Coverage~~

~~(1) "Individual major medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than~~

~~[$500,000]; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed ten thousand dollars ($10,000) per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed five percent (5%) of the aggregate maximum limit under the policy for each covered person for at least:~~

~~(a) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services;~~

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

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

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

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

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

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

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

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

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

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

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

~~G. Individual Basic Medical Expense Coverage~~

~~(1) "Individual basic medical expense coverage" is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $250,000; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed $25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed ten percent (10%) of the aggregate maximum limit under the policy for each covered person for at least:~~

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

~~(b) Miscellaneous hospital services;~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services;~~

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

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

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

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

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

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

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

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

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

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

~~(3) The minimum benefits required by 7G(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under 7G(1)(g) and other such special~~

~~or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, anindividual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.~~

~~H~~C. Disability Income Protection Coverage

"Disability income protection coverage" is a policy that provides for periodic payments, ~~weekly or monthly~~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 ~~periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62)~~ a plan is prohibited from reducing periodic payments based on age, except that a plan may reduce periodic payments provided that such reductions do not take place until 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;

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

~~(b)~~(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

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

(3) Has a ~~maximum~~ period of time of at least three (3) months for which it is payable during disability ~~of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month~~. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period~~. Section 7F does not apply to those policies providing business buy-out coverage~~; and

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

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

~~J~~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 ~~accident and sickness~~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, benefits~~ 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 *Uniform Individual Accident and Sickness Policy Provision Law* (UPPL) (#180), regarding multiple policies with the same insurer].

Drafting Note: Specified disease coverage is recognized as ~~supplemental~~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 ~~Group~~ *Coordination of Benefits Model Regulation* states that the definition of a "plan" (for the purpose of coordination of benefits) "shall not include individual or family insurance contracts." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

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

(j) Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge," "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."

(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 ~~$50~~$[X] per day; and

(III) A lifetime maximum benefit limit of at least ~~$10,000~~$[X].

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

(I) Convalescent home;

(II) Rest or nursing facility;

(III) Skilled nursing facility;

(IV) Rehabilitation unit; or

(V) Facility providing care or treatment for persons suffering from mental ~~diseases or~~ disorders ~~or care for the~~, who are aged, or ~~substance abusers~~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 ~~[$250]~~$[X] and an overall aggregate benefit limit of no less than ~~[$10,000]~~$[X] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

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

(ii) Treatment by a ~~legally qualified~~licensed physician, ~~or~~ 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."

(iii) Private duty services of a ~~registered~~licensed nurse ~~(R.N.)~~;

(iv) ~~X-ray, radium and other therapy procedures~~Tests, procedures, and other medical services and supplies used in diagnosis and treatment;

(v) Professional ambulance for ~~local~~ service to or from a ~~local~~ 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) The rental of an iron lung or similar mechanical apparatus;~~

~~(ix)~~(viii) ~~Braces, crutches and wheel chairs as are~~ Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(x)~~(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

~~(xi)~~(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 ~~[$25,000]~~$[X] payable at the rate of not less than ~~[$50]~~$[X] a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage ~~for each insured person~~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~~may be limited to amounts not in excess of the usual and customary charges, with a deductible amount not in excess of ~~[$250]~~$[X], ~~and~~ an overall aggregate benefit limit of not less than ~~[$10,000]~~$[X], and a benefit period of not less than three (3) years ~~shall provide at least the following minimum provisions:~~.

(b) A policy shall include at least the minimum benefits specified in this subparagraph. Coverages under items (i) through (xiv) of this subparagraph may be subject to cost-sharing by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an outpatient basis:

~~(a)~~(i) Treatment by, or under the direction of, a ~~legally qualified~~licensed physician, ~~or~~ 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)~~(ii) ~~X-ray, radium chemotherapy and other therapy procedures~~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)~~(iii) Blood transfusions and their administration, including expense incurred for blood donors;

~~(e)~~(iv) 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 local service to or from a local hospital;~~

~~(g)~~(v) Private duty services of a ~~registered~~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;~~

~~(i)~~(vi) ~~Braces, crutches and wheelchairs~~Durable medical equipment deemed necessary by the attending physician for the treatment of the disease;

~~(j)~~(vii) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; ~~and~~

~~(k)~~(viii) (I) Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. ~~The physician must certify that hospital confinement would be otherwise required. A "home health care agency" (1) is an agency approved under Medicare, or (2) is licensed to provide home health care under applicable state law, or (3) meets all of the following requirements:~~

~~(I) It is primarily engaged in providing home health care services;~~

~~(II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse;~~

~~(III) A physician or a registered nurse provides supervision of home health care services;~~

~~(IV) It maintains clinical records on all patients; and~~

~~(V) It has a full time administrator.~~

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

~~(ii)~~(II) Home health care includes, but is not limited to:

~~(I)~~a. Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

~~(II)~~b. 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)~~c. Physical, occupational or speech and hearing therapy; and

~~(IV)~~d. 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)~~(ix) Physical, speech, hearing and occupational therapy;

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

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

~~(o)~~(xii) Nursing home care for noncustodial services; ~~and~~

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

(xiv) Hospice services, as defined in paragraph (2)(m) above~~.~~;

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

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

(c) A policy may 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.

