Draft date: 10/17/24

2024 Fall National Meeting
Denver, Colorado

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Tuesday, November 19, 2024
9:30 – 10:45 a.m.
Gaylord Rockies Hotel—Aurora Ballroom C/D—Level 2

ROLL CALL

Anita G. Fox, Chair	Michigan	Alice T. Kane	New Mexico
Grace Arnold, Co-Vice Chair	Minnesota	Andrew R. Stolfi	Oregon
Glen Mulready, Co-Vice Chair	Oklahoma	Michael Humphreys	Pennsylvania
Trinidad Navarro	Delaware	Alexander S. Adams Vega	Puerto Rico
John F. King	Georgia	Jon Pike	Utah
Dean L. Cameron	Idaho	Mike Kreidler	Washington
Marie Grant	Maryland	Allan L. McVey	West Virginia
D.J. Bettencourt	New Hampshire		

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

AGENDA

1. Hear Opening Remarks—*Director Anita G. Fox (MI)*

2. Consider Adoption of its Summer National Meeting Minutes
   —*Director Anita G. Fox (MI)*

3. Consider Adoption of its Subgroup, Working Group, and Task Force Reports
   —*Director Anita G. Fox (MI)*
   A. Consumer Information (B) Subgroup—*David Buono (PA)*
   B. Health Innovations (B) Working Group—*Commissioner Nathan Houdek (WI)*
   C. Health Actuarial (B) Task Force—*Director Anita G. Fox (MI) and Kevin Dyke (MI)*
   D. Long-Term Care Insurance (B) Task Force—*Commissioner Andrew N. Mais (CT) and Paul Lombardo (CT)*
   E. Regulatory Framework (B) Task Force—*Commissioner Glen Mulready (OK)*
   F. Senior Issues (B) Task Force—*Commissioner Scott Kipper (NV)*

4. Consider Adoption of its 2025 Proposed Charges and its Task Forces' 2025 Proposed Charges—*Director Anita G. Fox (MI)*

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5. Consider Adoption of Revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171)* —*Commissioner Glen Mulready (OK)*

6. Hear a Presentation from *NORC at the University of Chicago* on Proposed Research to Assess the Use of Artificial Intelligence (AI) to Conduct Utilization Management—*Lucy Culp (The Leukemia & Lymphoma Society [LLS]) and Lauren Seno (NORC at the University of Chicago)*

7. Hear a Presentation from the Center for Insurance Policy and Research (CIPR) on Small Group Market Trends—*Kelly Edmiston (CIPR)*

8. Hear an Update from the Federal Centers for Medicare & Medicaid Services' (CMS') Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities—*Jeff Wu (CCIIO)*

9. Discuss Any Other Matters Brought Before the Committee —*Director Anita G. Fox (MI)*

10. Adjournment

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Agenda Item #1

Hear Opening Remarks—*Director Anita G. Fox (MI)*

Agenda Item #2

Consider Adoption of its Summer National Meeting Minutes
—Director Anita G. Fox (MI)

Draft Pending Adoption

Draft: 8/21/24

Health Insurance and Managed Care (B) Committee
Chicago, Illinois
August 15, 2024

The Health Insurance and Managed Care (B) Committee met in Chicago, IL, Aug. 15, 2024. The following Committee members participated: Anita G. Fox, Chair (MI); Grace Arnold, Co-Vice Chair (MN); Glen Mulready, Co-Vice Chair (OK); Trinidad Navarro (DE); John F. King (GA); Dean L. Cameron (ID); D.J. Bettencourt (NH); Alice T. Kane represented by Viara Ianakieva (NM); Andrew R. Stolfi represented by Alex Cheng and Cassie Soucy (OR); Michael Humphreys (PA); Alexander S. Adams Vega represented by Maria Morcelo (PR); Jon Pike (UT); Mike Kreidler represented by Ned Gaines (WA); and Allan L. McVey (WV). Also participating were: Paul Lombardo (CT); Andria Seip (IA); Joanna Coll (IL); Vicki Schmidt (KS); Kevin P. Beagan (MA); Mary Kwei (MD); Chrystal Bartuska and John Arnold (ND); and Maggie Reinert (NE).

1. Adopted its July 26, June 13, and Spring National Meeting Minutes

The Committee met July 26. During this meeting, the Committee adopted the Regulatory Framework (B) Task Force's revised 2024 charges, which revised the 2024 charges for the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.

The Committee also met June 13. During this meeting, the Committee took the following action: 1) adopted revisions to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves* (AG 51); 2) adopted revisions to Valuation Manual (VM)-26, Section 3B—Contract Reserves for Credit Disability Insurance; 3) adopted the Health Actuarial (B) Task Force's revised 2024 charges; 4) discussed the Health Actuarial (B) Task Force's findings from its review and discussion of an issue the Committee referred to the Task Force late last year on how possible changes to the cost sharing reduction (CSR) subsidy, like changes to silver loading, could impact plan options and costs to consumers; and 5) heard a presentation from the Center for Insurance Policy and Research (CIPR) on findings from a case study the CIPR completed as part of its Network Adequacy Project: Compensation of Travel Costs for In-Network Care in Mississippi.

Commissioner McVey made a motion, seconded by Commissioner King, to adopt the Committee's July 26 (Attachment One), June 13 (Attachment Two), and March 18 (*see NAIC Proceedings – Spring 2024, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

3. Adopted its Subgroup, Working Group, and Task Force Reports

Commissioner Arnold made a motion, seconded by Commissioner Mulready, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its July 29 (Attachment Three) and June 18 (Attachment Four) minutes; 2) the Health Innovations (B) Working Group; 3) the Health Actuarial (B) Task Force; 4) the Long-Term Care Insurance (B) Task Force; 5) the Regulatory Framework (B) Task Force; and 6) the Senior Issues (B) Task Force. The motion passed unanimously.

4. Heard a Federal Update

Brian R. Webb (NAIC) provided a federal update on issues of interest to the Committee, beginning with congressional legislative activities. He said the funding for the mental health parity grants to the states to assist them in enforcing the mental health parity requirements under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) remains elusive. He explained that the grant money, which is $10 million per year for five years, has been authorized but not appropriated. He noted that once

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again, the Senate Committee on Appropriations put in its year-end report that it believes the federal Centers for Medicare & Medicaid Services (CMS) has sufficient funds in its budget to start the grant program without an additional appropriation of funds. He said NAIC Government Relations staff will continue to work to get CMS to fund and start the grant program. Webb said that this year, both the U.S. House of Representatives (House) and the U.S. Senate have maintained the same level of State Health Insurance Assistance Program (SHIP) funding in their respective budget bills. He said that, typically, one chamber zeros out the funding, and the other one funds it. This year, both have included full funding for SHIP in their committee appropriation bills.

Webb said the NAIC recently sent a letter to Congress regarding the enhanced advance premium tax credits (APTCs) under the federal Affordable Care Act (ACA). He explained that the APTCs are currently scheduled to end in 2025. The NAIC letter urges that they be extended past 2025 for many good reasons, the principal reason being that the increased size and availability of the premium tax credits that have been available since the passage of the American Rescue Plan Act of 2021 have resulted in greater enrollment in marketplace plans in state individual health insurance markets. The greater subsidies have enhanced the affordability of coverage for families of modest means as well as those who were previously denied help with coverage costs due to income limits, those above 400% of the federal poverty level. Webb also noted the APTCs on reinsurance programs in states with an ACA Section 1332 waiver.

Webb said Medicare Advantage plan marketing continues to be a big issue and the subject of much discussion. He said NAIC Government Relations staff are continuing to work with the relevant Senate and House committees to add language to year-end Congressional budget legislation to make it clear that CMS can work with states through a cooperative enforcement agreement to enforce the federal rules related to Medicare Advantage marketing. He said some states have requested such an arrangement to address consumer complaints directly.

Webb said that in July, the Federal Trade Commission (FTC) released an interim staff report, "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies." The report is highly critical of pharmacy benefit managers (PBMs), their funding, and their effect on consumers. He said the NAIC Government Relations staff will continue to follow this issue and see if it triggers any additional Congressional legislative activity on PBMs.

Regarding federal rules, Webb said it is anticipated that the new federal rule revamping provisions implementing the MHPAEA and establishing new requirements regarding non-quantitative treatment limitation (NQTL) requirements will be finalized soon. He said the NAIC also continues to look for clarity on the co-payment accumulator issue since the U.S. District Court for the District of Columbia's Sept. 29, 2023, decision vacating the 2021 U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) rule to the extent it permitted health plans to use a co-payment accumulator policy and HHS' decision not to enforce the 2020 NBPP rule, which prohibited copay accumulators except where a medically appropriate generic alternative is available. He said it has been rumored that such clarity could be included in the 2026 NBPP rule. He said he is aware of two states enforcing the 2020 NBPP rule, but other states need guidance on the issue.

Webb said the last federal rule he wanted to discuss was the ACA's Section 1557 final rule. He said there continue to be issues related to the final rule's language prohibiting discrimination based on a disability or age and Medicare supplement insurance (Medigap) plans. He said NAIC Government Relations staff have been seeking clarity on this issue from the HHS Office for Civil Rights (OCR) since May, right after the rule was finalized in April. To date, the OCR has not been responsive. He said NAIC Government Relations staff will continue to reach out to the OCR for a meeting to discuss the issue.

Webb next discussed recent court rulings, beginning with *Loper Bright Enterprises v. Raimondo* and *Relentless v. Department of Commerce* (collectively referred to as *Loper Bright*) rulings, which overturned the so-called "Chevron Doctrine." He said it is too early to tell what impact the ruling will have on federal health rules and

federal rulemaking, but he has already seen the *Loper Bright* ruling mentioned in some court cases related to the ACA Section 1557 rule. Webb said NAIC Government Relations staff continue to track both the *Braidwood v. Becerra* case, which challenged the ACA's preventive service requirements, and the *Pharmaceutical Care Management Association (PCMA) v. Mulready* case, which challenges state insurance regulators' right to regulate PBMs. He said both cases are continuing to make their way through the federal courts, which could have major implications for state insurance regulators.

5. Heard an Update from a Consumer Perspective on Recent State Activity on the Prior Authorization Process

Carl Schmid (HIV+Hepatitis Policy Institute), Stephani Becker (Shriver Center on Poverty Law), and Lucy Culp (Leukemia & Lymphoma Society—LLS) provided an update from a consumer perspective on recent state activity improving the prior authorization process.

Schmid discussed how the prior authorization process impacts patients and providers. He said that according to a 2023 American Medical Association (AMA) survey on prior authorization, 94% of providers said the prior authorization process delays patients' accessing necessary care. He provided additional statistics highlighting the effect of the prior authorization process on providers. He discussed the recommendations from two reports—the Center on Health Insurance Reforms (CHIR) report, "The Good, The Bad, The Costly," and the Network for Excellence in Health Innovation (NEHI) report, "Improving the Prior Authorization Process Recommendations for California," prepared for the California Health Care Foundation (CHCF)—suggesting potential reforms to improve the prior authorization process.

Schmid and Becker discussed prior authorization reform legislation in several states, including California, Illinois, Minnesota, New York, Vermont, and Rhode Island. Becker explained that the Rhode Island law signed in 2023 required the Office of the Health Insurance Commissioner (OHIC) to convene the Administrative Simplification Task Force to make prior authorization recommendations. She said that in its June 28 final report, the OHIC committed to: 1) ensuring uniform interpretation of a reduction in the volume of prior authorization; 2) collecting data in new ways to measure volume reductions; and 3) creating a new public body to serve as a forum for ongoing dialogue between payers and providers to inform prior authorization process improvements. Becker also noted new or strengthened prior authorization laws in Colorado, Maine, Maryland, Minnesota, Mississippi, Oklahoma, Vermont, Virginia, and Wyoming.

Culp discussed CMS's Interoperability and Prior Authorization Final Rule. She explained that the federal rule applies to Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP), and qualified health plans (QHPs) on the federal marketplaces. The final rule's requirements include: 1) a specific reason for denial; 2) shortened prior authorization response times; 3) public reporting; and 4) automation. Culp noted that the federal final rule does not include prior authorization changes for prescription drugs, but she anticipates CMS issuing a proposed rule for prescription drugs later this year.

Culp also discussed CMS's 2024 Medicare Advantage and Part D Final Rule. She explained that although it applies only to Medicare Advantage plans, she believes its provisions include meaningful changes to the prior authorization process that states can borrow from. She said those changes include: 1) new limits on the use of prior authorization; 2) banning retroactive denials; and 3) continuing prior authorization approvals as long as they remain medically necessary. The final rule also includes limits on the use of artificial intelligence (AI) for prior authorization determinations.

Culp suggested the following next steps for the Committee to consider: 1) charging the Consumer Information (B) Subgroup to modify and use the Subgroup's new consumer prior authorization guide to educate consumers; 2) forming a new Committee working group to share information and work on implementation, best practices, and

enforcement; and 3) partnering with the Innovation, Cybersecurity, and Technology (H) Committee on the use of AI in the prior authorization process.

Commissioner Mulready said Schmid's remarks characterized the prior authorization process as a barrier to care. He said he thinks of the prior authorization process as more of a checkpoint. He noted that without such checkpoints, there would be no limits on the type and number of health care services provided, which would not help to reduce health care costs. He asked Schmid if he thought there was a role for prior authorization. Schmid said he believes there is a role, but he noted that insurers approve most prior authorization requests. Given this, he questioned why consumers and providers on their behalf are required to go through the prior authorization process if most are approved, which is why he believes the prior authorization process is a barrier to care. Schmid said there is a need to find the appropriate balance because the current prior authorization process appears to be tilted too far toward not providing access to care. Director Fox agreed with Schmid about the need to find a balance between access to care and controlling health care costs.

6. Heard Presentations from the CHIR and AHIP on Health Cost Transparency

Sabrina Corlette (CHIR) and Kelley Schultz (America's Health Insurance Plans—AHIP) presented on health cost transparency. Corlette discussed the importance of health cost transparency in identifying what is driving the growth in health care costs. She referenced *Health Affairs* and RAND Corporation studies suggesting that prices, not consumption, are driving up health care costs. She discussed the different policy options—price regulation, anti-trust oversight/enforcement, and transparency—identified in a September 2022 Congressional Budget Office (CBO) report to promote affordability.

Corlette discussed the federal price transparency rules and how states could use the transparency in coverage (TiC) data collected under federal TiC rules to improve health cost transparency. She said such data could be used: 1) to conduct market scans to identify price outliers and cost drivers; 2) to monitor compliance with anti-trust actions and enforcements; 3) to support employer purchasing efforts; 4) as an independent source of data on median in-network rates for purposes surprise billing; and 5) to conduct rate review. Corlette discussed current problems with the TiC data, such as difficulty finding the data, duplicative or irrelevant data, and lack of standardization. She discussed state-level options to improve TiC data, including: 1) requiring insurers to attest to the completeness or accuracy of the TiC files; 2) hosting a centralized website with links to all insurer TiC files; 3) requiring greater standardization; and 4) using TiC data to inform public-facing reports about health system cost drivers.

Schultz discussed the federal TiC rule requirements—machine-readable files (MRFs), a cost estimator tool, and advanced explanation of benefits (AEOB)—including their drawbacks and opportunities for improving health cost transparency. She also discussed the implementation timeline for the federal TiC rule. Schultz discussed what actions states can take to address health cost transparency, such as: 1) prioritizing solutions that provide direct consumer value; 2) considering approaches to expand consumer awareness and education of tools; 3) avoiding single-state solutions; and 4) engaging on the next iteration of review and updates to the federal MRF requirements.

7. Heard an Update from the CCIIO on its Recent Activities

Ellen Montz (federal Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO's recent activities of interest. Her update included a discussion of four main areas: 1) 2024 open enrollment; 2) continued focus on affordability of coverage; 3) improving coverage options; and 4) not losing momentum from the Medicaid unwinding.

Montz discussed a few recent trends the CCIIO has been seeing: 1) the lower quality of QHP plan enrollment (e.g., more bronze plan enrollment versus silver plan enrollment) despite the availability of APTCs to help lower the cost of premium; and 2) the increase in consumer complaints. To address the increase in consumer complaints, many of which relate to the unauthorized switching of consumers to other plans, she said the CCIIO has taken a number of steps, including: 1) improving agent and broker training and technical assistance; 2) creating data specific to agents and brokers to track enrollment outcomes; 3) leveraging partnerships with stakeholders, like state insurance regulators, to identify fraud and eliminate bad actors; and 4) updating and making technical system changes to block unwanted changes and plan switches. She noted that to date, the CCIIO has suspended 450 agents from participating in the federal marketplace enrollments because of suspected fraudulent activity.

Montz also highlighted CMS' recently launched anti-fraud campaign designed to protect consumers in the marketplace from fraud and provide partners, such as state insurance regulators, with the latest information, tips, and resources to help prevent fraud and educate consumers on what they can do if they suspect fraud.

Montz said the CCIIO is working to finalize the MHPAEA rule. She said the CCIIO plans to begin work soon on the proposed 2026 NBPP rule.

