***Model Regulation to Implement the Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#171)**

Suggested Revisions to Oct. 12, 2023, Draft

**(Assuming the proposed draft revisions are accepted)**

December 1, 2023, Comment Deadline Comments

|  |  |
| --- | --- |
| **Section 5. Definitions** | |
| For purposes of this regulation:  A. “Medicare” means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.  B. “Short-term, limited-duration insurance” means health insurance coverage offered or provided within the state pursuant to a contract by a health carrier, regardless of the situs of the delivery of the contract, that has an expiration date specified in the contract that is less than [X days or months] after the original effective date and, taking into account any extensions that may be elected by the policyholder with or without the carrier’s consent, has a duration of no longer than [X days or months] after the original effective date of the contract. | |
| **Schiffbauer Law Office** | **SCHIFFBAUER LAW OFFICE COMMENTS:** ADD: "C. EXCEPTED BENEFITS MEANS COVERAGE LISTED AT SECTION 2791(C) OF THE PUBLIC  HEALTH SERVICE ACT (OR SUBSEQUENTLY ADDED BY REGULATION WHERE AUTHORIZED)", OR SOMETHING SIMILAR. THE MODEL ACT REFERS TO "EXCEPTED BENEFITS" IN SECTION 5, AND IN SEVERAL DRAFTING NOTES.  C. “Excepted benefits” means coverage listed at section 2791(c) of the Public Health Service Act (or subsequently added by regulation where authorized. Put the definition in the first drafting note that references the term (yes, subgroup agreed to add in the first drafting note where referenced, 1/29/24). |
|  |  |
| **Section 6. Policy Definitions** | |
| **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; (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) 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. | |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE RECOMMEND REMOVING THE WORD “HOME” THROUGHOUT THIS DEFINITION AND REPLACE WITH “FACILITY” AS THIS IS OUTDATED LANGUAGE NO LONGER USED TO REFER TO THESE TYPES OF FACILITIES. FOR PARAGRAPH (1), THESE PARTS DESCRIBE A LEVEL OF CARE THAT IS INCONSISTENT WITH THE TERMS THEY ARE DEFINING ABOVE. FOR EXAMPLE, MANY CONTINUED CARE RETIREMENT COMMUNITIES DO NOT PROVIDE 24-HOUR NURSING, MEANING THIS DEFINITION IS UNNECESSARILY RESTRICTIVE. RECOMMEND REVISITING THESE DEFINITIONS OR CHANGING THE “AND” AT THE END OF (D) TO AN “OR”.  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. Remove “assisted living facility and continued care retirement community from this definition and add a new definition for these facilities without (d) agreed 1/29/24). Did not accept “home” suggestion either.  (1) A definition of the (did not accept 1/29/24) 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) Provide continuous twenty-four-hour-a-day nursing service by or under the supervision of a registered nurse; or (did not accept 1/29/24) (e) Maintain a daily medical record of each patient.  (2) The definition of the facility is permitted but is not required to exclude: (a) A facility or part of a facility used primarily for rest; (b) A facility for the aged and/or for the care of individuals with a substance use disorder; or (c) A facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.  **Drafting Note:** The laws of the states relating to nursing and extended care facilities recognized in health insurance policies are not uniform. Reference to the individual state or federal Medicare or Medicaid law may be required in structuring this definition. |
|  |  |
| **C. “Hospital” means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission.**  **(1) The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital: (a) Be an institution licensed to operate as a hospital pursuant to law; (b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and (c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.**  **(2) The definition of the term “hospital” is permitted but is not required to exclude: (a) Convalescent homes or, convalescent, rest or nursing facilities; (b) Facilities affording primarily custodial, educational or rehabilitory care; (c) Facilities for the aged or individuals with a substance use disorder; or (d) A military or veterans’ hospital, a soldiers’ home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services.** | |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE RECOMMEND DELETING PART (2) (d) AS THIS UNNECESSARILY ALLOWS FOR COVERAGE EXCLUSIONS FOR MEMBERS OF THE MILITARY OR VETERANS.  