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

(i) A fixed-sum payment of at least ~~[$100]~~$[X] for each day of hospital confinement for at least [365] days;

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

(iii) A fixed-sum payment of at least ~~$50~~$[X] per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(b) Benefits tied to ~~confinement~~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 ~~one-fourth~~[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 ~~one-fourth~~[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.

(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 ~~$1,000~~$[X].

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

~~K~~F. Specified Accident Coverage

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

~~L~~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, ~~C,~~ D, ~~E,~~ and F~~, G, I and K~~. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section ~~8L~~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 ~~7J~~7E and shall not be offered for sale as ~~a~~ "limited benefit health coverage."

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

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

Drafting Note: This regulation permits the combining of excepted benefit-type products described in this section with other excepted benefit plans. However, it should be noted that combining excepted benefit coverages described in this section with other coverages, whether or not described in this section, could cause the combined product to fail to meet the requirements for excepted benefits under HIPAA or for similar exemptions under state law. 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 should also require that supplementary coverage is not offered, marketed, or sold as a substitute for, or alternative to, comprehensive major medical coverage, including enforcement of the requirements in this regulation 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 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) Short-term, limited-duration health insurance 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 policy or certificate 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 health insurance policy or certificate 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 time without re-underwriting;

(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 the certificate holder, if the policy holder or the 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.

(6) A carrier may not rescind a short-term limited duration health insurance policy or certificate 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 policy or certificate. If the policy or certificate is rescinded, the carrier must refund all payments to the insured to the extent that they exceed claims paid under 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 policy or certificate will need to be tailored to the state's laws and regulations concerning such disclosures of prior coverage.

(7) A carrier may not cancel a short-term, limited-duration health insurance policy or certificate 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 insurance contract; or

(e) A change or implementation of a federal or 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 policy or certificate, 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].

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. In addition, states should review any relevant federal regulations establishing requirements for short-term, limited duration insurance coverage that could differ from the state's requirements.

Section ~~8~~9. Required Disclosure Provisions

A. General Rules

(1) (a) All applications, policies, and certificates for coverages ~~specified in Sections 7B, C, D, E, G, I, J, K and L~~ of supplementary or short-term health insurance shall ~~contain~~include a prominent disclosure statement~~, by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~ 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 needed to improve the accuracy and clarity of the disclosure and only with the approval of the commissioner.

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.

~~"The [policy] [certificate] provides limited benefits. Review your [policy][certificate] carefully."~~

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

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

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

(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, color, or italics.

Drafting Note: States should review their existing readability laws and regulations to help to ensure the statements above are readable. States should also review their existing laws and regulations to ensure the statements above are 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.

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

(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: States should review the above notice and disclosure requirements for hospital indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for hospital indemnity coverage that could differ from the state's requirements.

(4) For other fixed 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 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."

Drafting Note: States should review the above notice and disclosure requirements for other fixed indemnity coverage for consistency with their state regulations. In addition, states should review any relevant federal regulations establishing notice and disclosure requirements for other fixed indemnity coverage that could differ from the state's requirements.

~~(2) All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~

~~"The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully."~~

~~(3) All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:~~

~~"The [policy] [certificate] provides vision benefits only. Review your [policy] [certificate] carefully."~~

(5) For disability income protection coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "while you are disabled" made prominent:

"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."

(7) For specified disease coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "of a covered disease" made prominent:

"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, with the phrase "for a specifically identified type of accident" made prominent:

"This [policy] [certificate] provides benefits for a specifically identified type of accident as named in the [policy] [certificate]. 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."

(9) For limited benefit coverage, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the phrase "limited benefits and only for the events specified" made prominent:

"The [policy] [certificate] pays limited benefits and only for the events 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."

(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 expense." 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."

(12) For short-term health insurance, the application, policy, and certificate shall include a disclosure statement that reads as follows, with the word "Important" and the sentence "It is not comprehensive health insurance." made prominent:

"Important: This is short-term health insurance. This is temporary insurance. It is not comprehensive health insurance. Read your [policy] [certificate] 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, 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 for this policy.
- 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."

~~(4)~~(13) Each policy of individual ~~accident and sickness insurance and group supplemental health insurance~~ 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.

~~(5)~~(14) ~~Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all~~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 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~~s~~ in this paragraph ~~apply~~applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.

~~(6)~~(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.

~~(7)~~(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 a clear ~~an~~ explanation of the terms in its accompanying outline of coverage.