Director Cameron asked Montz if the data the CCIIO is collecting about agents and brokers focuses strictly on federal marketplaces or if it also includes state-based marketplaces. He also asked if the CCIIO is sharing the names of any bad actors with the states based on the data. Montz said state-based marketplaces are responsible for overseeing agents and brokers who enroll consumers through the state-based marketplaces. She said that given that state insurance regulators license agents, the CCIIO is working to ensure data-sharing is in place to inform the states of any bad actors. She acknowledged that such communication is improving and that the CCIIO is working to be able to share not only agent suspensions from enrollment on the federal marketplace but also any complaints the CCIIO receives.

8. Discussed Addressed Priorities and Priorities to be Addressed in Future Meetings

Director Fox said that the Committee member survey conducted at the beginning of 2024 identified several key priorities to address this year. She said that to date, the Committee has discussed network adequacy, ground ambulance, and senior issues, such as long-term care insurance (LTCI). The Committee has also addressed issues related to the improper marketing of Medicare Advantage plans during NAIC staff weekly meetings and meetings with CMS.

Director Fox said that some of the remaining identified priorities were addressed during today's meeting-- health cost transparency and the prior authorization process. Other outstanding priorities identified include: 1) claim denials, which the Committee discussed in 2023; 2) plan benefit design; and 3) issues facing the small group market. She explained that a few of the remaining identified priorities, such as PBMs and mental health parity, are the focus of the Committee's task forces and working groups. She said that as the Committee prepares for its final meeting at the Fall National Meeting, anyone with thoughts or recommendations on any specific topics or presenters that align with any of these remaining priorities should reach out to her or NAIC staff.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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Agenda Item #3

Consider Adoption of its Subgroup, Working Group and Task Force Reports
—Director Anita G. Fox (MI)

Virtual Meetings

CONSUMER INFORMATION (B) SUBGROUP
October 18, 2024 / October 8, 2024 / August 29, 2024

Summary Report

The Consumer Information (B) Subgroup met Oct. 18, Oct. 8, and Aug. 29, 2024. During these meetings, the Subgroup:

1. Adopted its Oct. 8 and Aug. 29 minutes.

2. Reviewed, discussed, and adopted revisions to the NAIC's Frequently Asked Questions (FAQs) About Health Care Reform, which is updated each year before the open enrollment period begins so state insurance regulators have accurate information to answer consumers' questions.

3. Discussed the use of current NAIC guides developed by the Subgroup.

4. Discussed potential future Subgroup projects, including using a Survey Monkey to solicit suggestions.

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Consumer Information (B) Subgroup
Virtual Meeting
October 18, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Oct. 18, 2024. The following Subgroup members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Debra Judy (CO); Michelle Baldock and Matthew Pickett (IL); Alex Peck (IN); Terri Smith (MD); Jeana Thomas, Amy Hoyt, and Jo LeDuc (MO); Jill Kruger (SD); Vickie Trice (TN); and Christina Keeley (WI). Also participating was: Susan Jennette (DE).

1. Considered Adoption of its Oct. 8 and Aug. 29 Minutes

Buono noted that the Subgroup's draft Oct. 8 and Aug. 29 minutes were posted on the Subgroup's web page and circulated with this meeting's announcement. During those meetings, the Subgroup discussed recommended amendments to the Affordable Care Act (ACA) frequently asked questions (FAQ) up to question 90.

Thomas made a motion, seconded by Kruger, to adopt the Subgroup's Oct. 8 (Attachment XX) and Aug. 29 (Attachment XX) minutes. The motion passed.

2. Discussed Recommended Amendments to the ACA FAQ

Buono thanked the Subgroup for its work on the Oct. 8 call. The draft circulated prior to today's call includes the revisions already adopted by the Subgroup and a few suggested edits discussed on the Oct. 8 call.

NAIC staff walked through the document, and the Subgroup adopted the edits suggested on the previous call. Beginning with question 90, the Subgroup considered the remaining possible revisions. Patton asked about the group size threshold under the Medicare secondary payer rules. Jennette provided a link to information, and the Subgroup recommended that staff edit the document to include the link and clearer information.

Erin Miller (Community Catalyst) suggested including language, noting that the answers provided in the document are subject to change. The Subgroup agreed. Miller also suggested adding the latest requirements on providing a Social Security number on the applications. The Subgroup agreed.

After considering the proposed edits, Patton recommended that NAIC staff make the changes suggested on this call and circulate them to Subgroup members for an electronic vote. The Subgroup agreed.

Buono reminded the Subgroup that open enrollment begins Nov. 1, and this document will be circulated to all departments of insurance (DOIs) as soon as it is approved so they can add state-specific information and use it to answer consumer questions. Jennette suggested that it also be circulated to State Health Insurance Assistance Programs (SHIPs).

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3. Discussed its Next Steps

Buono asked Subgroup members to provide their priorities for the upcoming guides the Subgroup will develop. Patton suggested using Survey Monkey to solicit suggestions. NAIC staff were asked to look into using such a tool.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Draft: 10/14/2024

Consumer Information (B) Subgroup
Virtual Meeting
October 8, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Oct. 8, 2024. The following Subgroup members participated: David Buono, Chair (PA); T.J. Patton, Vice Chair (MN); Anthony L. Williams (AL); Debra Judy (ID); Jeana Thomas (MO); Jill Kruger (SD); and Christina Keeley (WI). Also participating was: Susan Jennette (DE).

1. Discussed Recommended Amendments to the ACA FAQ

Buono thanked the regulators who volunteered to review the Affordable Care Act (ACA) FAQ and provided recommendations for updating the document. He also thanked other interested parties who provided constructive edits. He noted that NAIC staff had incorporated the number updates, grammatical corrections, and clarifying language that was submitted, but there were still several amendments to walk through.

Most of the edits recommended by commenters were accepted by the Subgroup, but a few require further discussion. For question 10, it was suggested that language be added noting that certain low-income persons have a year-round special enrollment period. For question 24, it was recommended that information on how to file a complaint be added with a link to Consumer Information (B) Subgroup guidance. For question 29, adding information on state balance billing laws was suggested. For question 34, the Subgroup agreed to strike "with subsidies" from the question. For question 40, additional information on health savings accounts (HSAs) and providing clearer information on how they work was recommended. It was suggested that question 16 be split into two questions: 1) where to go for help; and 2) where to go to enroll. It was recommended that throughout the document, the term "Producers (agents/broker)" be used. There was discussion about adding more information on unauthorized producer activity.

The Subgroup stopped at question 90. NAIC staff were instructed to incorporate the edits approved during the meeting and provide an updated draft with the suggested new language discussed. The Subgroup will meet again in a few weeks to finish walking through the document beginning at question 90 and consider the amendments suggested during this meeting

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Draft: 9/11/24

Consumer Information (B) Subgroup
Virtual Meeting
August 29, 2024

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Aug. 29, 2024. The following Subgroup members participated: David Buono, Chair (PA); Michelle Baldock (IL); Alex Peck (IN); Terri Smith (MD); Jeana Thomas (MO); Donna Dorr (OK); Jill Kruger (SD); Jennifer Ramcharan and Vickie Trice (TN); and Christina Keeley (WI). Also participating was: Susan Jennette (DE).

1. Discussed the Need for Volunteers to Review the ACA FAQ

Buono reminded Subgroup members and interested parties that one of the Subgroup's responsibilities is to ensure that the NAIC's Frequently Asked Questions (FAQ) About Health Care Reform is updated each year before the Open Enrollment Period begins so state insurance regulators have accurate information to answer consumers' questions.

A copy of the FAQ, with dates and dollar amounts updated by NAIC staff, was circulated with the invitation to today's meeting. Buono walked through the document and asked for volunteers to take the lead in reviewing each section. Suggested edits are due Sept. 20. State insurance regulators volunteered and were appointed for each section of the FAQ.

2. Discussed the Use of Current NAIC Guides Developed by the Subgroup

Buono noted that the Subgroup has been busy and has developed great information for consumers, including how to shop for insurance, how prior authorization and claims reviews work, and how they can appeal insurer decisions. He asked whether state insurance regulators even know this information is available since states are distributing it to consumers.

A few states said they use the materials for training, while others said they send it to consumers. Several states said they did not know about the information until they joined the Subgroup, and it was noted that it is hard to find on the NAIC website.

Brenda J. Cude (University of Georgia) suggested that the Subgroup distribute the materials to state public information officers (PIOs) and discuss them at zone meetings. Katie Dzurec (Examination Resources LLC) recommended reaching out to the Insurance Regulatory Examiners Society (IRES) Education Committee.

Buono said he would talk to the NAIC Communications team to discuss meeting with PIOs and updating the NAIC website to make the materials easier to find.

3. Discussed its Next Steps

Buono asked what projects, other than updating the FAQ, the Subgroup should be working on during the last third of the year.

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Dr. Cude recommended reviewing the consumer information posted by NAIC Communications. She noted that those posts sometimes conflict with materials developed by the Subgroup. Buono said he would reach out to Communications to discuss.

Jennette suggested developing information on the No Surprises Act (NSA) and how the Independent Dispute Resolution (IDR) process works.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Virtual Meeting

HEALTH INNOVATIONS (B) WORKING GROUP
October 15, 2024

Summary Report

The Health Innovations (B) Working Group met Oct. 15, 2024. During this meeting, the Working Group:

1. Heard a presentation on hospital price caps in Oregon, which limits payments to hospitals in the state employee plan to 200% of the Medicare amount.

2. Heard presentations from the Center on Health Insurance Reforms (CHIR) and America's Health Insurance Plans (AHIP) on the federal transparency in coverage (TIC) requirements.

3. Heard a presentation from the PhRMA Foundation on a U.S. Department of Veterans Affairs (VA) program that helps veterans understand their prescription drugs, eliminate prescriptions that are no longer needed, and prevent conflicting drug usage.

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Health Innovations (B) Working Group
Virtual Meeting
October 15, 2024

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met Oct. 15, 2024. The following Working Group members participated: Nathan Houdek, Chair, Barbara Belling, and Jennifer Stegall (WI); Amy Hoyt, Vice Chair (MO); Sarah Bailey, Jacob Lauten, and Chelsy Maller (AK); Debra Judy and Jill Mullen (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Joe Keith and Jeff Hayden (MI); Daniel Bradford and Laura Miller (OH); Andrew R. Stolfi (OR); Rachel Bowden and Amelia Berry (TX); Tanji J. Northrup and Heidi Clausen (UT). Also participating were: Martin Swanson and Maggie Reinert (NE); and Jill Reinking and Lauren White (WY).

1. Heard a Presentation on Hospital Price Caps in Oregon

Hoyt introduced Roslyn Miller (Brown University). Miller gave a presentation on hospital price caps in Oregon, which limit payments to hospitals in the state employee plan to 200% of the Medicare amount. Hoyt asked if Oregon implemented additional price transparency requirements to help consumers compare prices and shop for services. Miller said this was discussed but no additional transparency initiatives were implemented and noted that the materials provided for today's call include more information on the policy.

Reinert asked if hospitals are prohibited from dropping out of the networks. Miller said there is no prohibition but the program's 185% cap on payments for out-of-network payments is critical to preventing providers from leaving the network. She said that none of the 24 participating hospitals have left.

Seip asked how the state arrived at the 200% of the Medicare amount cap. She asked if actuaries were involved in setting the cap. Miller explained that she was not involved in that process, but the cap was set a little lower than the current average reimbursement levels, which are 237% of the Medicare amount.

Hoyt noted that this program applies to the state employee plans but asked who receives coverage from that plan. Miller said state employees and teachers are in the health plan, which is about 15% of the insured population in the state.

2. Heard a Presentation from CHIR and AHIP on Federal TiC Requirements for Health Insurers

Hoyt introduced Sabrina Corlette (Center on Health Insurance Reforms—CHIR) and Kelley Schultz (AHIP). Corlette and Shultz gave a presentation on the federal Transparency in Coverage (TiC) requirements for health insurers. This presentation was a follow-up of their presentations to the Health Insurance and Managed Care (B) Committee at the Summer National Meeting, which were cut short due to time constraints.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) asked if machine-readable files could be used to find pricing trends for certain procedures or types of procedures, or possible patterns of pricing for specific groups of consumers, such as preventive care for people with intellectual or developmental disabilities. Schultz noted that the information is not broken down by disability, but the data can be parsed by geography.

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3. Heard a Presentation from the PhRMA Foundation on a Veterans Affairs Program

Hoyt introduced Amy M. Miller (PhRMA Foundation), who introduced Helen Omuya (PhRMA Foundation). Omuya gave a presentation on a U.S. Department of Veterans Affairs (VA) program that helps veterans understand their prescription drugs, eliminate prescriptions that are no longer needed, and prevent conflicting drug usage. Hoyt asked if this could also be used in other programs, like Medicaid, which are less integrated. Omuya said that CancelRx, a health information technology (IT) tool, could be useful in other settings.

Having no further business, the Health Innovations (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Committees/B CMTE/Health Innovations WG/Fall 24/Health Innov – Minutes – Oct. 15.docx

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2024 Fall National Meeting
Denver, Colorado

HEALTH ACTUARIAL (B) TASK FORCE
Saturday, November 16, 2024
3:30 – 5:00 p.m.

Meeting Summary Report

The Health Actuarial (B) Task Force met Nov. 16, 2024. During this meeting, the Task Force:

1. Adopted its Summer National Meeting minutes.

2. Adopted its Oct. 1 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its 2025 proposed charges.
   B. Exposed an American Academy of Actuaries (Academy) draft of knowledge statements for appointed actuary roles for the health blank for a 30-day public comment period ending Oct. 31.

3. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on: 1) the proposed 2025 Notice of Benefits and Payment Parameters; and 2) a Notice of Funding Opportunity (NOFO) on Essential Health Benefits (EHB)-Benchmark Plan Modernization for states with a Federally Facilitated Exchange (FFE).

4. Heard an update from the Academy Health Practice Council on recent and upcoming activities, publications, and webinars.

5. Heard an Academy professionalism update.

6. Discussed comments received on the exposure of the Academy's draft knowledge statements for an appointed actuary for the health blank.

7. Heard a presentation on Nebraska Medicare Supplement market new business rate setting and underwriting issues.

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2024 Fall National Meeting
Denver, Colorado

LONG-TERM CARE INSURANCE (B) TASK FORCE
Sunday, November 17, 2024
10:15 – 11:15 a.m.

Meeting Summary Report

The Long-Term Care Insurance (B) Task Force met Nov. 17, 2024. During this meeting, the Task Force:

1. Adopted Summer National Meeting minutes.

2. Adopted its Oct. 2 minutes. During this meeting, the Task Force took the following action:
   A. Adopted a recommendation to the Health Insurance and Managed Care (B) Committee for 2025 proposed charges, which include disbanding the Long-Term Care Insurance (B) Task Force on Dec. 31, 2024, and recommending charges for the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force.

3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Nov. 16. During this meeting, the Working Group took the following action:
   A. Adopted its Summer National Meeting minutes.
   B. Adopted its Oct. 9 minutes. During this meeting, the Working Group took the following action:
      i. Discussed comments received on the exposure of the Minnesota Approach with adjustments to haircut percentages and cumulative rate increase ranges of the cost-sharing formula as a candidate for a single long-term care insurance (LTCI) multistate rate review approach methodology for use in multistate actuarial (MSA) filing reviews.
      ii. Adopted the Minnesota Approach with the current cost-sharing formula as the single multistate rate review approach methodology for use in MSA filing reviews.
      iii. Exposed the Minnesota Approach, with a particular focus on the cost-sharing factors and blending factors associated with the if-knew/makeup approach, for a 19-day public comment period that ended Oct. 28.
   C. Discussed proposed modifications to the Minnesota Approach for use as the single LTCI MSA rate review approach.
   D. Adopted modifications to the cost-sharing formula used in the single LTCI multistate rate review approach methodology for use in MSA filing reviews.

4. Exposed revisions to the Long-Term Care Insurance Multistate Rate Review Framework, including the proposed single LTCI MSA rate review approach and modifications to the cost-sharing formula, for a 25-day comment period ending Dec. 13, 2024.

5. Heard a presentation from the Center for Insurance Policy and Research (CIPR) on the progress of the study of reduced benefit options (RBOs) letters to consumers and consumer choices. The CIPR plans to continue to review the data and report on results during future meetings.

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2024 Fall National Meeting
Denver, Colorado

REGULATORY FRAMEWORK (B) TASK FORCE
Sunday, November 17, 2024
11:30 a.m. – 12:30 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met Nov. 17, 2024. During this meeting, the Task Force:

1. Adopted its Summer National Meeting minutes.

2. Adopted its Nov. 4 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its 2025 proposed charges.
   B. Adopted the proposed revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

3. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Oct. 17 and Sept. 9 minutes. During these meetings, the Subgroup took the following action:
   A. Discussed the comments received on the May 5 and Sept. 24 drafts of proposed revisions to Section 9—Required Disclosure Provisions of Model #171.
   B. Adopted the proposed revisions to Model #171.

4. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group.

5. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Summer National Meeting minutes. The Working Group will meet Nov. 18. During this meeting, the Working Group plans to take the following action:
   A. Discuss the federal mental health parity final regulation.
   B. Meet in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue discussion of the opioid use disorder issue.

6. Adopted the report of the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group, which will meet Nov. 18. During this meeting, the Working Group plans to take the following action:
   A. Discuss pharmacy benefit managers (PBMs) and how they function.
   B. Discuss providing potential assistance to the Producer Licensing Uniformity (D) Working Group to create a new section on PBM licensure best practices and uniform standards in the *State Licensing Handbook*.

7. Heard a presentation from AffirmedRX on PBM transparency initiatives. The presentation offered a brief overview of PBMs, emphasizing the importance of transparency in PBM operations and addressing related challenges and barriers. It explored the concept of public benefit corporations

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(PBCs) and PBC PBMs, highlighting how PBC PBMs focus on providing transparent and ethical drug pricing while ensuring access to medications for underserved populations. This approach enhances trust among stakeholders, partners, and the public; attracts socially conscious investors; and improves public image and reputation. The discussion also covered future directions, including PBM transparency emerging trends, the potential impact of new technologies, and ongoing legislative and regulatory efforts.

8. Heard a discussion on issues related to the implementation of the federal Affordable Care Act's (ACA's) Section 1557 final regulation, including the application of its nondiscrimination provisions to Medicare supplemental insurance (Medigap) and other excepted benefit products. The discussion noted the importance of excepted benefit products to consumers. It 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, and that federal guidance is needed to provide clarity on how the final regulation is to be implemented, particularly with respect to Medigap plans. The discussion also suggested that while the Section 1557 final regulations are still being debated, state insurance regulators can play an important role in ensuring that its non-discrimination protections are applied and enforced, such as through the complaint process and the review of plan benefit designs.

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2024 Fall National Meeting
Denver, Colorado

SENIOR ISSUES (B) TASK FORCE
Sunday, November 17, 2024
9:00 – 10:00 a.m.

Meeting Summary Report

The Senior Issues (B) Task Force met Nov. 17, 2024. During this meeting, the Task Force:

1. Adopted its Summer National Meeting minutes.

2. Adopted its Oct. 21 and Sept. 20 minutes. During these meetings, the Task Force took the following action:
   A. Adopted its 2025 proposed charges and forwarded them to the Health Insurance and Managed Care (B) Committee for consideration.
   B. Adopted a letter to the federal Centers for Medicare & Medicaid Services (CMS) regarding provider withdrawals from Medicare Advantage plans and the Medicare supplement insurance (Medigap) guaranteed issue (GI).

3. Discussed the Medicare Advantage/Medigap/Special Enrollment Period (SEP) issue with CMS.

4. Heard a discussion from NAIC consumer representatives on the Medicare Advantage/Medigap/SEP issue.

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Agenda Item #4

Consider Adoption of its 2025 Proposed Charges and its Task Forces' 2025 Proposed Charges—*Director Anita G. Fox (MI)*

Draft: 9/30/24
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 Health Actuarial (B) Task Force, Oct. 1, 2024

2025 Proposed Charges

HEALTH ACTUARIAL (B) TASK FORCE

The mission of the Health Actuarial (B) Task Force is to identify, investigate, and develop solutions to actuarial problems in the health insurance industry.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Actuarial (B) Task Force** will:
   A. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
   B. Provide support for issues related to implementation of, and/or changes to, the federal Affordable Care Act (ACA).
   C. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
   D. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
   E. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary to other NAIC groups relative to their work on health actuarial matters.
   F. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

2. The **Long-Term Care Actuarial (B) Working Group**:
   A. Assist the Health Actuarial (B) Task Force in completing the following charges:
   i. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate LTCI rates, rating practices, and rate changes.
   ii. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a PBR framework.
   iii. Develop LTCI experience reporting requirements in VM-50 and VM-51, Experience Reporting Formats, of the *Valuation Manual*.
   iv. Monitor and evaluate the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

Staff Support: Eric King

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Draft: 10/23/24
Adopted by the Executive (EX) Committee and Plenary,
Adopted by the Health Insurance and Managed Care (B) Committee,
Adopted by the Senior Issues (B) Task Force, Oct. 21, 2024

Proposed 2025 Charges

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to 1) consider policy issues; 2) develop appropriate regulatory standards; and 3) revise, as necessary, the NAIC models, consumer guides, and training material on Medicare supplement insurance, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Senior Issues (B) Task Force** will:
   A. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. Work with federal agencies to advance appropriate regulatory standards for Medicare supplement and other forms of health insurance applicable to older Americans. Review the *Medicare Supplement Insurance Minimum Standards Model Act* (#650) and the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651) to determine if amendments are required based on changes to federal law. Work with the federal Centers for Medicare & Medicaid Services (CMS) to revise the annual joint publication, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
   B. Monitor the Medicare Advantage and Medicare Part D marketplace. Assist states, as necessary, with regulatory issues. Maintain dialogue and coordinate with the CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Assist states and serve as a clearinghouse for information on Medicare Advantage plan activity.
   C. Provide the perspective of state insurance regulators to the U.S. Congress, as appropriate, and the CMS on insurance issues, including those concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme. Review and monitor state and federal relations with respect to senior health care initiatives and other impacts on the states.
   D. Monitor developments concerning State Health Insurance Assistance Programs (SHIPs), including information on legislation affecting the funding of SHIPs. Assist the states with issues relating to SHIPs and support a strong partnership between SHIPs and the CMS. Provide the perspective of state insurance regulators to federal officials, as appropriate, on issues concerning SHIPs.
   E. Monitor, maintain, and review, in accordance with changes to Model #651, a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by state insurance regulators and others. Review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in Model #651.
   F. Develop appropriate regulatory standards and revisions, as necessary, to the NAIC models, consumer guides, and training material on LTCI, including the study and evaluation of evolving LTCI product design, rating, suitability, and other related factors. Monitor ongoing research and maintenance of guidance regarding reduced benefit options (RBOs) and make necessary modifications to the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641). Work with federal agencies, as appropriate.
   G. Examine examples of health-related financial exploitation of seniors and work with other NAIC committees, task forces, and working groups on possible solutions.

SENIOR ISSUES (B) TASK FORCE *(continued)*

H. Examine the effects of structural racism and the COVID-19 pandemic on access, affordability, and outcomes for older insurance consumers.

NAIC Support Staff: David Torian

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 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 **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.

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.

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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.

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

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

To: Director Anita G. Fox (MI), Chair of Health Insurance and Managed Care (B) Committee

From: Paul Lombardo (CT), Chair of Long-Term Care Insurance (B) Task Force

Date: October 2, 2024

Re: Recommendation for 2025 Charges

In 2024, the Long-Term Care Insurance (B) Task Force and its Working Group have made important progress on the work of improving the multistate actuarial (MSA) rate review process and conducting research through the NAIC Center for Insurance Policy and Research (CIPR) on reduced benefit options (RBOs) and consumer notices. Based on this progress, it is recommended continued work on these topics will be better served by and align with the work of the Senior Issues (B) Task Force and the Health Actuarial (B) Task Force in 2025.

The following is recommended.

- The Long-Term Care Insurance (B) Task Force should disband as of December 31, 2024.
- Charges related to ongoing work on the MSA rate review process as outlined in the *Long-Term Care Insurance Multistate Rate Review Framework* (MSA Framework) should be moved to the Health Actuarial (B) Task Force in 2025.
- Charges related to research and maintenance of guidance for RBO's should be moved to the Senior Issues (B) Task Force in 2025
- The Long-Term Care Actuarial (B) Working Group should report to the Health Actuarial (B) Task Force in 2025.

The following are suggested amendments to those charges.

Recommendation for 2025 Charges:

Move the following charge to Health Actuarial (B) Task Force.

1. Monitor and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the Long-Term Care Insurance Multistate Rate Review Framework (MSA Framework), and make modifications as appropriate. Monitor state insurance department rate review actions subsequent to the implementation of the MSA Framework and MSA rate review recommendations.

Move the following charge to Senior Issues (B) Task Force.

1. Monitor and evaluate options to help consumers manage the impact of rate increases, including monitoring ongoing research, ~~an~~ evaluating ~~on of~~ the use and impact of ~~previously adopted~~ guidance for states regarding reduced benefit options (RBOs) and making modifications, as appropriate. This should be conducted in conjunction with the LTC Actuarial Working Group to assess the use and impact of guidance for states regarding reduced benefit options (RBOs) and make modifications as appropriate.

Amend charges and have the Working Group report to the Health Actuarial (B) Task Force.

The Long-Term Care Actuarial (B) Working Group will:

1. Provide recommendations, as appropriate, to address issues and provide actuarial assistance and commentary with respect to model requirements for appropriate long-term care insurance (LTCI) rates, rating practices, and rate changes.
2. Continue to develop health insurance reserving requirements (VM-25, Health Insurance Reserves Minimum Reserve Requirements) using a principle-based reserving (PBR) framework.
3. Develop LTCI experience reporting requirements in VM-50, Experience Reporting Requirements, and VM51, Experience Reporting Formats.
4. ~~Develop a uniform actuarial approach to multistate long-term care insurance (LTCI) rate increase reviews for use in the LTCI Long-Term Care Insurance Multistate Rate Review Framework (MSA Framework) in support of completing Long-Term Care Insurance (B) Task Force Charge~~ Monitor and evaluate ~~the progress of~~ the actuarial approach used in the multistate actuarial (MSA) rate review process as outlined in the MSA Framework document, and make modifications, as appropriate. ~~Monitor state insurance department rate review actions subsequent to the implementation of the MSA Framework and MSA rate review.~~ Additionally, monitor and evaluate the progress of the MSA rate review process and the state insurance department rate review actions related to the MSA Framework.

If you have any questions, please contact me, or NAIC Staff, Jane Koenigsman (jkoenigsman@naic.org).

Draft: 11/8/24
Adopted by the Executive (EX) Committee and Plenary, Nov. __, 2024
Adopted by the Health Insurance and Managed Care (B) Committee, TBD

2025 Proposed Charges

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Health Insurance and Managed Care (B) Committee** will:
   A. Respond to inquiries from the U.S. Congress (Congress), the White House, and federal agencies; analyze policy implications and their effect on the states of proposed and enacted federal legislation and regulations; and communicate the NAIC's position through letters and testimony, when requested.
   B. Monitor the activities of the Health Actuarial (B) Task Force.
   ~~C. Monitor the activities of the Long-Term Care Insurance (B) Task Force.~~
   ~~D~~C. Monitor the activities of the Regulatory Framework (B) Task Force.
   ~~E~~D. Monitor the activities of the Senior Issues (B) Task Force.
   ~~F~~E. Serve as the official liaison between the NAIC and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC).
   ~~G~~F. Examine factors that contribute to rising health care costs and insurance premiums. Review state initiatives to address cost drivers.
   ~~H~~G. Coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues.
   ~~I~~H. Coordinate with the Market Regulation and Consumer Affairs (D) Committee, as necessary, to collect uniform data and monitor market conduct trends on plans that are not regulated under the federal Affordable Care Act (ACA), including short-term, limited-duration (STLD) insurance, association health plans (AHPs), and packaged indemnity health products.

2. The **Consumer Information (B) ~~Subgroup~~Working Group** will:
   A. Develop information or resources, as needed, that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance.
   B. Review NAIC publications that touch on health insurance to determine if they need updating. If updates are needed, suggest specific revisions to the appropriate NAIC group or NAIC division to make the changes.

3. The **Health Innovations (B) Working Group** will:
   A. Gather and share information, best practices, experience, and data to inform and support health innovation at the state and national levels, including, but not limited to, state flexibility options through the ACA and other health insurance-related policy initiatives.
   B. Discuss state innovations related to health care—i.e., access, insurance plan designs, underlying medical and prescription drug costs, stability for health care and insurance as a whole, health insurer and provider consolidation or competition, the use of data in regulatory and policy decision making, and health care delivery and financing models—to achieve better patient outcomes and lower spending trends.
   C. Explore sources and methods for state insurance regulators to obtain data to inform health reform initiatives.

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D. 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.
E. Take up other matters as directed by the Health Insurance and Managed Care (B) Committee.

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

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Agenda Item #5

Consider Adoption of Revisions to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171)
—Commissioner Glen Mulready (OK)

PROJECT HISTORY

MODEL REGULATION TO
IMPLEMENT THE ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT (#171)

1. Description of the Project, Issues Addressed, etc.

Amendments to the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171)—Amendments to Model #171 are required for consistency with the federal Affordable Care Act (ACA) and the revisions to its companion model act, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170). Therefore, they did not require approval of a Request for NAIC Model Law Development by the Executive (EX) Committee.

In 2013, the Regulatory Framework (B) Task Force was charged with reviewing existing NAIC models related to health insurance to determine whether they needed to be amended, considering all the changes made by the ACA. During that review process, Model #170 and its companion model regulation, Model #171, were added to the list of NAIC models to be considered for revision, given the model's provisions for certain types of health insurance plans that would not be permitted under the ACA.

Beginning at the 2014 Fall National Meeting, the Task Force began discussing revisions to Model #170 and Model #171. At the 2015 Spring National Meeting, the Task Force decided, given its other priorities for 2015, specifically with respect to revising the formerly titled *Managed Care Network Adequacy Model Act* (#74), now the *Health Benefit Plan Network Access and Adequacy Model Act* (#74), to defer discussing additional revisions to the models until it finished its work on Model #74. The Task Force finished that work in late 2015.

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. At the 2017 Spring National Meeting, concerned with the uncertainty of the ACA's future, given congressional proposals to repeal, replace, and/or repair it, the Task Force decided to halt Subgroup meetings until there was more certainty about actions at the congressional level.

At the 2017 Fall National Meeting, the Task Force decided to move forward with discussing revisions to Model #170 and Model #171, and it directed the Subgroup to resume its work in early 2018. The Subgroup completed the revisions to Model #170 in late 2018, which the Executive (EX) Committee and Plenary adopted in February 2019.

Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus since late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup resumed its meetings in June 2021. The Subgroup has been meeting on a regular basis to discuss the comments received on Model #171. The Subgroup completed its review of all the comments received on Model #171 in September. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

The revisions to Model #171 revise the model for consistency with the revisions to Model #170. The revisions also add standards for short-term, limited-duration (STLD) plans. The revisions also clarify and enhance provisions on consumer disclosures and outline coverage requirements.

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2. Name of Group Responsible for Drafting the Model and States Participating

The Accident and Sickness Insurance Minimum Standards (B) Subgroup drafted the revisions to Model #171. At the time of adoption on Oct. 17, 2024, the Subgroup members were: Oklahoma, Co-Chair; Texas, Co-Chair; District of Columbia; Florida; Louisiana; Maine; Missouri; Nebraska; South Carolina; Utah; Vermont; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

In February 2016, the Task Force established the Accident and Sickness Insurance Minimum Standards (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #170 and Model #171. The Subgroup adopted the revisions to Model #170 in July 2018. Soon after completing its work on Model #170, with Oklahoma and Minnesota as co-chairs, the Subgroup began discussing revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus starting in late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup, with Oklahoma and Nebraska as co-chairs, resumed its meetings in June 2021. In late 2022, the Subgroup lost Nebraska as co-chair but resumed its meetings in early 2023, with Texas replacing Nebraska as co-chair. The Subgroup continued meeting on a regular basis to discuss the comments received on Model #171. The Subgroup completed its review of all the comments received on Model #171 in September 2024. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

Soon after completing its work on Model #170, the Subgroup began considering revisions to Model #171. The Subgroup met every two weeks until it lost one of its co-chairs in December 2019. After a long hiatus since late 2019 due to the loss of a co-chair, the COVID-19 pandemic, and other resource issues, the Subgroup resumed its meetings and discussions of the comments received in June 2021. The Subgroup met on a regular basis to discuss the comments received on Model #171 until it adopted the model revisions Oct. 17, 2024.

During the last few months of 2022, the Subgroup's discussions focused on Section 8—Supplementary and Short-Term Health Minimum Standards for Benefits. This section establishes minimum standards for benefits for the products subject to the model, including accident-only coverage, hospital indemnity or other fixed indemnity coverage, and disability income protection coverage. The revisions also include a new section establishing minimum benefits for STLD plans. The Subgroup completed its discussions of Section 8 in December 2022, including developing a new subsection establishing minimum benefit standards for STLD plans.

The Subgroup resumed its meetings in February 2023, reviewing and discussing comments received on the following Model #171 sections in this order: 1) the remainder of Section 8, including revisiting the proposed new subsection on STLD plans to discuss the Feb. 24, 2023, comments received on that section; 2) Section 7—Prohibited Policy Provisions; 3) revisit Section 5—Definitions and Section 6—Policy Definitions to reconcile any inconsistencies that may have arisen after the Subgroup's review of the substantive provisions of Model #171; and 4) Section 9—Required Disclosure Provisions. The Subgroup is

completing work on Section 9—Required Disclosure Provisions. In October 2023, the Subgroup completed its review of all the comments received on Model #171. The Subgroup set a public comment deadline of Dec. 1, 2023, to receive comments on the initial draft reflecting its discussions and preliminary revisions to Model #171.