C. “Hospital” means in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission.  (1) The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital: (a) Be an institution licensed to operate as a hospital pursuant to law; (b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and (c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.  (2) The definition of the term “hospital” is permitted but is not required to exclude: (a) Convalescent homes or, convalescent, rest or nursing facilities; (b) Facilities affording primarily custodial, educational or rehabilitory care; or (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..Retain (d), but broaden exception removing “emergency basis.” 2/12/24 |
|  |  |
|  |  |
| **H. “Partial disability” shall be defined to meant that, due to a disability, an individual:**  **(1) Is unable to perform one or more but not all of the “major,” “important” or “essential” duties of the individual’s employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and**  **(2) Is in fact engaged in work for wage or profit.** | |
| **NAIC consumer representatives**  **(NOTE TO THE SUBGROUP: A SIMILAR COMMENT WAS PREVIOUSLY DISCUSSED AND NOT ACCEPTED DURING A NOV. 19, 2019, CONFERENCE CALL)** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE RECOMMEND INCLUDING GOODS AND SERVICES IN THIS DEFINITION TO ACCOUNT FOR CARE PROVIDERS WHO MAY BE PARTIALLY OR FULLY COMPENSATED THROUGH HOUSING.  H. “Partial disability” shall be defined to meant that, due to a disability, an individual:  (1) Is unable to perform one or more but not all of the “major,” “important” or “essential” duties of the individual’s employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and  (2) Is in fact engaged in work for wage or profit, including for goods and services. Subgroup did not accept 2/12/24. |
|  |  |
|  |  |
| **I. (1) “Physician” means and includes words such as “qualified physician” or “licensed physician.” 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. | |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** THE SUBGROUP SHOULD REVIEW PARAGRAPH (2) TO ENSURE IT INTENDED TO CREATE SUCH A BROAD EXCLUSION. THE WAY WE INTERPRET THIS DEFINITION NOW, IT WOULD SEEM THAT THESE POLICIES COULD EXCLUDE CARE DELIVERED TO A HOSPITAL EMPLOYEE THEY MIGHT RECEIVE AT THE FACILITY IN WHICH THEY WORK OR FROM CARE DELIVERED BY A FAMILY MEMBER.  I. (1) “Physician” means and includes words such as “qualified physician” or “licensed physician.” 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. Left unchanged 2/12/24  **Drafting Note**: The laws of the states relating to the type of providers’ services recognized in health insurance policies are not uniform. References to the individual state law may be required in structuring this definition. |
|  |  |
| J. (1) “preexisting condition” means a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person.”  **Drafting Note:** This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer’s established standards and in accordance with state law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy or certificate will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured’s health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured’s health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.  **NOTE TO THE SUBGROUP: THE SUBGROUP NEEDS TO RETURN TO THIS DEFINITION TO DISCUSS A DEFINITION FOR STLD PLANS TO INCLUDE IN PARAGRAPH (2) BELOW. THE SUBGROUP SHOULD ALSO CONSIDER IF SUCH A DEFINITION IS NEEDED.**  ( agreed to this 2/26/24 | |
| **American Council of Life Insurers (ACLI)** | **ACLI COMMENTS:** WE BELIEVE THAT THE CURRENT DEFINITION IS APPROPRIATE AND SHOULD NOT BE CHANGED FOR THE SUPPLEMENTARY BENEFITS IN THE MODEL. WE BELIEVE IT IS IMPORTANT TO RECOGNIZE THAT STLDI IS VERY DIFFERENT IN PURPOSE, FORM, AND FUNCTION THAN SUPPLEMENTARY BENEFITS AND THEREFORE, IF THERE IS ANY CONSIDERATION OF MODIFYING THE DEFINITION TO REFLECT THE SHORT-TERM NATURE OF STLDI OR ANY OTHER FACTORS NOT APPLICABLE TO SUPPLEMENTARY BENEFITS, THAT SHOULD BE DONE BY CREATING A DEFINITION OF “PREEXISTING CONDITION” APPLICABLE TO STLDI THAT REMAINS SEPARATE AND DISTINCT FROM THE DEFINITION OF PRE-EXISTING CONDITION THAT APPLIES TO SUPPLEMENTARY BENEFITS. |