~~(8)~~(17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall ~~appear as~~be clearly explained in a separate paragraph of the policy or certificate ~~and be~~ labeled ~~as~~ "Preexisting Condition~~s~~ Limitations."

~~(9) All accident only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:~~

~~"Notice to Buyer: This is an accident only [policy][certificate] and it does not pay benefits for loss from sickness. Review your [policy][certificate] carefully."~~

~~Accident only [policies][certificates] that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer above: "This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~

~~(10)~~(18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in sans serif font on the first page of the policy or certificate or attached to it stating ~~in substance~~clearly that the policy~~holder~~ 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.

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

~~(11)~~(19) If age is to be used as a determining factor ~~for reducing~~to reduce the ~~maximum aggregate~~ benefits made available in the policy or certificate as originally issued, ~~that fact~~a clear explanation of how age is used shall be prominently set forth in the outline of coverage.

~~(12)~~(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~~clearly explain which persons are eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person ~~by whom~~who may exercise the conversion privilege ~~may be exercised~~. The provision shall clearly 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.

~~(13)~~(21) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital ~~confinement~~ indemnity or other fixed indemnity (Section ~~7E~~8B), specified disease (Section ~~7J~~8E), or limited benefit health coverages (Section ~~7L~~8G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections ~~F~~D and ~~J~~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~~is not a Medicare Supplement policy. If you are eligible for Medicare, ~~review~~ask the company for the Guide to Health Insurance for People ~~W~~with Medicare ~~available from the company~~.

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 should review how insurers should provide the notices required under paragraph (21)(a) to these individuals.

~~(14)~~(22) Insurers~~, except direct response 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. ~~Direct response insurers shall provide the Buyer's Guide upon request but not later than the time that the policy or certificate is delivered.~~

Drafting Note: Paragraph (22) only applies if a state has such a Buyer's Guide.

~~(15) All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate], a prominent statement as follows: Notice to Buyer: This is specified disease [policy] [certificate].This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your [policy] [certificate] carefully with the outline of coverage and the Buyer's Guide.~~

~~**Drafting Note:** The second sentence of this caption should only be required in those states where the commissioner exercises discretionary authority and requires the guide.~~

~~(16) All hospital confinement indemnity policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a hospital confinement indemnity [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~

~~(17) All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a limited benefit health [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."~~

~~(18) All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a basic hospital expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."~~

~~(19) All basic medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a basic medical-surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."~~

~~(20) All basic hospital/medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This is a basic hospital/medical-surgical expense [policy][certificate]. This [policy][certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."~~

~~(21) All individual basic medical expense policies shall display prominently by type, stamp or other appropriate means on the first page of the policy, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:~~

~~"Notice to Buyer: This is an individual basic medical expense policy. This policy provides benefits that are not as comprehensive as individual major medical expense coverage and should not be considered a substitute for comprehensive health insurance coverage."~~

~~(22) All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This [policy] [certificate] provides dental benefits only."~~

~~(23) All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:~~

~~"Notice to Buyer: This [policy] [certificate] provides vision benefits only."~~

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant ~~or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans~~ 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 sans serif 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 ~~not identical to~~different from the outline of coverage ~~provided upon~~you received when you [~~application~~applied][~~enrollment~~enrolled]~~,~~. ~~and the~~The coverage ~~originally~~you applied for ~~has~~was not ~~been~~ issued."

~~(3) The appropriate outline of coverage for policies or contracts providing hospital coverage that only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Sections 7C and E or Sections 7B, C, and E shall be the statement contained in Section 8G.~~

~~(4)~~(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.

~~(5)~~(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. Basic Hospital Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~BASIC HOSPITAL EXPENSE COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE~~

~~OUTLINE OF COVERAGE~~

Read Your [Policy][Certificate] Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!

(2) Basic hospital coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital out-patient services; and

(d) Other benefits, if any.]

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.

(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.]

D. Basic Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical-surgical expenses.

(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

(a) Surgical services;

(b) Anesthesia services;

(c) In-hospital medical services; and

(d) Other benefits, if any]

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.

(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.]

E. Basic Hospital/Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Sections 7B and C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed.

[COMPANY NAME]

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS AND
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR
COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your [Policy][Certificate] Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

~~(3) [A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:~~

~~(a) Daily hospital room and board;~~

~~(b) Miscellaneous hospital services;~~

~~(c) Hospital outpatient services;~~

~~(d) Surgical services;~~

~~(e) Anesthesia services;~~

~~(f) In-hospital medical services; and~~

~~(g) Other benefits, if any.]~~

~~**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.~~

~~(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.]~~

~~F~~C. Hospital ~~Confinement~~ 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 ~~7E~~8B of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~HOSPITAL CONFINEMENT INDEMNITY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

[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.