The Subgroup resumed its meetings in January 2024 to discuss the comments received. The Subgroup completed that review in April 2024 and distributed a final draft, dated May 3, to stakeholders in anticipation of adopting the proposed revisions in June. The Subgroup received additional comments on that draft, and as a result, it resumed its meetings in June 2024 to discuss the comments. The Subgroup completed its review of those comments in September 2024 and distributed another final draft in anticipation of adopting the revisions to Model #171 during a meeting in October. The Subgroup adopted the revisions to Model #171 during a meeting Oct. 17, 2024.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers, and legislators was solicited)

Throughout the drafting process the Subgroup solicited comments from stakeholders, which included consumer and industry representatives, as well as state insurance regulators. The Subgroup discussed and reviewed those comments during public meetings. All the comments received were posted on the Subgroup's webpage. Each proposed revision draft was also posted on the Subgroup's web page.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

Among the issues debated during the drafting process concerned the purpose of excepted benefit products and the fact that they are not intended to be comprehensive major medical coverage. In addressing this issue, the Subgroup enhanced the consumer disclosure provisions and outline of coverage provisions to ensure consumers will be aware that excepted benefit products are not meant to be comprehensive health insurance coverage. The Subgroup also included additional language in the draft highlighting that insurers should not offer, market, or sell excepted benefit products as a substitute for, or alternative to, comprehensive major medical coverage.

In addition, during the drafting process, the Subgroup and stakeholders involved had to keep in mind that the model sets minimum standards, which means the states and insurance carriers can go above them. In addressing another issue that arose during the process concerning potential and recurring federal changes related to hospital indemnity or other fixed indemnity plans and STLD plans, the Subgroup included in the revisions suggestions that, prior to adopting the model revisions, states review any relevant federal regulations, establishing that requirements for these products that could differ from the state's requirements.

One significant issue discussed and addressed during the drafting process related to the provisions establishing standards for STLD plans, including what benefits should be included. In resolving this issue, the STLD plan provisions rely on a state's requirements for benefits and coverage under such plans.

Another significant issue discussed concerned a provision in the model that allows plans to exclude mental health and substance use coverage from excepted benefit plans. During this discussion, it was highlighted that these are excepted benefit products, not major medical coverage subject to the ACA's guarantee issue and preexisting condition exclusion requirements. Excepted benefit plans are medically

underwritten and subject to preexisting condition exclusions. It was also noted that this provision is optional, which means states can require such coverage if they feel it is appropriate. In addition, as already noted, for short-term, limited-duration plans, the benefits and coverages for these plans are tied to a state's requirements. If a state requires these plans to include mental health and substance use benefits, then they must include the coverage.

7. List the key provisions of the model (sections considered most essential to state adoption)

This is not applicable. All the sections are essential to state adoption.

8. Any Other Important Information (e.g., amending an accreditation standard)

This is not an accreditation model.

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Proposed Revisions to Model #171

Language from the permitted exclusion section 7D:

D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except 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 addiction;

Drafting Note: This provision is optional. States should review the desirability of permitting such exclusions, particularly those exclusions related to mental health and substance use, included in subsections D(2) and D(4) of this section, in short-term limited duration and disability policies.

Short-Term, Limited Duration Coverage Language from Section 8H.

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.

Drafting Note: States should consider whether mental health and substance use disorder benefits, as described in Sections 7, D(2) and D(4), should be permitted exclusions to short-term limited duration policies.

November 8, 2024

Director Anita G. Fox, Chair
Commissioner Grace Arnold, Co-Vice Chair
Commissioner Glen Mulready, Co-Vice Chair,
Members of the NAIC Health Insurance and Managed Care (B) Committee
Via email: jmatthews@naic.org

RE: Support for Adoption of Model #171 – The Supplementary and Short-Term Health Insurance Minimum Standards Model Act

Dear Health Insurance and Managed Care (B) Committee Members,

We, the undersigned representatives of AHIP, the American Council of Life Insurers (ACLI), and the Health Benefit Institute (HBI), are writing to express our strong support for the adoption of the proposed Model Regulation to Implement the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (Model #171).

This regulation is a critical step forward in standardizing and simplifying the terms and coverages of supplementary and short-term health insurance. By implementing these minimum standards, we can enhance public understanding and comparison of coverage options, eliminate misleading or confusing provisions, and ensure full disclosure in the marketing and sale of these insurance products. This model reflects a significant step forward for consumers.

We would like to acknowledge the many hours of diligent work by the Accident and Sickness Subgroup, chaired by Andy Schallhorn (OK) and Rachel Bowden (TX). Their dedication and expertise have been instrumental in developing this comprehensive regulation. NAIC staffer Jolie Matthews has shown great patience and has also shown her expertise throughout this process.

The consumer representatives' challenge to decisions made by the regulator experts on the Subgroup does not reflect the spirit of compromise the industry brought to the table. All the decisions in this model were reviewed by the Accident and Sickness subgroup numerous times in a public forum including several times earlier this year. Additionally, there were multiple opportunities for written comments. The Subgroup extensively considered the structure and function of the products regulated under Model 171 and because of their deliberations the finalized model is well reasoned.

We believe the adoption of this model regulation as approved by the Subgroup and by the Regulatory Framework Task Force will significantly benefit consumers by ensuring they have access to clear, understandable, and reliable supplemental health coverage options and by creating a more consistent regulatory framework for short-term limited duration coverage that allows for state

flexibility. It will also support insurers in maintaining compliance with state laws and regulations, thereby fostering a more stable and trustworthy insurance market.

We commend the efforts of the NAIC and the Regulatory Framework (B) Task Force in developing this comprehensive regulation and urge its adoption during the 2024 NAIC Fall Meeting. We are confident this regulation will serve as a robust framework for protecting consumers and enhancing the integrity of the health insurance market.

Thank you for your consideration of our support for this important regulation.

Sincerely,

JP Wieske
VP of State Affairs
Health Benefits Institute

Cindy Goff
VP, Supplemental and Group Ins
American Council of Life Insurers

Kris Hathaway
VP of State Affairs
AHIP

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

Section 2. Authority

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

Section 3. Applicability and Scope

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

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

C. This regulation shall not apply to:

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

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

(3) TRICARE (Chapter 55, Title 10 of the United States Code) supplement insurance policies; or

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

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

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

Section 4. Effective Date

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

Section 5. Definitions

For purposes of this regulation:

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

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

C. "Short-term, limited-duration insurance" has the meaning stated in Section 3I of the Act.

Section 6. Policy Definitions

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

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

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

(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;

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

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

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

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

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

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

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

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

C. "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.

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

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

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

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

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

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

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

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

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

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

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

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.

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

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" means that, due to a disability, an individual:

(1) Is unable to perform one or more but not all 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" means and includes words such as "qualified physician" or "licensed physician" and may not be defined more narrowly than applicable state licensing 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" means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person."

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

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

M. "Sickness" means sickness, illness, or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be modified to exclude sickness or disease for which benefits are provided under a 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.

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

Section 7. Prohibited Policy Provisions

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

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

(3) A policy, other than an accident only policy or a short-term, limited duration health insurance 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 reproductive organs, varicose veins, adenoids, and tonsils, except when the specified diseases or conditions are treated on an emergency basis.

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

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

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

D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except 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 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 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 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 for reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly that has resulted in a functional defect;

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

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

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

(8) Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal 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) Eyeglasses, hearing aids and examination for the prescription or fitting of them;

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

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

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

Drafting Note: Some of the exclusions set forth in this provision may be unnecessary or in conflict with existing state legislation and should be deleted.

E. Notwithstanding Subsection D of this section, 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.

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

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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 8. Supplementary and Short-Term Health Insurance Minimum Standards for Benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. 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 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 5B and C of the NAIC *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*].

A. General Rules

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

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

(2) (a) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 9A.

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

(c) Except as provided 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.

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(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 supplementary policy covering 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 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), must be guaranteed renewable except for reasons stated in PHSA § 2742 (42 U.S.C. § 300gg-42), unless it is an excepted benefit as described in PHSA § 2791(c) (42 U.S.C. § 300gg-91(c)). Applicable state law may impose requirements that mirror or exceed the federal requirements.

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

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

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

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

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

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

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

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income protection benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

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

(13) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage and the disclosure materials required under Section 9 of this regulation the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(14) Termination of the policy shall be without prejudice to the right to receive benefits for a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(15) A policy providing coverage for certain illnesses and injuries may not define covered illnesses and injuries in a way that is misleading or includes unfair exclusions. For example, a policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

B. Hospital Indemnity or Other Fixed Indemnity Coverage

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

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

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

(3) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

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

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

C. Disability Income Protection Coverage

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

(1) Provides that a plan is prohibited from 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;

(c) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or

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

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

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

D. Accident Only Coverage

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

E. Specified Disease Coverage

(1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules in paragraph (2) and one of the following sets of minimum standards for benefits:

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

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

(2) General Rules

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

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

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

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

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

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

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

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

(g) Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(h) 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 supplementary coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the *Coordination of Benefits Model Regulation* states that the definition of a "plan" (for the purpose of coordination of benefits) "shall not include

individual or family insurance contracts." States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

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

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

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

(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 a named preexisting condition is specifically excluded.

(m) Hospice Care.

(i) "Hospice" means a provider licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(I) For terminally ill patients whose life expectancy is less than six (6) months;
(II) Provided on an inpatient or outpatient basis; and

(III) Directed by a physician.

(ii) Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:

(I) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less;

(II) A fixed-sum payment of at least $[X] per day; and

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

(iii) Hospice care does not cover 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 disorders , who are aged, or who have a substance use-related disorder.

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

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

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

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

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

(iii) Private duty services of a licensed nurse;

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

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

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

(vii) Drugs and medicines prescribed by a physician;

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

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

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

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

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

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

(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:

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

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

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

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

(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;

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

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

(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;

(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.

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

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

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

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;

c. Physical, occupational or speech and hearing therapy; and

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;

(ix) Physical, speech, hearing and occupational therapy;

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

(xi) Prosthetic devices including wigs and artificial breasts;

(xii) Nursing home care for noncustodial services;

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

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

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

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

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

(iii) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

(iv) Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in (b)(i) and (b)(ii) whether by definition or otherwise, shall be no more restrictive than those under Medicare.

(6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:

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

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

(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease unless there are clearly identifiable subtypes with significantly lower treatment costs, in which case lesser amounts may only be payable 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 exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

F. Specified Accident Coverage

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

G. Limited Benefit Health Coverage

(1) "Limited benefit health coverage" is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, D, and F. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7E and shall not be offered for sale as "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 long-term care insurance policies, and should be subject to the *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).

Drafting Note: This regulation permits the combining of excepted benefit-type products described in this section 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 9. Required Disclosure Provisions

A. General Rules

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

(b) The disclosures required by this section may be modified only as 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.

(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.

(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."

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

(14) All riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirement in this paragraph applies to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium.

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

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

(17) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall be clearly explained in a separate paragraph of the policy or certificate labeled "Preexisting Conditions Limitations."

(18) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed in sans serif font on the first page of the policy or certificate or attached to it stating clearly that the policy or certificate holder shall have the right to return the policy or certificate within thirty [30] days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason.

Drafting Note: This paragraph should be included only if it is consistent with applicable state law.

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

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

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

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

Drafting Note: 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.

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

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

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant 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 different from the outline of coverage you received when you [applied][enrolled]. The coverage you applied for was not issued."

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

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

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

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

[COMPANY NAME]

[Hospital Indemnity] [Other Fixed Indemnity] Coverage

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

OUTLINE OF COVERAGE

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

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

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

(a) When the benefits are payable;

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

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

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

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

D. Disability Income Protection Coverage (Outline of Coverage)

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

[COMPANY NAME]

Disability Income Protection Coverage

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

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

(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 reservation of right to change premiums.]

E. Accident-Only Coverage (Outline of Coverage)

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

[COMPANY NAME]

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

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

(3) [Brief, but clear and specific, description of the benefits and a description of any deductible or copayment provisions applicable to the benefits described.]

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

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

An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Sections 8E and F of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

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

(3) [Specified disease][Specified accident] coverage is designed to pay limited benefits as a result of the diagnosis or treatment [of a covered disease] or [resulting from a specifically identified type of accident]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) [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.

G. Limited Benefit Health Coverage (Outline of Coverage)

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

[COMPANY NAME]

Limited Benefit Health Coverage

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

OUTLINE OF COVERAGE

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

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

(3) [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.]

(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.]

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, description 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, description 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.]

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

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

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. However, this notice is not required in the solicitation of accident-only policies or the replacement of single-premium nonrenewable policies.

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

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

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

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

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

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

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

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

_____
(Date)

_____
(Applicant's Signature)

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

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

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

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

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

(3) [To be included only if the application is attached to the policy]. If you decide to buy a new policy, read the copy of the attached application and be sure that all questions are answered fully and

correctly. If they are not, the company could refuse to pay an otherwise valid claim. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left off the application.

[COMPANY NAME]

Drafting Note: The sentence "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 11. Separability

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

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Adopted by the Health Insurance and Managed Care (B) Committee - TBD
Adopted by the Regulatory Framework (B) Task Force – Nov. 4, 2024
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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].

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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.

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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

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(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.

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~~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 ~~addiction~~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.

GE. Notwithstanding Subsection D of this section, Thisthis 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.

HF. The enumeration in this section of specific precluded Policypolicy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with [cite Section 34B of the Accident and Sickness*Supplementary and Short-Term Health Insurance Minimum Standards Act*] that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

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 78. 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 supplementalA 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 8L9H 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 coverage~~s 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).

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(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

notices beis not required in the solicitation of the following types of policies: accident-only policies or the replacement of and single-premium nonrenewable policies.

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

NOTICE TO APPLICANT 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 furnishedprovided], you intend to lapse or otherwise terminate existing end the accident and sicknesssupplementary or short-term health insurance you have now and replace it with a policy to be issued bythe [insert company name] Insurance Company will issue. For your own information and protection, you should be aware of and seriously consider certain factors thatknow how replacing your policy with a new one maymight affect the insurance protection available to you under the new policyyour coverage.

(1) A new policy might not pay claims that the policy you have now would pay. A new policy might not cover Healthhealth conditions which you maythat you might presently have, now (preexisting conditions) or maymight not be immediately or fully covered under the new policycover 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 agentTalk with your current insurance agent regarding the proposed replacement of your presentor company representative about replacing your policy. This is not only your right, but itIt is also in your best interests to makebe sure you understand all the relevant factors involved in replacing your presenthow 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 certainbe sure to truthfully and completely answer all questions on the application concernabout your medical/health history. Failure to include all material medical information on an application may provide a basis forIf you do not, the company tocould deny any future claims and to refund your premium as though your policy had never been in force. After theCheck that the information on your application has been completedis 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 furnishedprovided], you intend to lapse or otherwise terminate existingend the accident and sicknesssupplementary 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 interest~~s~~ 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

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Agenda Item #6

Hear a Presentation from *NORC at the University of Chicago* on Proposed Research to Assess the Use of Artificial Intelligence (AI) to Conduct Utilization Management—*Lucy Culp (The Leukemia & Lymphoma Society [LLS]) and Lauren Seno (NORC at the University of Chicago)*

NORC Health

Artificial Intelligence in Health Insurance

The use and regulation of AI in utilization management

Presentation to the NACI Health Insurance and Managed Care (B) Committee

11.19.2024

Agenda

01 Report Overview

02 Key Findings

03 Recommendations

04 Conclusion

NORC Health

Our expertise in health-related issues, from aging to immunizations to insurance and health systems, informs programs and policies that affect the lives of millions.

Research You Can Trust™

Report Overview

NORC Health

The report was developed in partnership with the NAIC Consumer Representatives for Health

CONSUMER HEALTH ADVOCACY

AT THE NAIC

The research was divided into three phases:

1. **Environmental Scan** – Review and summarize white and grey literature to examine the current landscape of AI in health insurance decision making processes, with a focus on prior authorization as a form of utilization management (UM), and preliminary efforts to regulate it.
2. **Key Informant Interviews** – Supplement the environmental scan to create a more holistic view on the industry's current use and challenges of AI, including information that is not publicly known or published.
3. **Synthesis (White Paper Development)** – Combine the environmental scan and in-depth interview findings with policy recommendations.

Important Terminology

Artificial intelligence (AI) is a catch-all term referring to technologies that enable computers and machines the ability to mirror human learning and decision-making. Within AI, there are many different models and capabilities.

For this report, we are primarily focused on applications of **natural language processing (NLP) and machine learning (ML).** NLP is a form of AI that allows computers to understand, interpret, and generate human language. ML refers to the ability of computer systems to learn and adapt beyond its initial instructions.

Key Findings

NORC Health

KEY FINDINGS

1 PLAN USE

AI is regularly used by health insurance plans to conduct utilization management.

2 IMPACT

Stakeholders see immense opportunities but warn that proper safeguards are missing today and need to be in place protect consumers.

3 OVERSIGHT & REGULATION

Some states have begun to regulate the development and use of AI in health insurance but have not been able to keep up with the proliferation of the use of AI itself.