| **AHIP** | **AHIP COMMENTS (IN PART):** AHIP RECOMMENDS THE SUBGROUP CREATE A SEPARATE PREEXISTING CONDITION DEFINITION THAT REFLECTS THE DIFFERENCE BETWEEN THE MAJOR MEDICAL COVERAGE PROVIDED BY STLDI AND SUPPLEMENTAL COVERAGE. … THE DEFINITION OF “PREEXISTING CONDITION” CREATED BY THE SUBGROUP FOR THE PRODUCTS COVERED BY THE MODEL, EXCLUDING STLDI, RECOGNIZES THAT A MAJORITY OF THESE PRODUCTS ARE GUARANTEED RENEWABLE AND WILL LIKELY BE HELD BY THE INSURED FOR MULTIPLE YEARS. THE DEFINITION IS APPROPRIATE FOR THE PRODUCTS TO WHICH IT IS APPLIED. ON THE OTHER HAND, A MORE STRINGENT DEFINITION CREATED SPECIFICALLY TO REFLECT THE REDUCED DURATION OF STLDI PLANS WOULD NOT BE APPROPRIATE TO APPLY TO SUPPLEMENTAL PRODUCTS AND WOULD INCREASE BOTH ADVERSE SELECTION AND PREMIUMS FOR SUPPLEMENTAL PRODUCTS. |
| **Health Benefits Institute (HBI)** | **HBI COMMENTS:** HBI SUPPORTS KEEPING THE PROPOSED DEFINITION AND APPLYING THE SAME LANGUAGE TO SHORT-TERM LIMITED DURATION. |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESNTATIVE COMMENTS:** WE RECOMMEND USING ONE DEFINTION ACROSS ALL PLAN TYPES—DELETING PROPOSED PARAGRAPH (2) AND REMOVING THE EXCEPTION FOR SHORT-TERM PLANS IN PARAGRPAH (1). |
|  |  |
| **L. “Sickness” means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be modified to exclude sickness or disease for which benefits are provided under a worker’s compensation, occupational disease, employers’ liability or similar law.** | |
| **Schiffbauer Law Office** | L. “Sickness” means sickness, illness, or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be modified to exclude sickness or disease for which benefits are provided under a worker’s compensation, occupational disease, employers’ liability or similar law. **Accepted 2/26/24** |
|  |  |
| **NOTE TO THE SUBGROUP: THE SUBGROUP HAS NOT DISCUSSED THE DEFINITION OF “TOTAL DISABILITY.”**  **M. “Total disability”**  **(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.**  **(2) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual’s inability to: (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.** | |
| **AHIP** | **AHIP COMMENTS:** AHIP SUPPORTS THE DEFINITION OF “TOTAL DISABILITY” AS INCLUDED IN THE WORKING DRAFT |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE RECOMMEND INCLUDING GOODS AND SERVICES IN THIS DEFINITION TO ACCOUNT FOR CARE PROVIDERS WHO MAY BE PARTIALLY OR FULLY COMPENSATED THROUGH HOUSING. WE ALSO NOTE THAT THE USE OF “MAY” THE FIRST TIME IN PARAGRAPH (2) IS INACCURATE AND SHOULD BE CHANGED TO “SHALL” TO ALIGN WITH PARAGRAPH (1).  M. “Total disability”  (1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit, including goods and services. (**did not accept 2/26/24)**  (2) Total disability shall 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. **(did not accept 2/26/24)**  (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 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 policy or a short-term, limited duration health insurance plan, 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.** | |
| **Schiffbauer Law Office** | 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 plan, 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. **(accepted 2/26/24)** |
|  |  |
| **D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:**  **Drafting Note:** States should review the provisions of this subsection carefully to determine if any of the exceptions to limiting or excluding coverage by type of illness, accident, treatment or medical condition included in the subsection should apply to short-term, limited-duration health insurance coverage.  **(1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;**  **(2) Mental or emotional disorders, alcoholism and drug addiction;**  **Drafting Note:** This provision is optional. States should review the desirability of its use.  **(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 that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly that has resulted in a functional defect; (accepted changes 2/26/24)**  **NOTE TO THE SUBGROUP: THE SUBGROUP AGREED TO ADD THE ITALIZED LANGAUGE IN PARAGRAPH (5) ABOVE SUBJECT TO SOMEONE PROVIDING CLARITY ON THE MEANING OF “MALFORMED.”**  **(6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;**  **(7) Chiropractic care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;**  **Drafting Note:** States should examine any existing “freedom of choice” statutes that require reimbursement of treatment provided by chiropractors, and make adjustments if needed.  **(8) Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workmen’s 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 medical condition or clinical status of the covered person, including but not limited to, reconstructive surgery;**  **(10) Eye glasses, hearing aids and examination for the prescription or fitting of them;**  **(11) Rest cures, custodial care, transportation and routine physical examinations;**  **(12) Territorial limitations; and**  **Drafting Note:** The intent of paragraph (12) above is to have this exclusion or limitation of coverage would apply to territories outside of the United States. This exclusion or limitation of coverage is not intended to apply to the U.S. territories.  **(13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.** | |