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully.~~—~~ This outline of coverage ~~provides a very brief description of~~briefly describes your coverage's ~~the~~ important feature~~s of coverage~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) [Hospital ~~confinement~~ indemnity] [Other fixed indemnity] coverage is designed to ~~provide, to persons insured, coverage in the form of~~pay a fixed ~~daily~~dollar benefit as a result of a ~~during periods of~~ covered ~~hospitalization resulting from a~~ [hospital stay] [event] due to a ~~covered accident or~~ sickness or injury~~, subject to any limitations set forth in the policy~~. The benefit may be limited in ways described in the [policy] [certificate]. ~~Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.~~ The fixed dollar benefit may be less than the [hospital stay's] [event's] cost.

(3) [A brief, but clear and specific, description of the benefits in the following order:

(a) ~~Daily benefit payable during hospital confinement~~When the benefits are payable; ~~and~~

(b) The d~~D~~uration of benefits described in (a); and

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

~~Drafting Note~~: ~~The above description of benefits shall be stated clearly and concisely.~~

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

(6) [~~Any~~A clear description of any benefits provided in addition to the ~~daily~~fixed dollar [hospital] [event] benefit.]

~~G. Individual Major Medical Expense Coverage (Outline of Coverage)~~

~~An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7F of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:~~

~~[COMPANY NAME]~~

~~INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE~~

~~OUTLINE OF COVERAGE~~

~~(1) Read Your Policy Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!]~~

~~(2) Individual major medical expense voverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in hospital medical services, and out of hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.~~

~~(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:~~

(a) Daily hospital room and board;

(b) Miscellaneous hospital services,

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services,

(f) Out-of-hospital care;

(g) Maximum dollar amount for covered charges; and

(h) Other benefits, if any]

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.

(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.]

H. Individual Basic Medical Expense Coverage

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 7G of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

INDIVIDUAL BASIC MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Individual basic medical expense coverage is designed to provide, to persons insured, limited coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in hospital medical services, and out of hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(3) [A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

(a) Daily hospital room and board;

~~(b) Miscellaneous hospital services,~~

~~(c) Surgical services;~~

~~(d) Anesthesia services;~~

~~(e) In-hospital medical services,~~

~~(f) Out-of-hospital care;~~

~~(g) Maximum dollar amount for covered charges; and~~

~~(h) Other benefits, if any]~~

~~**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.~~

~~(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.]~~

~~I~~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 ~~7H~~8C of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~DISABILITY INCOME PROTECTION COVERAGE~~
Disability Income Protection Coverage

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [~~P~~policy] [certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of~~briefly describes your coverage's ~~the~~ important features ~~of your policy~~. ~~This~~It is not the insurance contract. ~~and only the actual policy provisions will control.~~ The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR POLICY CAREFULLY~~read your [policy] [certificate] carefully!

(2) Disability income protection coverage is designed to ~~provide, to persons insured, coverage~~pay a benefit for disabilities resulting from a covered ~~accident or~~ sickness or injury~~, subject to any limitations set forth in the policy~~. The benefit may be limited in the ways described in the [policy] [certificate].~~Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~ The benefit might not fully replace your income.

(3) [~~A brief~~Brief, but clear and specific, description of the benefits contained in ~~this~~the [policy] [certificate].]

~~**Drafting Note**: The above description of benefits shall be stated clearly and concisely.~~

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

~~J~~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 ~~7I~~8D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~ACCIDENT-ONLY COVERAGE~~

~~THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Accident-Only 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 ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of the coverage~~. ~~This~~It is not the insurance contract. ~~and only the actual policy provisions will control~~. The [policy] [certificate] ~~itself sets forth in detail~~details ~~the~~your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) Accident-only coverage ~~is designed to provide, to persons insured, coverage~~pays benefits for ~~certain losses resulting~~covered injuries from a covered accident ~~ONLY, subject to any limitations contained in the policy~~. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate]. ~~Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~

(3) [~~A brief~~Brief, but clear and 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 7A(13) of this regulation.~~

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

~~K~~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 ~~7J~~8E and ~~K~~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:

[COMPANY NAME]

~~[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE~~

~~THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

Specified Disease or Specified Accident Coverage (Outline of 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) ~~This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.~~ Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

Drafting Note: States should review whether they have the Buyer's Guide to Specified Disease Insurance referenced above. If they do, the state should determine if it is up to date before requiring such a guide to be provided. If the state does not have such a guide, then the state should revise this outline of coverage accordingly.