The primary benefit of using AI for utilization management is the ability to reduce clerical burden, expedite approvals for patients, and enable practitioners to practice at the top of their license.

– Health Plan Executive

The chance to monitor and test AI systems is a chance to test and monitor outcomes to the standard that society expects.

– Technical Expert

The AI tools being used today are based on historically biased data.

It's one thing to look at a model and say, 'this algorithm is biased based on the data that we use to develop it,' but there is also a gap in the patients who are able to fight back against the denials.

– Consumer Advocate

Health plans leverage the abilities of AI to make UM decisions, specifically to respond to prior authorization requests

Health plan sees the potential for AI to:

- Reduce administrative burden
- Allow clinical reviewers to work at the top of their license
- Speed approvals

Research focused on three primary ways health plans are using AI in UM:

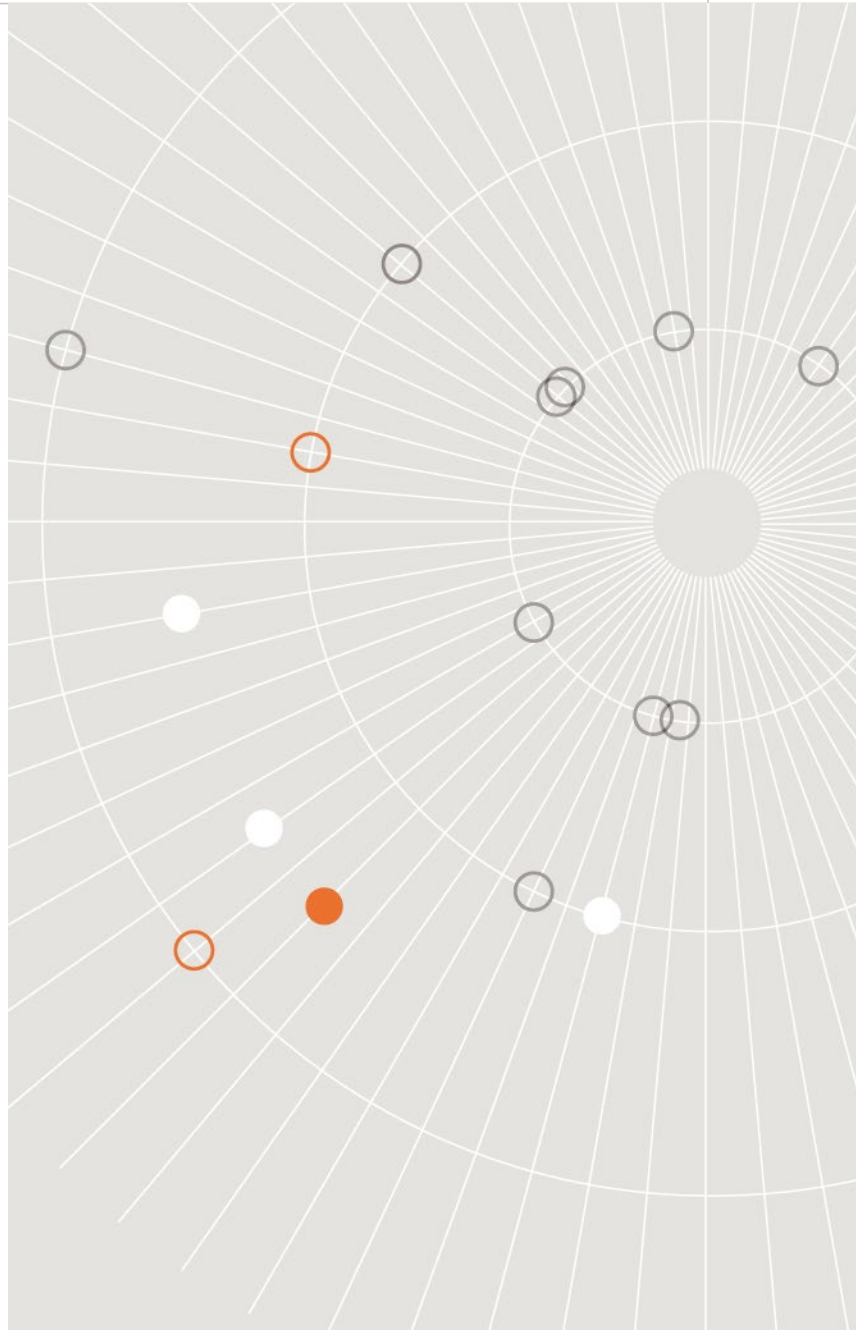
- Administrative-Only AI
- Decision-Making AI
- AI Learning Model

	Scans Large Datasets	Uses Fixed Inputs to Make Case Determinations	Evolves Algorithm Based on Data
Administrative-Only AI	✓		
Decision-Making AI	✓	✓	
AI Learning Model	✓	✓	✓

As AI tools are developed and deployed to make coverage decisions, concerns arise

In the absence of a comprehensive regulatory framework for the use of AI in health insurance, stakeholders have started to identify the potential risks that may adversely impact care delivery and health outcomes:

- **Tools trained by biased datasets**
- **Algorithms developed with misaligned incentives**
- **Machine learning systems developing their own processes**



As AI in UM expands, the state regulatory landscape has been uneven in its ability to keep up with advancements

- **States have started to develop their own approaches on how to best regulate this evolving environment**

- **Many organizations have developed frameworks on how AI should be used and regulated in health insurance practices**

NAIC	NHeLP	National Health Council	AMA	AHIP

NHeLP = National Health Law Program; AMA = American Medical Association, AHIP = America's Health Insurance Plans

CONSUMER HEALTH ADVOCACY AT THE NAIC

RECOMMENDATIONS

CONSUMER HEALTH ADVOCACY AT THE NAIC

Transparency, both to regulators and consumers, is seen as a crucial component of AI oversight as seen in both regulatory and legislative action to date, and as reflected in the guiding principles for AI put forward by health care advocates.

Transparency is critical to hold health insurance plans accountable, and when appropriate, liable for the harm caused by the integration of AI into UM activities. Accountability is necessary to hold parties liable for harm.

Regulators need to ensure that health insurance companies place humans with the appropriate clinical training, authority, at the center of decisions that impact patient care. Accessible appeals processes must be considered a right for all consumers.

Transparency, both to regulators and consumers, is seen as a crucial component of AI oversight

CONSUMER HEALTH ADVOCACY AT THE NAIC

- **Meaningful transparency is critical**; it must be clear, to both regulators and consumers, when AI is being used by health insurance plans for the purposes of UM and what role the AI plays in making determinations about coverage for care
- **Transparency must extend to disclosures about the data used to develop, train, and test the AI tools** (with an emphasis on consent for use and representativeness of the population), and the extent to which any AI tool can begin to train itself
- **Existing laws that are used to regulate data should be assessed for their applicability** to AI in utilization management

The reliance on proprietary technologies obscures accountability for decisions when harm is done

CONSUMER HEALTH ADVOCACY AT THE NAIC

- **Transparency is a necessary precursor** for any complaint or action taken to enforce regulation
- **Regulatory standards must clearly identify which parties are accountable** (e.g., health plans, technology developers, etc.) when AI tools are used in UM decisions that lead to consumer harm, including discrimination, breeches of privacy, and incorrect adverse determinations
- **Regular audits**, conducted on behalf of state regulatory agencies by parties with specialization in testing AI technologies, can be an effective way to both understand the ways AI is used in making UM decisions and hold the plans accountable for its use
- AI tools intended for UM decisions should be **built on standards of care that aim to achieve the highest level of quality**, and penalties for non-compliance need to be significant enough to have influence
- Governance structures that **measure and prevent harm to historically marginalized and minoritized populations** must be required

Human oversight is important, but is not a panacea and accessible appeals processes must be prioritized

CONSUMER HEALTH ADVOCACY AT THE NAIC

- **Robust and accessible appeals processes** for coverage denials need to be established and considered a guaranteed right for all health insurance consumers
- **Human oversight must be embedded into UM when AI is used** and those reviewers must have the authority and ability to overturn decisions made by the AI without undue consequences
- **AI regulation needs to be considered an evolving practice**, that relies on collaboration between regulators, technical experts, industry stakeholders, consumers, and consumer advocates

CONSUMER HEALTH ADVOCACY AT THE NAIC

CONCLUSIONS

CONSUMER HEALTH ADVOCACY AT THE NAIC

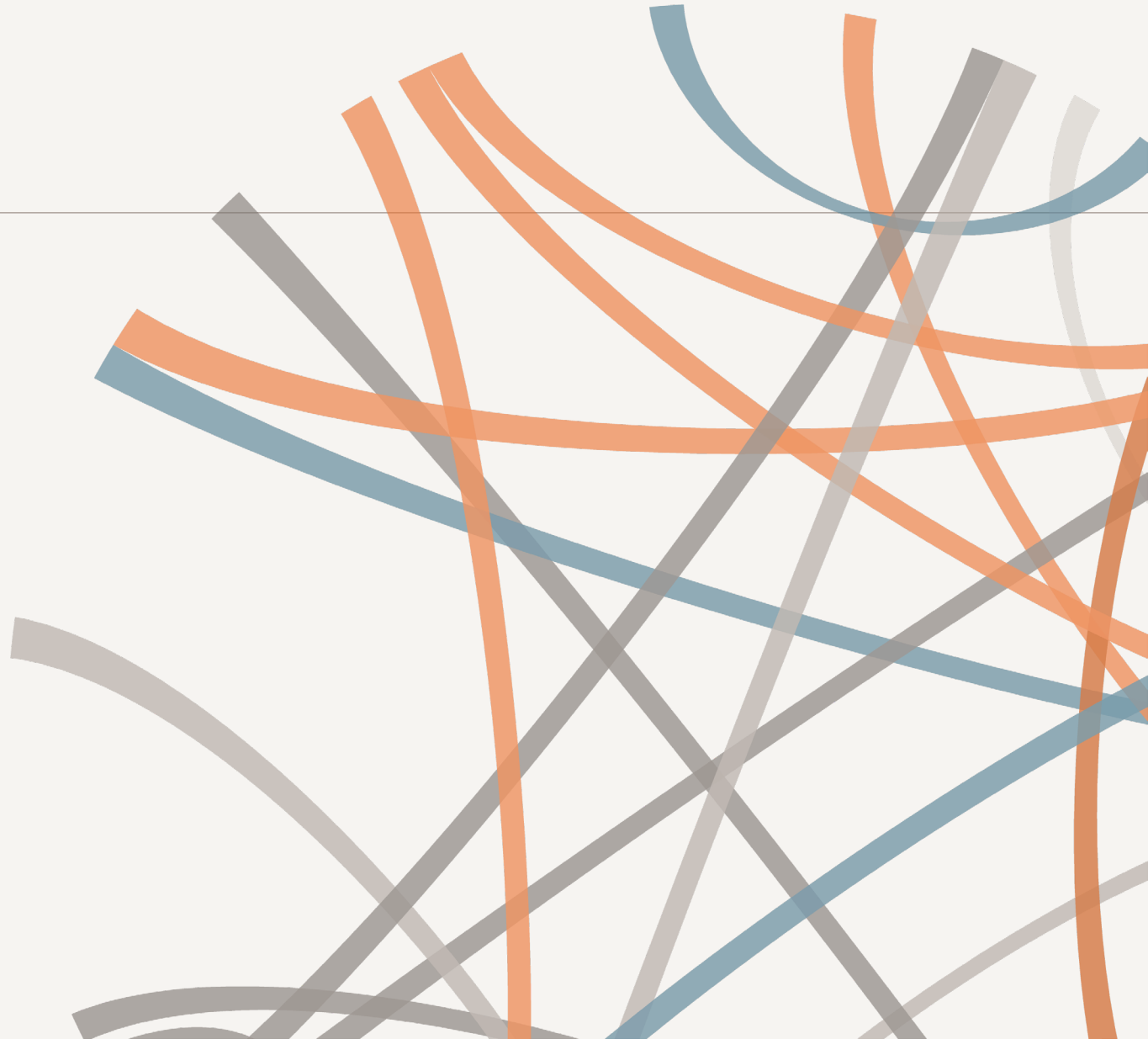
The time to act is now

The rapid expansion of AI tools in health care insurance demands immediate regulatory attention to protect consumers from potential harm and discrimination, when AI is used in UM decisions.

While this report outlines some key considerations, it is not exhaustive and instead attempts to offer a foundation for understanding current AI use cases in UM and highlights the urgent need for state and industry leaders to examine and regulate these practices.

The importance of acting now cannot be overstated. Without immediate safeguards, the risks posed by unchecked AI in health insurance processes will only continue to grow.

Questions?



Thank you.

Lauren Seno
Director
seno-lauren@norc.org

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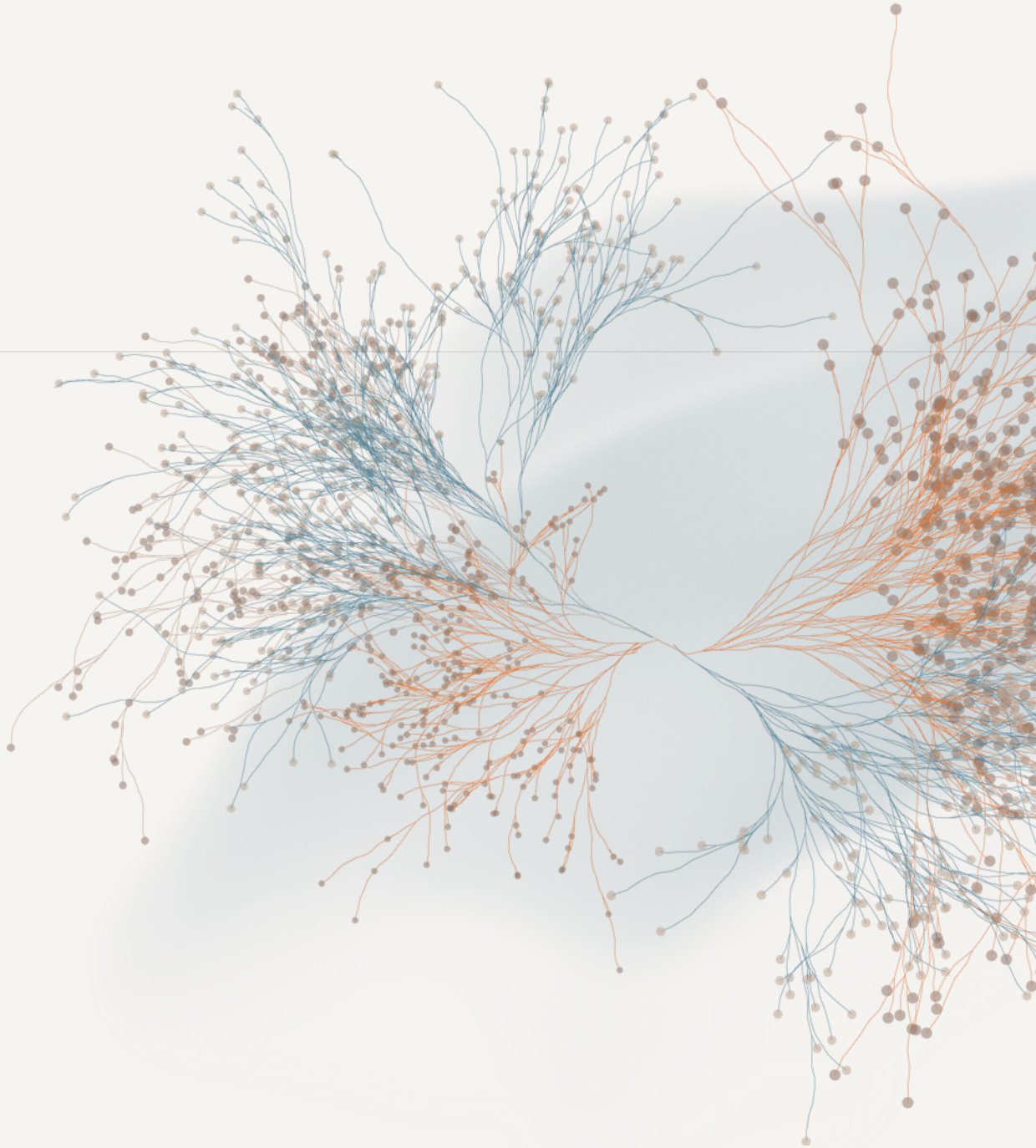
Appendix



Environmental scan search terms were grouped into three main categories

1. **Utilization Management**
   - Use of AI by health plans in UM
   - Most common applications of AI in UM
2. **Equity and Bias**
   - How is bias measured and monitored in AI generally? By plans or regulators specific to AI in UM?
   - Status of state regulatory actions – have states implemented self-assessments or currently monitor for bias?
3. **Technical Components**
   - Are the tools or applications leveraging AI in UM aligned with intended purpose?
   - How are the tools trained, tested, and monitored?

Search Parameters

- Limited to materials published in/related to the US only
- Date range: 2009 – 2014
  - Expected most literature to be from 2018 – present, but wanted to be inclusive
- 219 initial results (113 included after secondary review)

Complete primary and detailed search terms are available in the Appendix.