| **ACLI** | **ACLI COMMENTS:** THE WORK GROUP IS SEEKING INPUT OR CLARITY ON THE MEANING OF “MALFORMED.” MEDICAL DICTIONARIES DEFINE “MALFORMED” AS “A STRUCTURAL DEFECT IN THE BODY DUE TO ABNORMAL EMBRYONIC OR FETAL DEVELOPMENT.” WE SUGGEST THAT THE WORK GROUP START WITH THIS MEDICAL DEFINITION AND CONSIDER WHETHER THERE ARE INSTANCES WHERE AN EXCEPTION SHOULD BE MADE FOR MALFORMATIONS NOT RESULTING DURING FETAL DEVELOPMENT, FOR EXAMPLE MALFORMATIONS CREATED BY ABNORMAL GROWTH OF BLOOD VESSELS UNDER THE SKIN, WHICH CAUSE A FUNCTIONAL DEFECT IN THAT PART OF THE BODY. |
| **AHIP** | **AHIP COMMENTS:** COSMETIC SURGERY IN 7(D)(5) - AHIP SUPPORTS THE PROVISION AS INCLUDED IN THE WORKING DRAFT. |
| **HBI** | **HBI COMMENTS:** HBI GENERALLY SUPPORTS THE ADDITIONAL LANGUAGE ADDED TO CLARIFY COVERAGE. HOWEVER, IT IS OUR BELIEF THAT THE PROPOSED REVISION IS LIKELY ALREADY COVERED UNDER THE EXISTING LANGUAGE AND IS VERY SIMILAR TO THE LANGUAGE THAT FOLLOWS:  (5) COSMETIC SURGERY, EXCEPT THAT “COSMETIC SURGERY” SHALL NOT INCLUDE RECONSTRUCTIVE SURGERY WHEN THE SERVICE IS INCIDENTAL TO OR FOLLOWS SURGERY RESULTING FROM TRAUMA, INFECTION OR OTHER DISEASES OF THE INVOLVED PART, AND RECONSTRUCTIVE SURGERY BECAUSE OF CONGENITAL DISEASE, *TO IMPROVE THE FUNCTION OF A MALFORMED BODY PART* OR ANOMALY OF A COVERED DEPENDENT CHILD THAT HAS RESULTED IN A FUNCTIONAL DEFECT; |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** AS STATED AT THE BEGINNING OF THIS LETTER, WE ARE DEEPLY CONCERNED BY THE ALLOWABLE EXCLUSIONS FOR MENTAL HEALTH-RELATED CONDITIONS. AS SUCH, WE RECOMMEND THE DELETION OF PARTS OF PARAGRAPH (2) AND PARAGRAPH (4)(b). PARAGRAPH (4)(d) APPEARS TO BE OUT-DATED LANGUAGE THAT IS NO LONGER NECESSARY WITH THE INCLUSION OF SHORT-TERM LIMITED DURATION INSURANCE TO MODEL #171 AND THE DEFINITION THE SUBGROUP ADOPTED. WE RECOMMEND DELETING PARAGRAPH (4)(d) IN PART. THE WORD “MALFORMED” IS UNNECESSARY IN PARAGRAPH (5). WE RECOMMEND REMOVAL. FOR PARAGRAPH (10), SIMILAR TO WHAT THE SUBGROUP ADOPTED FOR DENTAL CARE IN PARAGRAPH (9), WE RECOMMEND THIS PARAGRAPH INCLUDE AN EXCEPTION FOR MEDICAL NECESSITY.  D. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:  **\*\*\*\***  (2) Mental or emotional disorders, alcoholism and drug addiction;  \*\*\*\*  (4) Illness, treatment or medical condition arising out of: (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; (b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; (c) Non-commercial or recreational aviation; (d) With respect to short-term nonrenewable policies, interscholastic sports; and (e) With respect to disability income protection policies, incarceration.  **Drafting Note:** What should be an allowable exclusion in disability income protection insurance policies generates much debate. States should be aware that some argue for exclusion of certain diseases or conditions that are difficult to diagnose or are potentially subject to frequent claims (e.g., carpal tunnel and chronic fatigue syndromes). Others argue that carriers have the ability to detect fraudulent claims and deny payment on that basis without singling out specific conditions for blanket exclusion.  (5) Cosmetic surgery, except that “cosmetic surgery” shall not include 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, *to improve the function of a malformed body part* or anomaly of a covered dependent child that has resulted in a functional defect;  \*\*\*\*\*  (9) Dental care or treatment, except where the provision of dental services is medically necessary due to the underlying 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;  \*\*\*\* |
|  |  |
|  |  |
| **E. 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.**  **NOTE TO THE SUBGROUP: THE SUBGROUP DISCUSSED THE NAIC CONSUMER REPRESENTATIVES’ SUGGESTION TO DELETE SUBSECTION E ABOVE. THE SUBGROUP DEFERRED MAKING A DECISION ON WHETHER TO ACCEPT OR REJECT THE SUGGESTED REVISION.** | |