(2) Read ~~Y~~your [policy] [certificate] ~~[Outline of Coverage]~~ ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features ~~of coverage~~. ~~This~~It is not the insurance contract ~~and only the actual policy provisions will control~~. The [policy] [certificate] ~~itself sets forth in detail the~~details your rights and obligations ~~of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY] [CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(3) [Specified disease][Specified accident] coverage is designed to ~~provide, to persons insured, restricted coverage paying benefits ONLY~~ pay limited benefits ~~when certain losses occur~~ as a result of the diagnosis or treatment [of a ~~[specified diseases~~covered disease] or [resulting from a ~~[specified accidents~~specifically identified type of accident]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) [~~A brief~~Brief, but clear and 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 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 7A(13) of this regulation.~~

~~L~~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 ~~7~~8B, D and G~~C, D, E, F, G, I and K~~ of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

~~LIMITED BENEFIT HEALTH COVERAGE~~

~~BENEFITS PROVIDED ARE SUPPLEMENTAL AND
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES~~

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 ~~Y~~your [~~P~~policy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail~~details ~~the~~your rights and obligations~~ of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you~~ READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~ read your [policy] [certificate] carefully!

(2) Limited benefit health coverage~~ is designed to provide, to persons insured, limited or supplemental coverage~~ pays limited benefits. This [policy] [certificate] is not major medical insurance and does not replace it.

(3) [~~A brief~~Brief, but clear and specific, description of the benefits, including dollar amounts 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 provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.~~

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

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:

[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) [Brief, but clear and specific, description of the benefits in the following order:

(a) Benefits covered by the policy or certificate, including required cost-sharing;

(b) Benefits that are not covered by the policy or certificate; and

(c) Duration of benefits described above.]

(4) A clearly worded prominent notice that cost-sharing limitations do not apply to benefits not covered by the policy or certificate.

(5) [A clear 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.]

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

~~M~~I. Limited Scope Dental ~~Plans~~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:

[COMPANY NAME]

Limited Scope Dental Coverage

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

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [p~~P~~olicy][~~C~~certificate] ~~C~~carefully. ~~—~~This outline of coverage ~~provides a very brief description of the~~briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations~~ of both you~~ and those of your

insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~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 care it covers and any cost-sharing that may be your responsibility.

~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]

~~(3)~~(4) [A clear 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 ~~(1)~~(3) above.]

~~(4)~~(5) [A clear ~~descripton~~description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

~~N~~J. Limited Scope Vision ~~Plans~~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:

[COMPANY NAME]

Limited Scope Vision Coverage

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

OUTLINE OF COVERAGE

(1) Read ~~Y~~your [p~~P~~olicy][~~C~~certificate] ~~C~~carefully.~~—~~ This outline of coverage ~~provides a very brief description of the~~ briefly describes your coverage's important features~~ of your policy~~. ~~This~~It is not the insurance contract~~ and only the actual policy provisions will control~~. The [policy] [certificate] itself ~~sets forth in detail the~~details your rights and obligations~~ of both you~~ and those of your insurance company. It is~~, therefore,~~ important that you ~~READ YOUR [POLICY][CERTIFICATE] CAREFULLY~~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 care it covers and any cost-sharing that may be your responsibility.

~~(2)~~(3) [~~A brief~~Brief, but clear and specific, description of the benefits.]

~~(3)~~(4) [A clear 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 ~~(1)~~(3) above.]

~~(4)~~(5) [A clear description of ~~policy~~ provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

Section ~~9~~10. Requirements for Replacement of Individual ~~Accident and Sickness Insurance~~Supplementary and Short-Term Health Insurance Coverage

~~**Drafting Note:** Group supplemental health insurance is not addressed here because it is addressed in the Group Coverage Discontinuance and Replacement Model Regulation, which is applicable. States may also have other statutes or regulations that apply.~~

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 ~~accident and sickness~~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: a~~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 REGARDING REPLACEMENT~~

~~OF ACCIDENT AND SICKNESS INSURANCE~~
Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~ end the ~~accident and sickness~~supplementary or short-term health insurance you have now and replace it with a policy ~~to be issued by~~the [insert company name] Insurance Company will issue. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one ~~may~~might affect ~~the insurance protection available to you under the new policy~~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~~health conditions ~~which you may~~that you might ~~presently~~ have~~,~~ now (preexisting conditions) or ~~may~~might not ~~be immediately or fully covered under the new policy~~cover them right away. ~~This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy~~ 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) ~~You may wish to secure the advice of your present insurer or its agent~~Talk with your current insurance agent ~~regarding the proposed replacement of your present~~or company representative about replacing your policy. ~~This is not only your right, but it~~It is ~~also~~ in your best interests ~~to make~~be sure you understand ~~all the relevant factors involved in replacing your present~~how replacing your policy could affect your future coverage.

(3) If~~, after due consideration, you still wish to terminate your present~~ you decide to buy a new policy~~, and replace it with new coverage, be certain~~be sure to truthfully and completely answer all questions on the application ~~concern~~about your medical/health history. ~~Failure to include all material medical information on an application may provide a basis for~~If you do not, the company ~~to~~could deny any future claims and ~~to~~ refund your premium as though your policy had never been in force. ~~After the~~Check that the information on your application ~~has been completed~~is complete and correct ~~and~~ before you sign it~~, reread it carefully to be certain that all information has been properly recorded~~.