Primary Search Terms	Detailed Search Terms
Utilization Management	
Application*, **or use*** of AI in insurance utilization management practices	(“application” OR “use”) AND (“AI”) AND (“HEALTH INSURANCE”) (“utilization management” OR “prior authorization” OR “denials” OR “care management” OR “managed care” OR “claims analytics”)
Application*, **or use*** of AI in insurance utilization management practices by service line	(“application” OR “use”) AND (“AI”) AND (“HEALTH INSURANCE”) AND (“SERVICE LINE” OR “CONDITION” OR “DISEASE” OR “HEALTH CONCERN”) (“utilization management” OR “prior authorization” OR “denials” OR “care management” OR “managed care” OR “claims analytics”)
Equity / Bias	
Standards*, **or measures*, or assessments*,** to prevent biases in AI training in health care*, **or health insurance***	(“standards” OR “measures” OR “assessments) AND (“prevent” OR “mitigate”) AND (“biases in AI training” OR “biases in AI development”) AND (“health care” OR “health insurance”)
Current tests for detecting biases in AI in health care*, **or health insurance***	(“current” OR “existing” OR “validated”) AND (“tests for detecting biases in AI”) AND (“health care” OR “health insurance”)
Technical Components	
AI for utilization management in health care*, **or health insurance***, intended use*, **or purpose*, or application***	(“AI”) AND (“utilization management” OR “prior authorization” OR “denials” OR “care management” OR “managed care” OR “claims analytics”) AND (“health care” OR “health insurance”) AND (“intended use” OR “intended purpose” OR “intended application”)
AI for health care*, **or health insurance*,** training standards*, **or measures*, or practices*** at development*, **or ongoing**	(“AI”) AND (“health care” OR “health insurance”) AND (“training standards” OR “training measures” OR “training practices”) AND (“development” OR “ongoing”)

Each interview had a tailored interview guide, but each conversation aimed to cover five main questions

1.

How has the use of AI in UM evolved in the past five to ten years?

How are plans using AI today? How might that evolve in the future?

2.

What are the intended outcomes for the use of AI in UM?

When functioning as intended, what impact is AI having on cost and quality of care?

3.

What unintended outcomes have we seen that are the biggest concern?

What impact does AI in UM have on historically marginalized and minoritized communities?

4.

How do current policy or regulatory actions address these concerns?

What state and federal policies exist today that can be applied to AI in UM? Where are the gaps?

5.

What policy or regulatory actions are needed to prevent consumer harm?

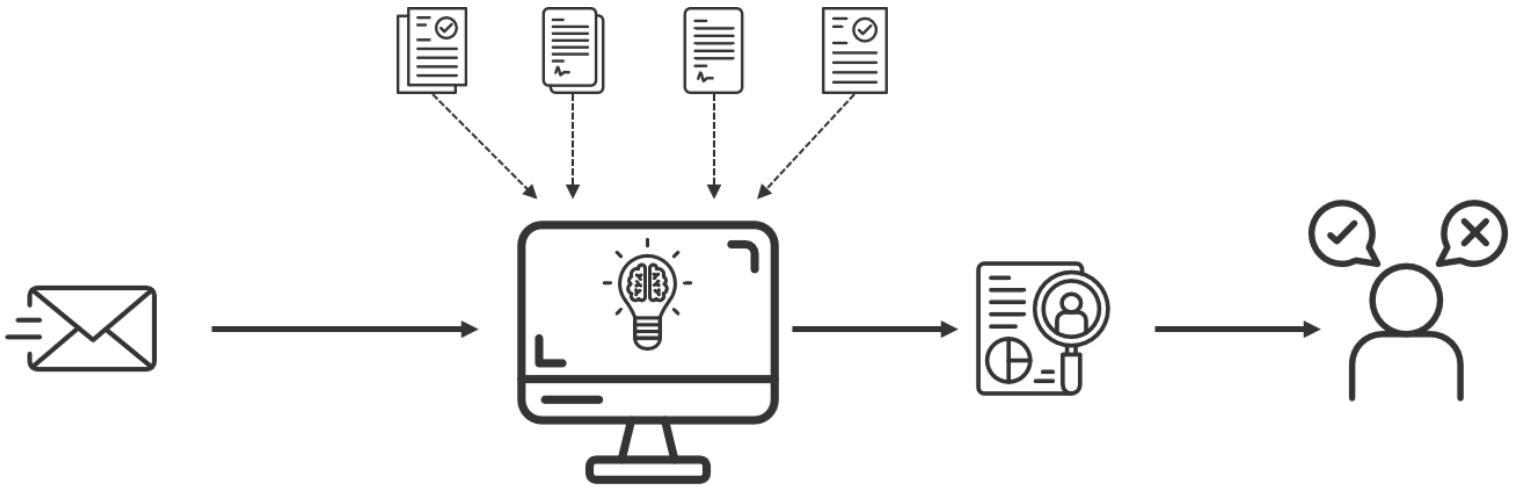
What should regulators consider when shaping potential action to prevent harm when AI is used in UM?

Key Informant Interview Participants

Perspective	High-Level Descriptor
Health Plan	Analytics Executive at a Regional Health Plan
Thought Leader	Health Policy Professor
Consumer Advocate	Attorney for Underserved Patients and Families
Consumer Advocate	Leader at a Patient Advocacy Organization*
Regulator	Representative from a State Department of Insurance
Technical Expert	Algorithmic Design and Measurement Consultant
Provider	Representatives from a Trade Group for Physicians

*The second consumer advocate provided written responses to the structured interview questions.

Example 1: Administrative-Only AI in UM

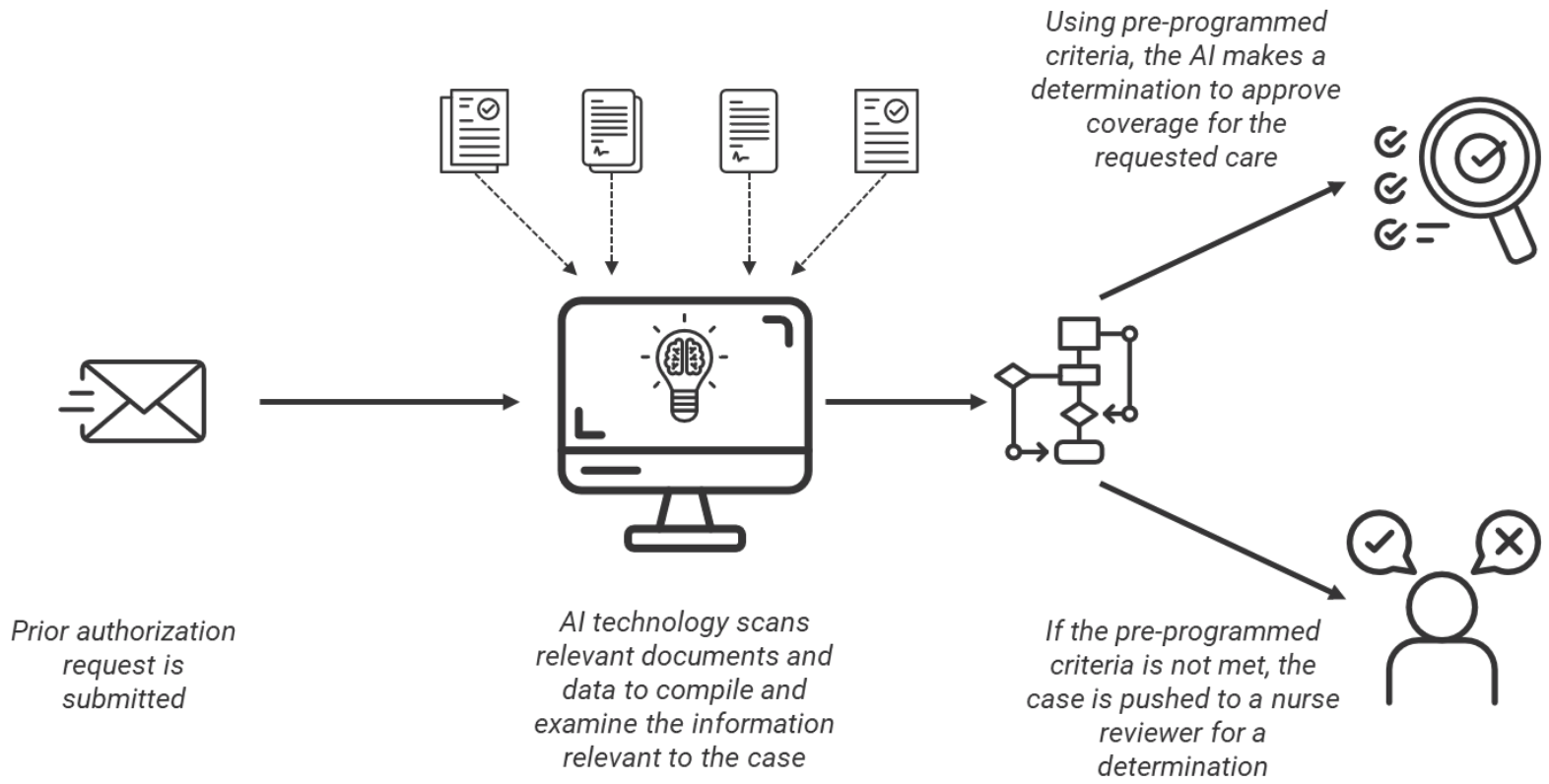


Prior authorization request is submitted

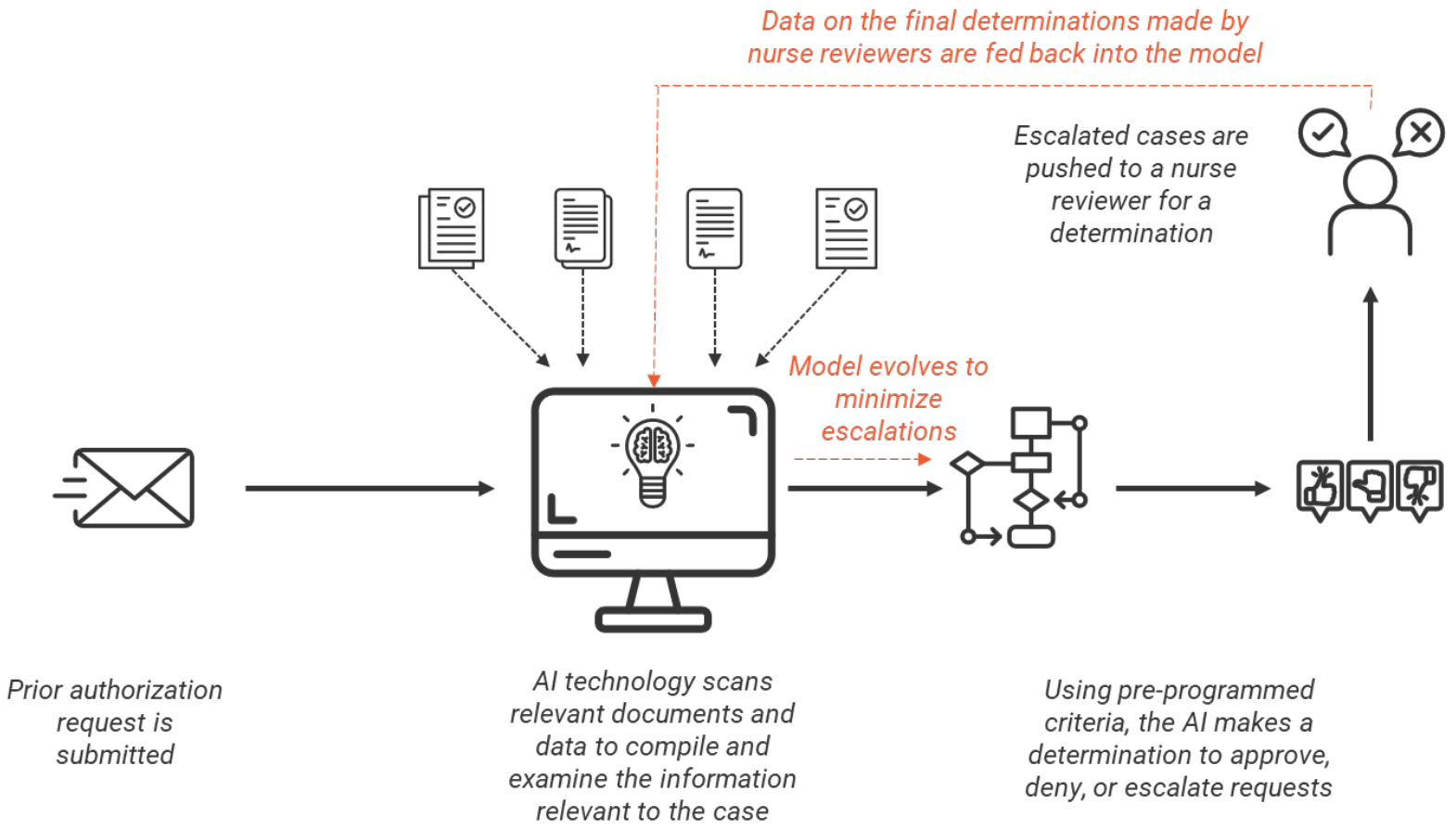
AI technology scans relevant documents and data to pull forward the information relevant to the case

The relevant information is submitted to the nurse reviewer for their determination

Example 2: Decision-Making AI in UM



Example 3: AI Learning Model for UM



Agenda Item #7

Hear a Presentation from the Center for Insurance Policy and Research (CIPR) on Small Group Market Trends—*Kelly Edmiston (CIPR)*

Trends in the Small Business Health Insurance Market

Kelly D. Edmiston, Ph.D.
Policy Research Manager

with Gayle Brekke

NAIC 2024 Fall National Meeting

11/19/2024

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Insurance Requirements for Small Businesses Under the ACA

- **< 50 FTE**
  - **Not required** to provide health insurance; no penalty if do not offer health insurance.
  - May use the **Small Business Health Options Program (SHOP)** (*later*)

- **≥ 50 FTE** (< 400 FTE)
  - **Required** to provide health insurance that meets certain minimum standards or may be subject to the **Employer Shared Responsibility Payment**.
    - Do not offer coverage to at least 95 percent of FTE that meets ACA requirements.
    - Do not cover minimum actuarial value (60%).
    - Is not affordable (≤ 9.66% HH income).

Penalties

- Penalties are considerably smaller than for ALEs (Applicable Large Employers).
  Do Not Offer Coverage: Penalty = (FTE – 30) x (1/12)($2,000) monthly
  Do Offer Coverage: Penalty = $3,000 x (FTE receiving premium tax credits) annually

Key Challenges

Cost is the Primary Challenge

Trends in the Small Business Health Insurance Market

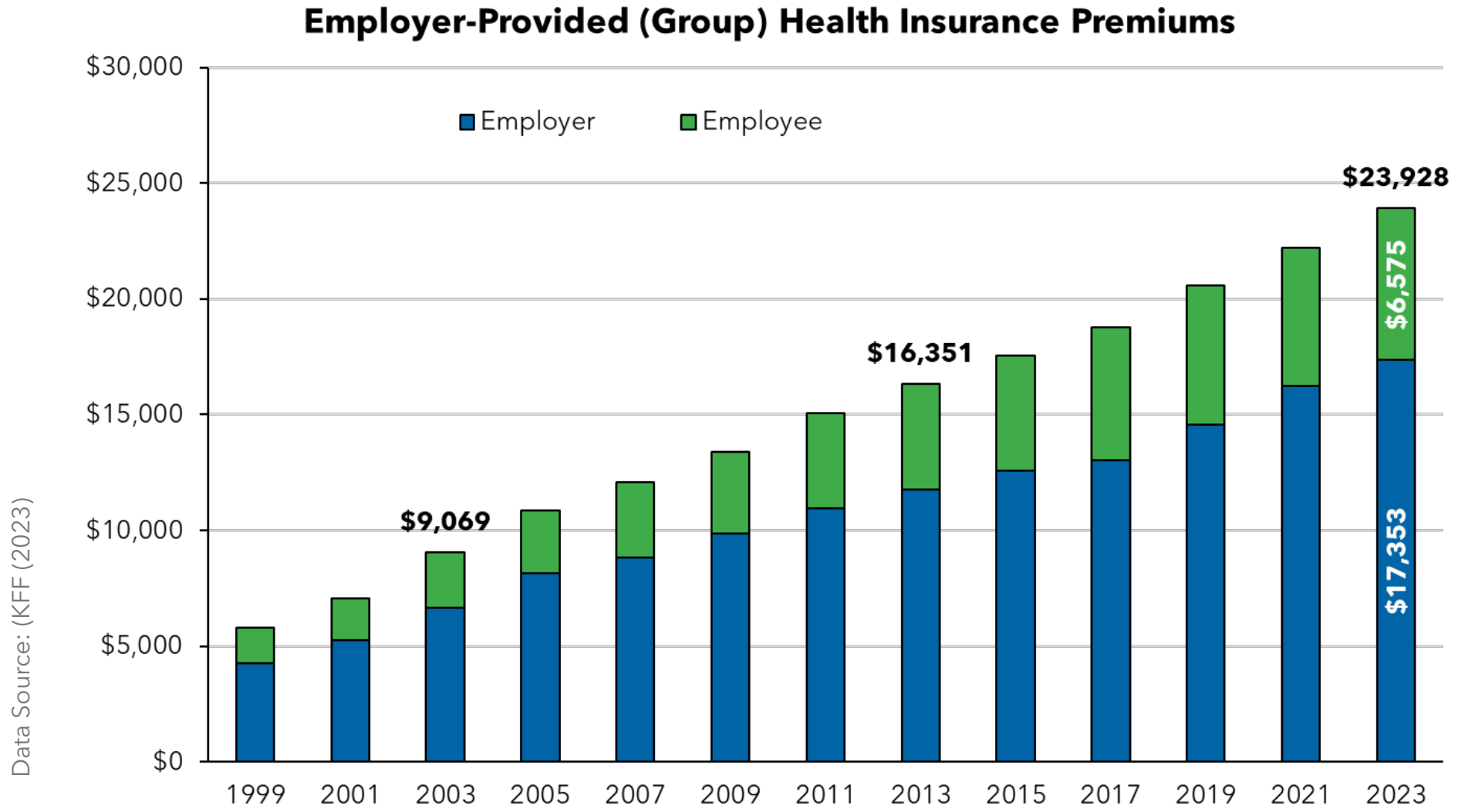
NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Key Challenges