| **ACLI** | **ACLI COMMENTS:** THIS SUBSECTION ALLOWS INSURERS TO ISSUE WAIVERS THAT EXCLUDE OR LIMIT COVERAGE FOR CERTAIN PREEXISTING CONDITIONS OR HAZARDOUS ACTIVITIES. A SUGGESTION WAS MADE TO ELIMINATE THAT PROVISION. WE RECOMMEND KEEPING THAT PROVISION IN THE MODEL BECAUSE IF THIS PROVISION IS REMOVED, IT IS LIKELY THAT PEOPLE WITH THESE PREEXISTING CONDITIONS WILL BE DENIED COVERAGE COMPLETELY. THE CURRENT LANGUAGE ALLOWS PEOPLE TO ACCESS COVERAGE FOR ALL OTHER COVERED BENEFITS EVEN THOUGH A PREEXISTING CONDITION MIGHT OTHERWISE PRECLUDE THEM FROM ELIGIBILITY FOR COVERAGE. THE WAIVER ALLOWS THEM TO HAVE COVERAGE FOR ALL BUT THE PRECLUDING CONDITION OR HAZARDOUS ACTIVITY. |
| **AHIP** | **AHIP COMMENTS:** AHIP SUPPORTS THE CONTINUED INCLUSION OF THIS PROVISION IN THE MODEL. IF THE PROVISION WERE TO BE STRUCK, THEN THE MODEL WOULD INCLUDE NO REGULATION FOR THE STRUCTURE OR USE OF THESE WAIVERS OR FOR THE CONSUMER DISCLOSURE AND ACCEPTANCE OF NEW WAIVERS. |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE CONTINUE TO RECOMMEND THAT THIS SECTION BE DELETED. WE FIND THIS SECTION BOTH UNNECESSARY AND AT ODDS WITH THE PURPOSE OF THIS WORKING GROUP. AS STATED IN THE DRAFTING NOTE ABOVE, SOME OF THESE EXCLUSIONS ARE UNNECESSARY OR CONFLICT WITH EXISTING LAW, MEANING STATES WILL NEED TO REVIEW THIS LIST CAREFULLY WHEN DETERMINING HOW TO UPDATE THEIR REGULATIONS. RATHER THAN GO THROUGH THE EFFORT OF ADOPTING MINIMUM STANDARDS, ONLY TO ALLOW THEM TO BE WAIVED, STATES SHOULD ADOPT MINIMUM STANDARDS AND HOLD PLANS ACCOUNTABLE TO THAT MINIMUM. |
|  |  |
| **Section 8. Supplementary and Short-Term Health Insurance Minimum Standards for Benefits** | |
| **A. General Rules**  **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 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*].**  **(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.**  **NOTE TO THE SUBGROUP: THE WORD “SPOUSE” IS HIGHLIGHTED ABOVE IN PARAGRAPH (1) BECAUSE THE SUBGROUP COULD NOT DECIDE ON WHAT WORD TO REPLACE IT WITH AND DEFERRED UNTIL LATER. SAME QUESTION FOR PARAGRAPH (3).**  **(2) (a) The terms “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” shall not be used without further explanatory language in accordance with the disclosure requirements of Section 9A.**  **(b) The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual supplementary policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.**  **(c) An individual supplementary policy or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy at least until the insured has reached full retirement age, as defined under the federal Social Security Act, to receive Social Security benefits, while actively and regularly employed.**  **NOTE TO THE SUBGROUP: THE SUBGROUP REQUESTED THAT THE REVISIONS TO PARAGRAPH (2)(c) ABOVE BE FLAGGED FOR THE ITS RE-REVIEW.**  **(d) Except as provided above, the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.**  **(3) In an individual supplementary policy covering the 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 revisions to 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 accordingly.  **NOTE TO THE SUBGROUP: THE WORD “SPOUSE” IS HIGHLIGHTED ABOVE IN PARAGRAPH (3) BECAUSE THE SUBGROUP COULD NOT DECIDE ON WHAT WORD TO REPLACE IT WITH AND DEFERRED UNTIL LATER.**  \*\*\*\*  **(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.**  **NOTE TO THE SUBGROUP: THE SUBGROUP DISCUSSED POSSIBLY MOVING PARAGRAPH (10) ABOVE TO SUBECTION C—DISABILITY INCOME PROTECTION COVERAGE.**  \*\*\*\* | |
| **Schiffbauer Law Office** | A. General Rules  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*]. |
| **ACLI** | **ACLI COMMENTS:** USE OF THE WORD “SPOUSE”: WE PREFER TO KEEP THE WORD SPOUSE AS IT IS A GENDER-NEUTRAL TERM. IF THE INTENTION IS TO ALLOW COUPLES THAT ARE NOT LEGALLY MARRIED TO SHARE IN THE COVERAGE, A SOLUTION ALREADY EXISTS IN WHICH THE TERMS “CIVIL UNION OR DOMESTIC PARTNER” CAN BE ADDED TO THE POLICY LANGUAGE. THIS IS USUALLY NOT NECESSARY AS THE PARTNER IN THESE RELATIONSHIPS IS USUALLY REFERRED TO AS THE “SPOUSE” FOR LEGAL PURPOSES.  RECURRENCE PROVISIONS IN PARAGRAPH (10): THE WORK GROUP SEEKS COMMENT ON WHETHER THE LANGUAGE ON “RECURRENCE BENEFITS” SHOULD BE MOVED TO THE DISABILITY INCOME SECTION OF THE MODEL SINCE IT SPECIFICALLY DESCRIBES RECURRENT “DISABILITIES.” WE NOTE THAT BEYOND DI INSURANCE, SPECIFIED DISEASE POLICIES ALSO SOMETIMES INCLUDE RECURRENCE PROVISIONS. WE REQUEST THAT THE PROVISION NOT BE MOVED SINCE IT IS APPLICABLE TO MORE THAN JUST DI, HOWEVER WE SUGGEST SOME CLARIFYING LANGUAGE SUCH AS:  (10) A policy may contain a provision relating to recurrent illnesses or disabilities; but a provision relating to recurrent disabilities shall not specify that recurrent disability be separated by a period greater than six (6) months. |