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 REGARDING REPLACEMENT~~

~~OF ACCIDENT AND SICKNESS INSURANCE~~
Notice to Applicant About Replacement of [Supplementary] [Short-Term] Health Insurance

According to [your application] [information you have ~~furnished~~provided], you intend to lapse or otherwise ~~terminate existing~~end the ~~accident and sickness~~supplementary or short-term health insurance you have now and replace it with the attached policy ~~delivered herewith~~ issued by [insert company name] Insurance Company. ~~Your new policy provides~~You have thirty days ~~within which you may~~to decide ~~without~~at no cost ~~whether you desire to~~if you want to keep the new policy. For your own ~~information and~~ protection, you should ~~be aware of and seriously consider certain factors that~~know how replacing your policy with a new one ~~may~~might affect ~~the insurance protection available to you under the new policy~~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~~health conditions ~~that~~ you ~~may presently~~ have~~,~~ now (preexisting conditions) ~~may not be immediately or fully covered under the new policy~~or might not cover them right away. ~~This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~A new policy might cover some but not all the costs related to preexisting conditions.

(2) ~~You may wish to secure the advice of your present insurer or its~~ Talk with your insurance agent or company representative ~~regarding the proposed replacement of your present~~about replacing your policy. ~~This is not only your right, but it~~It is ~~also~~ in your best interests to ~~make~~be sure you understand ~~all the relevant factors involved in replacing~~how replacing your policy could affect your ~~present~~future coverage.

(3) [To be included only if the application is attached to the policy]. If~~, after due consideration,~~ you ~~still wish to terminate your present~~decide to buy a new policy, ~~and replace it with new coverage,~~ read the copy of the attached application ~~attached to your new policy~~ and be sure that all questions are answered fully and correctly. ~~Omissions or misstatements in the application could cause~~If they are not, the company could refuse to pay an otherwise valid claim ~~to be denied~~. 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 ~~out of~~off the application.

[COMPANY NAME]

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

Section ~~10~~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.

W:\Drafts\04 – Model Laws, Regulations & Guidelines\# 171 – Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act\MO171v10.docx

Draft: 11/5/24
Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. __, 2024
Adopted by the Regulatory Framework (B) Task Force, Nov. 4, 2024

2025 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~~2025.
   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 excepted benefits coverage and 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~~2. 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~~3. 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~~4. 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. 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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2024 Fall Meeting/011_RFTF 2025.docx

Draft: 10/28/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
Oct. 17, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Oct. 17, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Christina Jackson (FL); Amy Hoyt and Camille Anderson-Weddle (MO); Martin Swanson (NE); Heidi Clausen (UT); Christine Menard-O'Neil and Jamie Gile (VT); and Ned Gaines (WA).

1. Adopted Revisions to Model #171

The Subgroup continued its discussion of proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171). Jolie H. Matthews (NAIC) said Brenda J. Cude (NAIC consumer representative) submitted additional comments suggesting more revisions to Section 9—Required Disclosure Provisions. She said most were clarifying, non-substantive suggested revisions; however, one suggested revision is more substantive. Cude suggested that for consistency with other provisions in Section 9, language should be added to Section 9I and Section 9J to outline coverage provisions for limited scope dental coverage and limited scope vision coverage, respectively. The Subgroup reviewed NAIC staff's suggested language to address Cude's comments (Attachment Two-A). After discussion, the Subgroup accepted the suggested language. The Subgroup also accepted Cude's clarifying, non-substantive suggested revisions.

Swanson made a motion, seconded by Gaines, to adopt the proposed revisions to Model #171 (*see NAIC Proceedings – Fall 2024, Regulatory Framework (B) Task Force, Attachment One-A*). The motion passed unanimously.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/Accident and Sickness Subgrp/Accident and Sickness Ins Min Stds Subgrp 10-17-24 MtgMin.docx

NAIC STAFF SUGGESTED REVISIONS TO ADDRESS CUDE COMMENTS

I. Limited Scope Dental Coverage (Outline of Coverage)

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

[COMPANY NAME]

Limited Scope Dental Coverage

The benefits in this [policy] [certificate] are limited. 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 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 care it covers and any cost-sharing that may be your responsibility.

(3) [Brief, but clear and specific, descriptions of the benefits.]

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

J. Limited Scope Vision Coverage (Outline of Coverage)

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

[COMPANY NAME]

Limited Scope Vision Coverage

The benefits in this [policy] [certificate] are limited. 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 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 care it covers and any cost-sharing that may be your responsibility.

(3) [Brief, but clear and specific, descriptions of the benefits.]

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2024 Fall Meeting/Limited Dental and Limited Vision Outline of Coverage Suggested Revisions.docx

Draft: 9/27/24

Accident and Sickness Insurance Minimum Standards (B) Subgroup
Virtual Meeting
Sept. 9, 2024

The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met Sept. 9, 2024. The following Subgroup members participated: Andy Schallhorn, Co-Chair (OK); Rachel Bowden, Co-Chair (TX); Howard Liebers (DC); Amy Hoyt and Camille Anderson-Weddle (MO); Eric Dunning (NE); Heidi Clausen (UT); and Anna Van Fleet and Jamie Gile (VT).