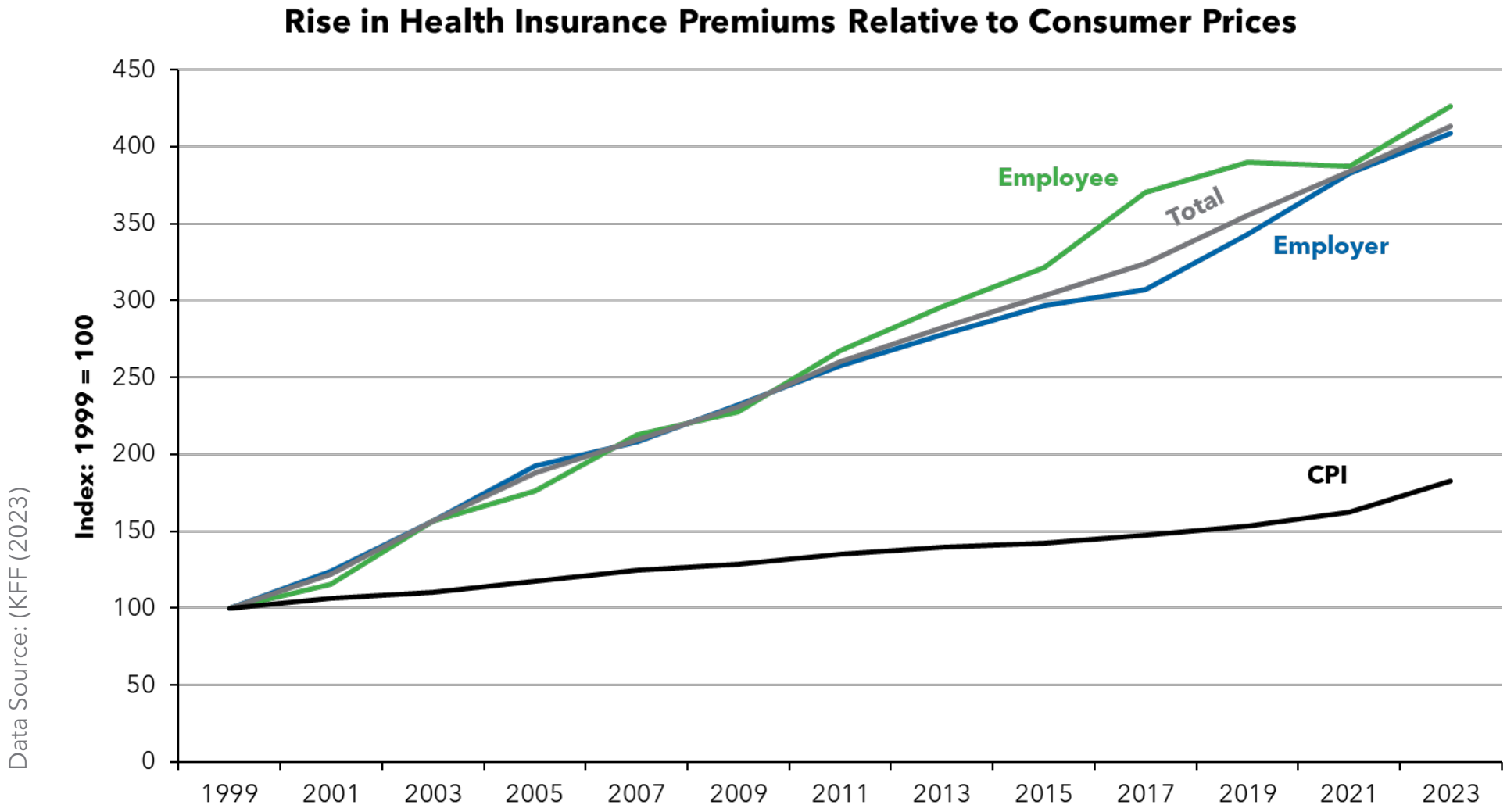
- Prior to the ACA, small-group insurance was largely **risk-rated**.
- Small businesses have **smaller populations** over which to **pool risk** and **spread fixed costs**.
- Still, there were thriving markets for small business health insurance, so the problem was **not so much obtainability as cost**.
  - Employers with older and/or sicker workers or employees with high-risk jobs found health insurance especially **difficult to afford**.
  - Small business employee coverage, especially for businesses with few workers or lower-wage workers, generally was **cost-prohibitive**.
- Under the ACA, insurers must accept every small employer that applies for coverage and all its employees. But **guaranteed issue does not guarantee affordability**.

†Drawn largely from Jost (2012).

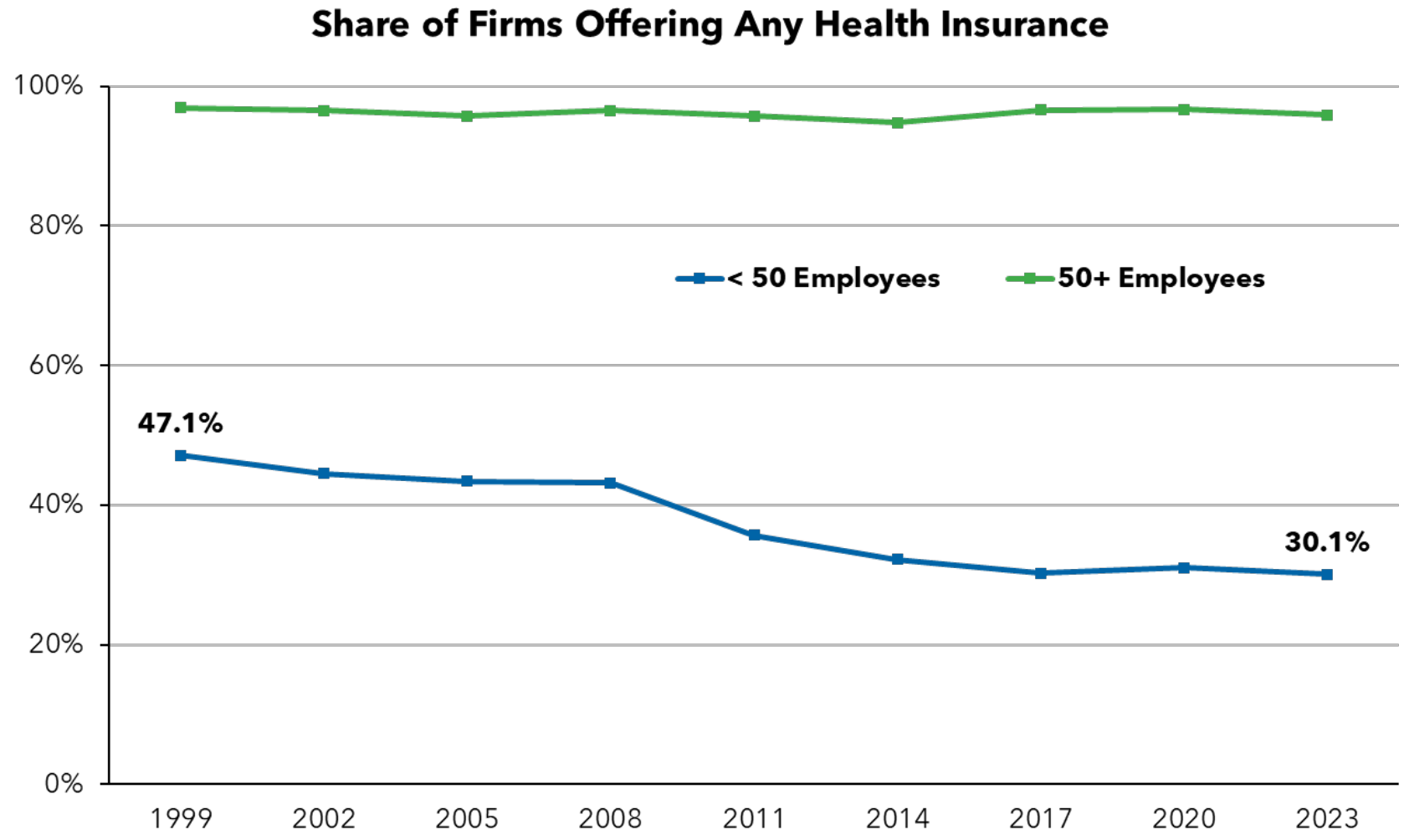
Health Insurance Premiums Are Rising Dramatically



Health Insurance Premiums Are Rising Dramatically

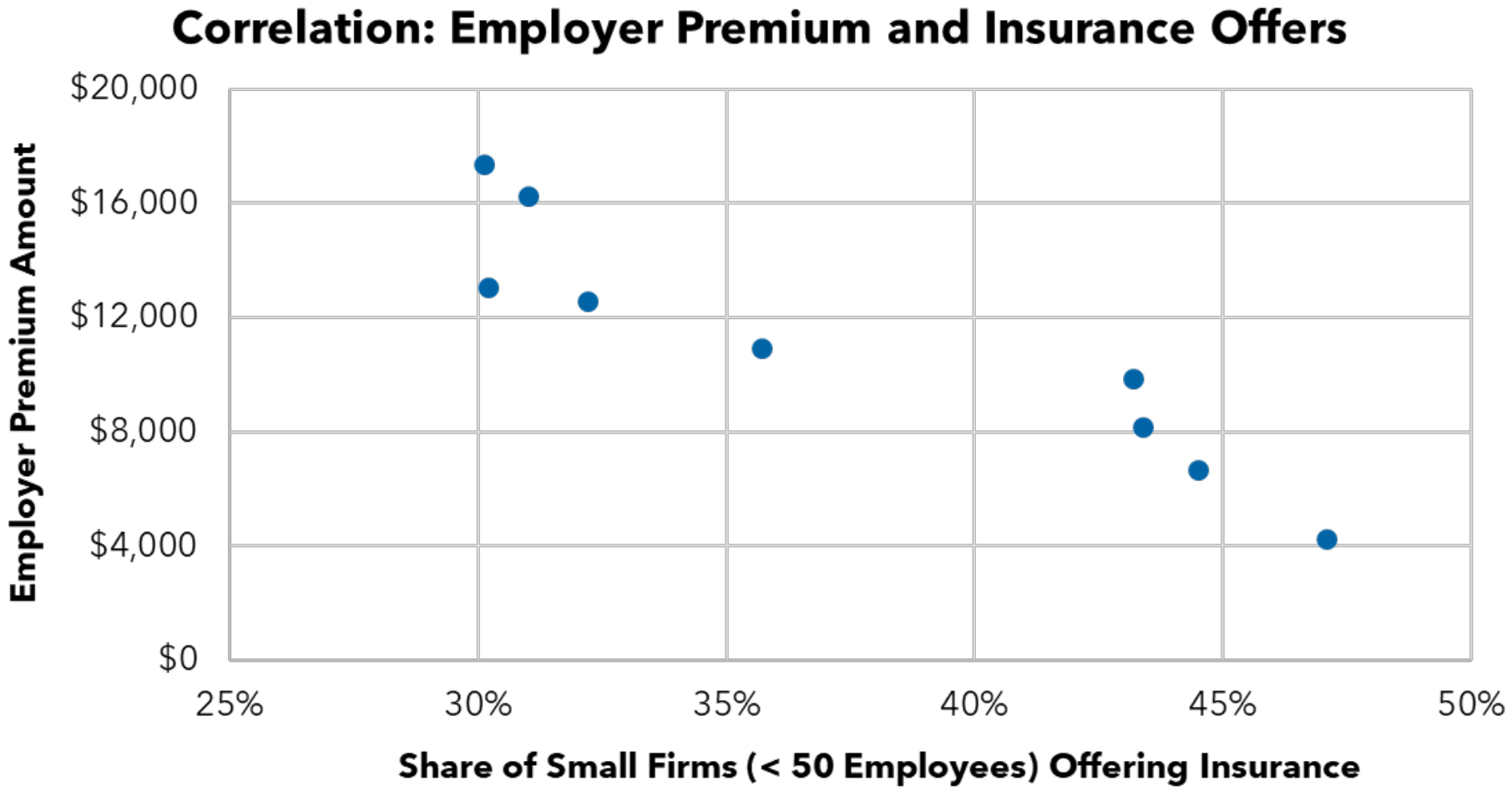


Firms Offering Health Insurance: Small (< 50) vs. Large (≥ 50)