| **AHIP** | **AHIP COMMENTS:**  USE/REPLACEMENT OF “SPOUSE”  AHIP RECOMMENDS THE SUBGROUP KEEP THE TERM “SPOUSE” IN THE MODEL AND INCLUDE A DRAFTING NOTE RECOMMENDING THAT EACH STATE INSERT REPLACEMENT OR ADDITIONAL TERMS IN ACCORDANCE WITH THEIR STATE LAWS.  RETIREMENT AGE IN 8(A)(2)(C)  AHIP RECOMMENDS THE PROVISION REMAIN IN ITS CURRENT FORM.  RECURRENT DISABILITIES PROVISIONS  AHIP RECOMMENDS THE SUBGROUP LEAVE THIS PROVISION IN SECTION 8(A) – GENERAL RULES, AS THESE PROVISIONS ARE NOT APPLIED SOLELY TO DISABILITY INCOME PROTECTION PRODUCTS. MOVING THE PROVISION TO SECTION 8(C) WOULD REMOVE THE CONSUMER PROTECTIONS FOR THOSE OTHER PRODUCTS. |
| **HBI** | **HBI COMMENTS:** HBI HAS NO STRONG FEELINGS ON THE ISSUE, WE WOULD NOTE THAT THE TERM IS GENDER NEUTRAL, APPLIES TO BOTH MEMBERS OF VARIOUS LEGAL PARTNERSHIPS, AND IMPLIES A LEGAL RELATIONSHIP TO THE INSURED PERSON. THE TERM APPLIES REGARDLESS OF LEGAL STATUS – MARRIAGE, DOMESTIC PARTNERSHIP, OR COMMON LAW MARRIAGE. IT IS A COMMONLY USED TERM INSIDE INSURANCE POLICIES AND WOULD NOT NEED TO BE RE-DEFINED.  REGARDLESS OF THE SPECIFIC TERM, A TERM IS NECESSARY TO PROTECT BOTH PARTNER’S RIGHTS IN A LEGAL RELATIONSHIP, WHICH MAY INCLUDE SPECIFIC CONTINUATION RIGHTS IN CASE OF DEATH OR DIVORCE. |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE RECOMMEND REPLACING THE WORD “SPOUSE” WITH “SPOUSE OR DOMESTIC PARTNER” THROUGHOUT THE SUBSECTION. |
|  |  |
| **B. Hospital Indemnity or Other Fixed Indemnity Coverage**  **(1) “Hospital indemnity or other fixed indemnity coverage” provides benefits triggered by 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.  \*\*\*\*  **Drafting Note:** Hospital indemnity or other fixed indemnity coverage is supplemental 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 resemble comprehensive major medical coverage. Indemnity products should not be developed, 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. | |
| **Schiffbauer Law Office** | **SCHIFFBAUER LAW OFFICE COMMENTS:** CONFORM TO THE SAME CONSENSUS TEXT USED IN THE DISCLOSURES. ELIMINATE USE OF "TRIGGERED BY". ADD LANGUAGE TO DRAFTING NOTE.  (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.  \*\*\*\*  **SCHIFFBAUER LAW OFFICE COMMENTS:** THE PHRASE "SUPPLEMENTAL" SHOULD BE "SUPPLEMENTARY". THE PHRASE SUPPLEMENTARY" MEANS "IN ADDITION TO" RATHER THAN TO WRAP AROUND AN EXISTING COVERAGE SUCH AS MEDIGAP BEING SUPPLEMENTAL TO MEDICARE. SECOND DRAFTING NOTE. CHANGE THE WORD "RESEMBLE" (AMBIGUOUS · MEANS "SEEMS LIKE" FOR EXAMPLE AND IS AMBIGUOUS) · PERHAPS USE "COULD BE MISTAKEN FOR" INSTEAD. ALSO, SHOULD CHANGE "DEVELOPED" TO "OFFERED" ("DEVELOPED" IS AN INTERNAL PRODUCT CREATION PROCESS).  **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. |
|  |  |
| **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) Ninety (90) days in the case of a coverage providing a benefit of one year or less; (b) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one year but not greater than two (2) years; or (c) Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury;**  **Drafting Note:** The elimination period cannot exceed 50% of the benefit period.  **(3) Has a maximum period of time for which it is payable during disability of at least three (3) months. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period;**  **(4) Where a policy provides both total disability benefits and partial disability benefits, only one elimination period may be required.** | |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE RECOMMEND THAT THE DRAFTING NOTE FOR PARAGRAPH (2) BE INCORPORATED INTO THE STANDARDS FOR THE ELIMINATION PERIOD TO PROVIDE CLARITY AND OFFER BETTER VALUE TO CONSUMERS. WE ALSO RECOMMEND THAT THE SUBGROUP REVISIT THE FIRST SENTENCE OF PARAGRAPH (3). THE DISCUSSION AROUND THIS PROVISION WAS QUITE CONFUSING WHEN ADDRESSED THE FIRST TIME AND WE BELIEVE HAS INADVERTANTLY BECOME LESS PROTECTIVE FOR CONSUMERS, RATHER THAN MORE SO. |
|  |  |
|  |  |
| **D. Accident Only Coverage**  **“Accident only coverage” is a policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least $[X] and a single dismemberment amount shall be at least $[X].** | |