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

The Subgroup continued its discussion of the comments submitted by Robert Wake (ME) and Brend Cude (NAIC Consumer Representative) 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*), beginning with Section 9A(4)—Required Disclosure Provisions for other fixed indemnity coverage. Cude suggests for Section 9A(4) through Section 9A(12) deleting drafting notes requiring specific phrases and sentences be made prominent in the disclosures and adding that language to the substantive provisions. The Subgroup accepted those suggested revisions.

The Subgroup discussed and accepted Wake's non-substantive, clarifying suggested revisions to Section 9A(16) and Section 9A(17). The Subgroup discussed and accepted Wake's suggestion to delete the last sentence in both Section 9A(18) and Section 9A(19) because it duplicates requirements outlined in Section 9A(2). The Subgroup discussed and accepted Wake's suggested non-substantive, clarifying suggested revisions to Section 9A(20). Consistent with its decisions for Section 9A(4) through Section 9A(12), the Subgroup also accepted Cude's suggested revisions to Section 9A(21) to delete the drafting note and move the language in the drafting note to the substantive provision.

The Subgroup next discussed Section 9A(22), which requires insurers to provide a Buyer's Guide approved by the commissioner to individuals applying for specified disease insurance. In her comments, Cude questions whether such a guide exists. After discussion, the Subgroup asked NAIC staff to add a drafting note to Section 9A(22) stating that the Section 9A(22) only applies if the state has such a guide.

The Subgroup next discussed Section 9B(1)—Outline of Coverage Requirements. In her comments, Cude questioned whether the language in Section 9B(1) requiring an insurer to deliver an outline of coverage to an applicant prior to sale was accurate given the requirements of Section 6B and Section 6C of the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). After discussion, the Subgroup agreed to delete the words "prior to sale" in Section 9B(1) to resolve the issue.

The Subgroup next discussed Wake's and Cude's non-substantive, clarifying suggested revisions on Section 9C through Section 9J. These provisions outline the requirements for the outline of coverage for the types of coverages regulated under the revised Model #171. The Subgroup accepted all the suggested revisions. The Subgroup also agreed to add a drafting note to Section 9F—Specified Disease or Specified Accident Coverage (Outline of Coverage) suggesting that states review their regulations to determine if they have the Buyer's Guide to Specified Disease Insurance referenced in Section 9F(1) before requiring insurers to provide the guide to consumers for them to read.

The Subgroup next discussed Wake's non-substantive, clarifying suggested revisions to Section 10—Requirements for Replacement of Individual Supplementary and Short-Term Health Insurance Coverage. After discussion, the Subgroup accepted the suggested revisions.

Jolie H. Matthews (NAIC) said the Subgroup has discussed all the Wake and Cude comments on the proposed revisions to Model #171 and no additional comments have been received. She said she will distribute a final draft of the proposed revisions to Model #171 reflecting the Subgroup's discussions to date for the Subgroup to consider adoption during a meeting sometime in October.

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

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Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Chicago, Illinois
August 14, 2024

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Chicago, IL, Aug. 14, 2024. The following Working Group members participated: Erica Weyhenmeyer, Chair (IL); Jane Beyer, Vice Chair (WA); Crystal Phelps (AR); Debra Judy (CO); Kurt Swan (CT); Elizabeth Nunes (GA); Andria Seip (IA); Julie Holmes (KS); Mary Kwei (MD); T.J. Patton (MN); Jo LeDuc (MO); Robert Croom and Tracy Biehn (NC); Chrystal Bartuska (ND); Michelle Heaton (NH); Alejandro Amparan (NM); Kyla Dembowski (OH); Ashley Scott (OK); Shannen Logue (PA); Jill Kruger (SD); Matthew Tarpley (TX); Ryan Jubber and Shelley Wiseman (UT); Julie Fairbanks (VA); Rebecca Rebholz (WI); Joylynn Fix (WV), and Jill Reinking (WY).

1. Heard Presentations on Clinical Guidelines for Behavioral Health Care

A. MCG Health

Ravi Sitwala (MCG Health) provided background on the history of MCG Health and its parent company, Hearst Health. He said MCG Health has more than 6,000 clients, including the majority of health plans, more than 3,000 hospitals, and many state and federal agencies. For behavioral health specifically, he cited hundreds of provider organizations, health plans, and hospitals as users. He said MCG Health guidelines are continually updated to keep current with the standard of medical care, with thousands of new articles reviewed and new citations added to the latest edition. He described a three-step process for developing guidelines, including searching medical literature, reviewing sources for quality and relevance, and grading the available evidence. He said behavioral health guidelines are written by a board-certified psychiatrist and reviewed by external, active professionals. He said MCG Health is the only nationally recognized, independently published source for clinical criteria since it is not owned by a health insurer or providers.