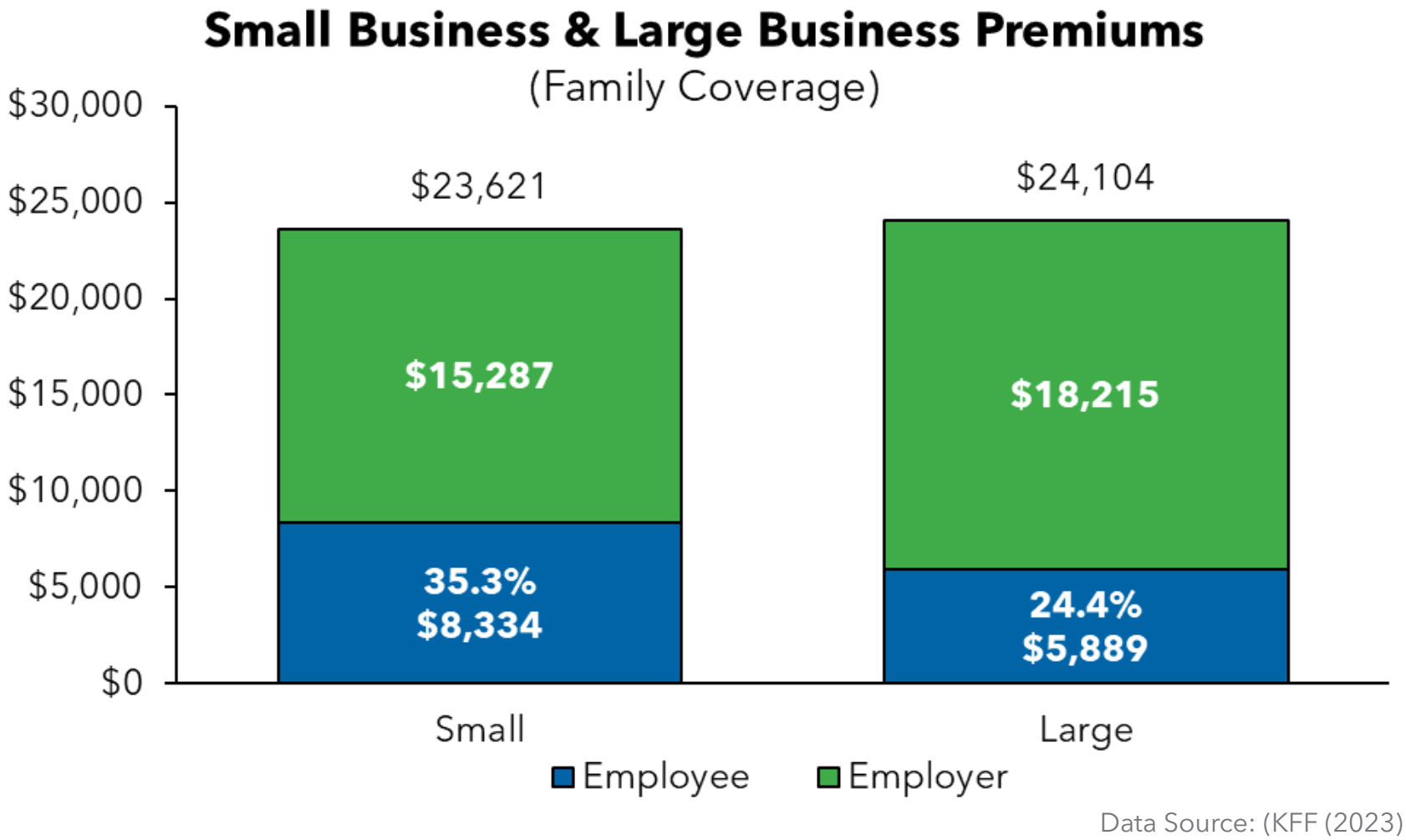
Data Source: MEPS-IC

Correlation Between Employer Premium & Insurance Offers



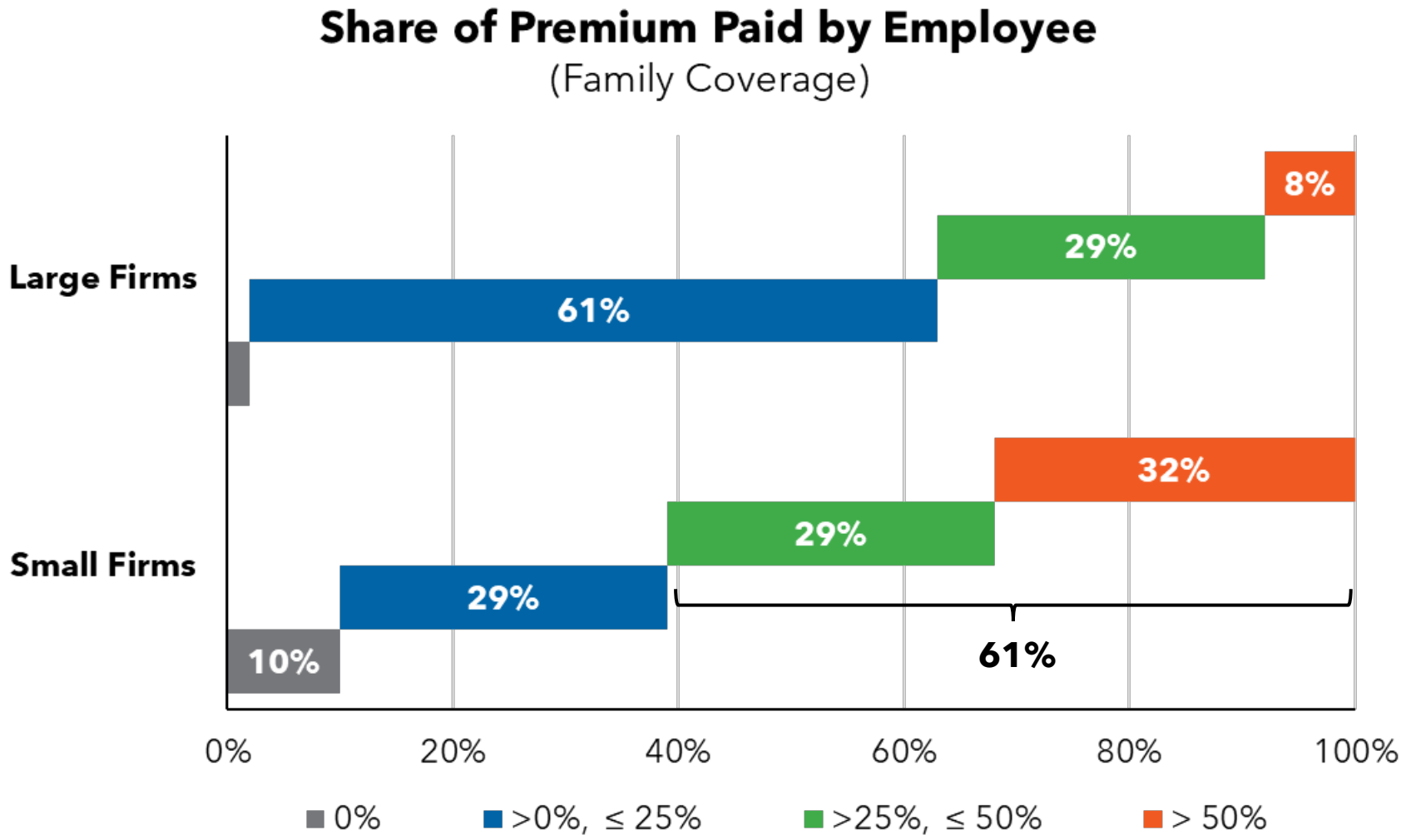
Data Sources: (KFF (2023); MEPS-IC

Employees at Small Businesses Pay More for Coverage



Data Source: (KFF (2023)

Employees at Small Businesses Pay More for Coverage



Data Source: (KFF (2023)

Small Business Health Insurance Options

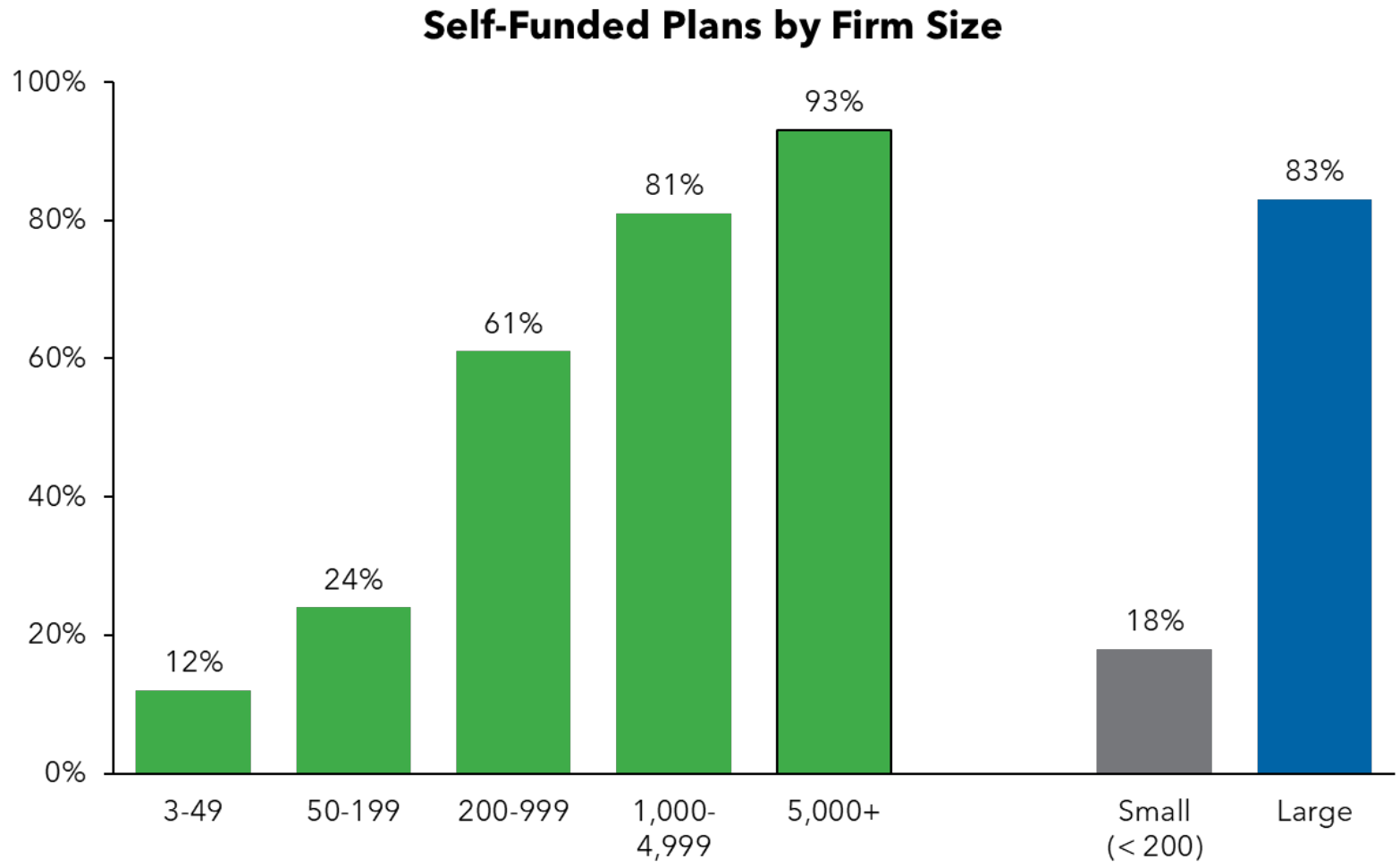
Trends in the Small Business Health Insurance Market

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Small Business Health Insurance Options

- Purchase a **Small Group Plan** directly from a commercial health insurance company that serves small businesses or through a broker.
  - Gives employer control over which plans to offer
  - But also, may require COBRA or mini-COBRA plans (< 20) (varies by state).
- Use a **Self-Funded Plan** – employer takes responsibility for paying employee health claims.
  - Typically relies on a commercial health insurer to administer the provider network and process claims.
  - Can avoid some high-cost requirements of the ACA.
  - **Increasingly, small businesses are opting for self-funded coverage**. But the risk is large, especially for the smallest firms.

Firms with Self-Funded Health Insurance Plans by Size

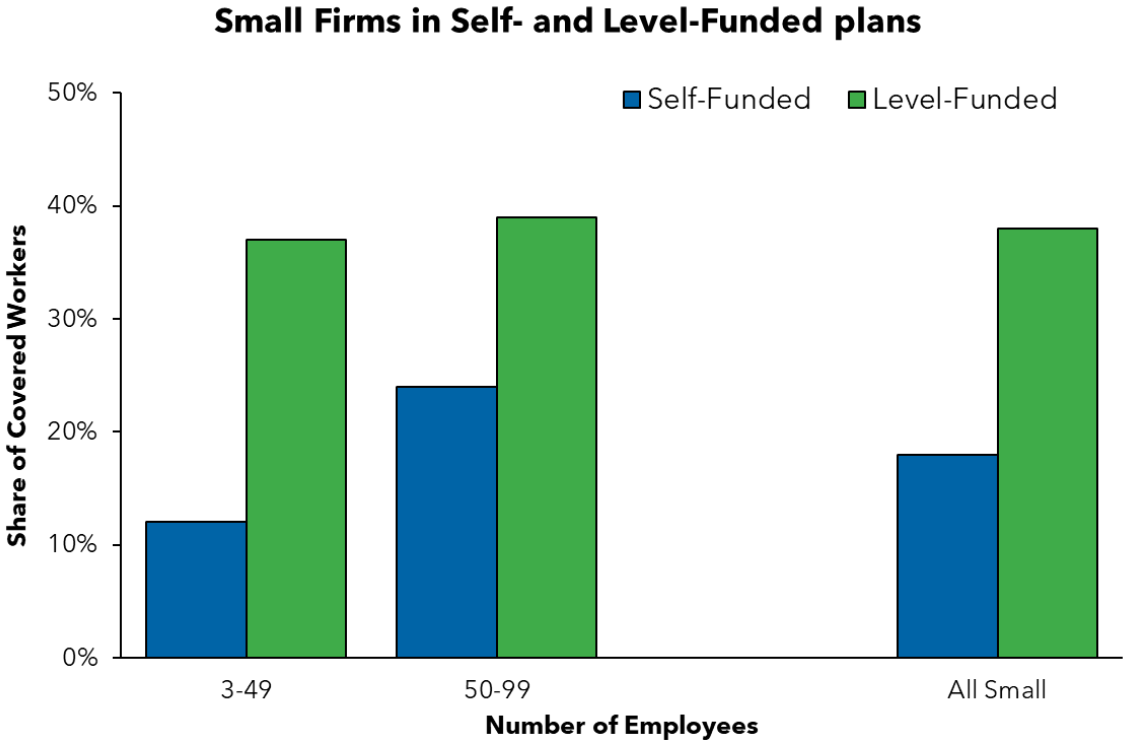


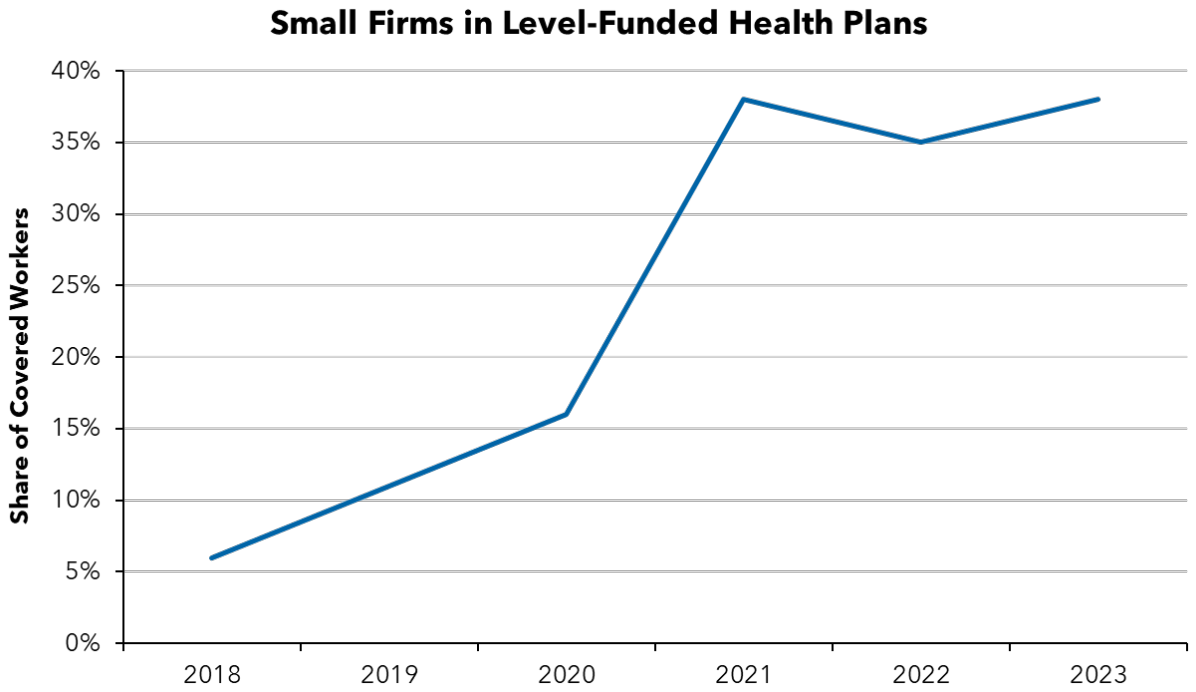
Data Source: (KFF (2023)

Small Business Health Insurance Options

- Use a **Level-Funded Plan** – nominally self-funded plans designed for small- and medium-sized businesses.
  - Incorporate stoploss insurance with relatively low attachment points.
  - Employer pays a level "premium" to the insurer (expected claims, administrative), usually with a settling at year-end.
  - Small employers are often **protected from any meaningful additional liability**.
  - Because they are self-funded plans, they are **not subject to state regulatory requirements**.
  - For employers with < 50 employees, not subject to community rating and benefit standards in the ACA.
  - **Small firms are taking up level-funded plans in large numbers**.

Firms with Level-Funded Health Insurance Plans





Data Source: (KFF (2023)

Small Business Health Insurance Options

- **Offer a Health Reimbursement Arrangement** (HRA) – an employer-funded group plan that pays employees back for qualified health expenses up to a maximum annual amount.
  - Employers choose an amount to give each employee to **purchase their own coverage**.
  - May also cover deductibles, copays, coinsurance, etc. (*employees must have individual coverage or Medicare to take advantage*)
    - An **Individual Coverage HRA** (**ICHRA**) allows employees to use funds to buy their own health insurance with pretax dollars (also deductibles, copays, etc., if desired).
    - The similar **Qualified Small Employer HRA** (**QSEHRA**) is for companies with fewer than 50 FTE that do not offer a group plan. Allows small businesses to subsidize their employees' health care costs. Money reimbursed through the plan is tax-free for employees and tax-deductible for employers.
- These plans also are **increasingly popular** for small businesses.

Small Business Health Options Program (SHOP)

- Leverage the **Small Business Health Options Program** (**SHOP**), which offers one or multiple options to employees on the ACA Marketplace.

- An exchange where firms with < 100 employees (2017) could purchase health insurance; **similar to individual exchanges** (Marketplace).
  - Enrollment **lagged from the start**; never really took off.
  - Difficult to find insurers that want to offer small business on the Marketplace.
  - Some states (8?) have a SHOP component on their state-based exchanges.

- Efforts to energize the Marketplace and more attractive options and better experiences seem to be **targeted to the individual purchase exchanges**.

Contact Information

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References

Jost, T. S. (2012). Employers And The Exchanges Under The Small Business Health Options Program: Examining The Potential And The Pitfalls. *Health Affairs*, *31*(2), 267-274. doi:10.1377/hlthaff.2011.1011.

Kaiser Family Foundation [KFF] (2023). 2023 Employer Health Benefits Survey. October 18. [§§1, 6, 10]

Agenda Item #8

Hear an Update from the Federal Centers for Medicare & Medicaid Services' (CMS') Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities
—Jeff Wu (CCIIO)

Agenda Item #9

Discuss Any Other Matters Brought Before the Committee
—Director Anita G. Fox (MI)