| **Schiffbauer Law Office** | **SCHIFFBAUER LAW OFFICE COMMENTS:** THIS SUGGESTED REVISION WOULD TIE BACK TO THE "POLICY DEFINITIONS" ON PAGE 4 THAT CLARIFY THE "ONLY" IN ACCIDENT·ONLY MEANS BENEFITS ARE PAID ONLY WHEN THE CAUSE IS AN ACCIDENT, AND NOT WHEN CAUSED BY SICKNESS, ILLNESS, DISEASE, WORKERS COMPENSATION, ETC. · THE PHRASE "ONLY" MEANS THE COVERED INJURY IS CAUSED ONLY BY AN ACCIDENT AND NOT SICKNESS, ILLNESS, DISEASE, WORKERS COMPENSATION, ETC.  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 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:**  **\*\*\*\***  **(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.  **\*\*\*\***  **(6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:**  **(a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $[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.  **\*\*\*\*** | |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE RECOMMEND THE INCLUSION OF THE PARAGRAPH IN WHICH THE RULES ARE FOUND TO FURTHER CLARIFY THIS DEFINITION AND TO BE CONSISTENT WITH SUBPARTS (A) AND (B) THAT FOLLOW.  (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. |
| **Schiffbauer Law Office** | **SCHIFFBAUER LAW OFFICE COMMENTS:** FOR THE SPECIFIED DISEASE DRAFTING NOTE IN PARAGRAPH (2)(f), QUESTION: SHOULD STATES PROHIBIT INDIVIDUALS COVERED BY MEDICAID FROM PURCHASING A SPECIFIED DISEASE POLICY? MEDICAID DOES NOT COVER ALL EXPENSES ANY MORE THAN A COMMERCIAL HEALTH INSURANCE POLICY DOES · SUCH AS TRAVEL, PARKING, HOTEL, ETC. 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 INSURANCE.  **SCHIFFBAUER LAW OFFICE COMMENTS:** FOR PARAGRAPH (6), ADD THIS LANGAUGE TO DRAFTING NOTE.  (6) The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease:  (a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $[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.  \*\*\*\* |
|  |  |
|  |  |
| **G. Limited Benefit Health Coverage**  **(1) “Limited benefit health coverage” is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, D, and F. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8H of this regulation is completed and delivered as required by Section 8B of this regulation and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Section 8A(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 7E and shall not be offered for sale as a “limited 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 plans, and should be subject to the *Limited Long-Term Care Insurance Model Act* (#642) and its implementing regulation, the *Limited Long-Term Care Insurance Model Regulation* (#643).  **Drafting Note:** This regulation permits the combining of excepted benefit-type products described in this section. However, combining other types of products not described in this section could cause the product not to be considered an excepted benefit-type product and major medical insurance requirements may apply. | |
| **Schiffbauer Law Office** | **SCHIFFBAUER LAW OFFICE COMMENTS:** SECOND DRAFTING NOTE SUGGESTED REVISIONS:  **Drafting Note:** This regulation permits the combining of excepted benefit-type products described in this section. However, combining other types of products that are not excepted benefit-type products will cause the product not to be considered an excepted benefit-type product and major medical insurance requirements may apply. 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 insurance. |
|  |  |
| **H. Short-Term, Limited-Duration Health Insurance Coverage**  **\*\*\*\***  **NOTE TO THE SUBGROUP: THE SUBGROUP AGREED TO PRELIMINARILY INCLUDE PARAGRAPH (7) BELOW IN THE WORKING DRAFT SUBJECT TO REVISING THAT DECISION DEPENDING ON THE NUMER OF STATES THAT ALREADY HAVE SUCH LANGUAGE IN THEIR LAWS AND REGULATIONS ESTABLISHING GENERAL CANCELLATION REQUIREMENTS FOR ALL COVERAGES, INCLUDING STLD PLAN COVERAGE.**  **(7) A carrier may not cancel a short-term, limited-duration health insurance plan during the coverage period except in the following circumstances: (a) Nonpayment of premium; (b) Violation of the carrier’s published policies approved by the commissioner; (c) An insured’s commitment of fraudulent acts as to the carrier; (d) An insured’s material breach of the health plan; or (e) A change or implementation of a federal or a state law or regulation that no longer permits the continuing offering of the coverage.** | |
| **HBI** | **HBI COMMENTS:** WE BELIEVE THE MODEL INCLUDES A VERY CONSUMER PROTECTIVE CANCELLATION POLICY FOR SHORT-TERM LIMITED DURATION PLANS. WE DO NOT BELIEVE ANY OF THE PROPOSED CHANGES SHOULD BE REMOVED. |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE STRONGLY SUPPORT THE INCLUSION OF PARAGRAPH (7) AS IT IS AN IMPORTANT AND NECESSARY CONSUMER PROTECTION TO ENSURE PLANS CANNOT BE CANCELED FOR ARBITRARY REASONS OR THOSE OUTSIDE THE CONTROL OF THE CONSUMER. |