Donna Baker-Miller (MCG Health) added that MCG Health guidelines are subscription-based, so MCG Health is not paid based on whether claims are approved or denied. Sitwala said MCG Health care guidelines align with those from specialty societies like the American Society of Addiction Medicine (ASAM). He noted that MCG Health guidelines are specifically crafted to support substance use disorder (SUD) management. He said MCG Health supports a single workflow that allows clinicians to integrate references to other guidelines in one location. He pledged to share MCG Health guidelines with state insurance regulators.

B. Optum

Chrissy Finn (Optum) and Sarah Johnson (Optum) described the InterQual clinical guidelines. Finn said the guidelines are intended to ensure patients get the right care at the right time in the right setting, efficiently. She said inappropriate care, slow adoption of evidence, increasing complexity, and unexplained variance in care contribute to inefficiency. She described InterQual criteria as an innovative technology used by thousands of hospitals and hundreds of health plans and government payers. She said InterQual develops evidence-based criteria in the same way for physical health and behavioral health. She said content development follows a rigorous cycle, including research, critical appraisal, clinical review, peer review and validation, and quality assurance and release. Johnson said InterQual criteria support mental health parity and proactively direct to the next level of care. She said the criteria incorporate content like the ASAM Criteria.

C. LOCUS

Dr. Michael Flaum (American Association for Community Psychiatry—AACP) presented on the Level of Care Utilization System (LOCUS) family of tools. He asked Working Group members about their current level of familiarity with LOCUS, and members responded that they had minimal familiarity. He said LOCUS has been under development since the 1990s and now includes tools that cover treatment for children, adolescents, and early childhood. He said LOCUS has two major components: evaluation parameters with six dimensions and a level of care continuum with seven ordered categories of service intensity. He said a LOCUS report can be completed in less than 10 minutes in a process that can be interactive, collaborative, and iterative. He said ratings can change over a short period of time, for example, when a patient has changes in their level of stress or support. He described the major goal of LOCUS as promoting a common language among people served, providers, payers, and policymakers. Flaum said LOCUS strives for transparency and clarity. He said LOCUS should be seen as complementary with other sources of clinical guidelines, like MCG Health or InterQual.

D. ASAM

Maureen Boyle (ASAM) presented on the ASAM Criteria, Fourth Edition. She said the ASAM Criteria is the most widely used set of standards for determining the appropriate level of care for SUDs. She said dozens of health plans license the Criteria for medical necessity, and 15 states require commercial payers to use the Criteria for medical necessity. She said the overdose crisis drives its growing adoption, expanded coverage under the Affordable Care Act (ACA), mental health parity regulations, and other factors.

Boyle identified the core components of the ASAM Criteria as the level of care assessment, decision rules, and the patient's placement in the continuum of care. She said the fourth edition added a new dimension of person-centered considerations to the existing dimensions, which include intoxication and withdrawal, biomedical conditions, psychiatric conditions, substance use risks, and the recovery environment. She said the continuum of care includes levels from outpatient to medically managed inpatient. The decision rules recommend the least intensive level of care where the patient can be safely and effectively treated. She said the Criteria are intended to be integrated, patient-centered, holistic, and oriented to chronic care. Boyle said the ASAM Criteria are supported by a number of implementation tools that aid in the education of users, assessment, and decision support. She mentioned training resources, ASAM software developed in partnership with InterQual, and service request forms that allow providers to structure information and summarize treatment plans and progress.

Beyer asked how MCG Health and InterQual guidelines deal with situations when the most appropriate level of care is unavailable due to a provider shortage. Sitwala said the guidelines would take a patient to the next level of care. He said one of the considerations in the guidelines is what facilities are available. He said an additional benefit of the guidelines is that they provide an outline of evidence-based care that may be helpful for providers when more specialized providers are unavailable. Johnson said a lack of provider availability is a real problem. She said InterQual guidelines are screening guidelines that do not indicate a final decision. She said a health plan would make a final decision that takes provider availability into account. Finn said users of InterQual implement the guidelines very differently from each other. Flaum said using a common standard allows benchmarking across systems. He said under LOCUS, a health plan would be expected to fund a higher level of care when the most appropriate level is unavailable. Boyle said ASAM allows for stepping up a request to a higher level when a certain level is unavailable.

Fix asked whether clients of MCG Health are contractually permitted to adjust the guidelines. Sitwala said MCG Health guidelines are not algorithms that decide whether a user should or should not do something. He said the guidelines collect evidence and allow payers to make their own judgments. He said payers may customize the

guidelines, but when they do, the payer cannot say they are applying MCG Health guidelines to make a decision. Finn said InterQual content is no longer considered InterQual content once a payer updates it; it is then considered custom content.

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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