|  |  |
| **Additional Section 8 Sections** | |
| **NAIC consumer representatives** | **NAIC CONSUMER REPRESENTATIVE COMMENTS:** WE WANT TO ALERT THE WORKING GROUP THAT WHILE THIS MODEL RULE APPLIES TO VISION AND DENTAL COVERAGE THERE IS NO MINIMUM STANDARDS SECTION FOR EITHER. WE STRONGLY RECOMMEND THAT THESE NEW SUBSECTIONS BE ADDED TO SECTION 8. |
|  |  |
| **Section 9. Required Disclosure Provisions** | |
| **A. General Rules**  **(1) Any disclosures, and the documents to which they refer, shall be delivered in the written medium the applicant requests. These documents shall be available before the applicant submits a completed application.**  **(2) (a) All applications, policies, and certificates for coverage of supplementary or short-term health insurance shall include a prominent disclosure statement, as required by this section, that reflects the type of coverage being provided.**  \*\*\*\*  **(d) In the application, the disclosure statement shall be placed in close proximity to the applicant’s signature block on the application.**  \*\*\*\* | |
| **Schiffbauer Law Office** | SCHIFFBAUER LAW OFFICE COMMENTS: IN PARAGRAPH (1), THE PHRASE “SHALL BE AVAILABLE” IS AMBIGUOUS. PERHAPS IT SHOULD SAY INSTEAD “SHALL BE PROVIDED.” IN PARAGRAPH (2)(d), THE PHRASE “IN CLOSE PROXIMITY TO” IS AMBIGUOUS. PERHAPS IT SHOULD SAY INSTEAD “DIRECTLY ABOVE.”  (1) Any disclosures, and the documents to which they refer, shall be provided in the written medium the applicant requests. These documents shall be available before the applicant submits a completed application.  (2) (a) All applications, policies, and certificates for coverage of supplementary or short-term health insurance shall include a prominent disclosure statement, as required by this section, that reflects the type of coverage being provided.  \*\*\*\*  (d) In the application, the disclosure statement shall be placed directly above the applicant’s signature block on the application. |
|  |  |
| **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:**  \*\*\*\*  **OUTLINE OF COVERAGE**  \*\*\*\*  **NOTE TO THE SUBGROUP: THE LANGUAGE IN PARAGRAPH (2) BELOW IS INTENDED TO BE CONSISTENT WITH THE APPLICATION LANGUAGE IN SECTION 9A(3) AND (4).**  **(2) [Hospital indemnity] [Other fixed indemnity] coverage is designed to pay a fixed dollar benefits as a result of a covered [hospital stay] [event] due to a sickness or injury. The benefits may be limited in ways described in the [policy] [certificate]. The fixed dollar benefit may be less than the [hospital stay’s] [event’s] cost.**  \*\*\*\* | |
| **Schiffbauer Law Office** | **SCHIFFBAUER LAW OFFICE COMMENTS**: FOR PARAGRAPH(2), THE DESCRIPTION SHOULD CONFORM TO THE CONSENSUS DISCLOSURE LANGUAGE BY STRIKING "IS DESIGNED TO" AND INSERT "PAYS" AND OTHER CONFORMING LANGUAGE FROM PAGE 25. |
|  |  |
| **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:**  \*\*\*\*  **(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].**  \*\*\*\* | |
| **Schiffbauer Law Office** | **SCHIFFBAUER LAW OFFICE COMMENTS:** IN SUBPARAGRAPH (2) ADD THE PHRASE ",OR INJURY". THIS WOULD TIE BACK TO THE "POLICY DEFINITIONS" ON PAGE 4 THAT CLARIFY THE "ONLY" IN ACCIDENT-ONLY · MEANS BENEFITS ARE PAID ONLY WHEN THE CAUSE IS AN ACCIDENT, AND NOT WHEN CAUSED BY SICKNESS, ILLNESS, DISEASE, WORKERS COMPENSATION, ETC. · THE PHRASE "ONLY" MEANS THE COVERED INJURY IS CAUSED ONLY BY AN ACCIDENT AND NOT SICKNESS, ILLNESS, DISEASE, WORKERS COMPENSATION, ETC.  (2) Accident-only coverage pays benefits for covered injuries from a covered accident or injury. It does not provide benefits resulting from sickness. The benefits may be limited in ways described in the [policy] [certificate]. |
|  |  |
| **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:**  \*\*\*\*  **(2) [Specified disease][Specified accident] coverage is designed to pay limited benefits as a result of the diagnosis or treatment of a [covered disease] or a [specifically identified type of accident]. Read the Buyer’s Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.**  \*\*\*\* | |
| **Schiffbauer Law Office** | **SCHIFFBAUER LAW OFFICE COMMENTS**: FOR PARAGRAPH(2), THE DESCRIPTION SHOULD CONFORM TO THE CONSENSUS DISCLOSURE LANGUAGE BY STRIKING "IS DESIGNED TO" AND INSERT "PAYS" AND OTHER CONFORMING LANGUAGE FROM PAGE 26. |
|  |  |