

ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this Act is to standardize and simplify the terms and coverages of individual accident and sickness insurance policies and group accident and sickness insurance 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 Act is also intended to facilitate public understanding and comparison, to eliminate provisions contained in individual accident and sickness insurance policies and group supplemental health insurance that may be misleading or unreasonably confusing in connection either with the purchase of these coverages or with the settlement of claims. This Act also provides for full disclosure in the sale of accident and sickness coverages, group supplemental health insurance and dental and vision plans.

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. Applicability and Scope

- A. This Act shall apply to coverages of individual accident and sickness insurance policies and group supplemental health insurance policies.

Drafting Note: The term “individual” as used this Act corresponds to its use in the NAIC Uniform Individual Accident and Sickness Policy Provisions Law, thus extending the coverage of the Act to “family” policies. The term “group” as used in this Act corresponds to its use in the NAIC Group Health Insurance Definition and Group Health Insurance Standards Provisions Model Act.

- B. This Act shall apply to dental plans and vision plans only as specified.

- C. This Act 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 Act;
- (2) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this Act;

- (3) Medicare supplement policies subject to [insert reference to state law equivalent to the NAIC Medicare Supplement Insurance Minimum Standards Model Act];
- (4) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Act]; or

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 plans, and should be subject to this Act and its implementing regulation.

- (5) Civilian Health and Medical Program of the Uniformed Services (Chapter 55, title 10 of the United States Code) (CHAMPUS) supplement insurance policies.

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

Section 3. Definitions

- A. “Accident and sickness insurance” means insurance written under [insert reference to state law authorizing accident and sickness insurance]. Accident and sickness insurance does not include credit accident and sickness insurance.

Drafting Note: The phrase “accident and sickness” should be replaced by “accident and disability,” “accident and health,” or other phrase appropriate under state law.

- B. “Certificate” means a statement of the coverage and provisions of a policy of group accident and sickness insurance, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.
- C. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Where the word “commissioner” appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

- D. “Dental plan” means insurance written to provide coverage for dental treatment.
- E. “Direct response solicitation” means a communication through a sponsoring or endorsing entity or individually through mail, telephone, the internet or other mass communication media.
- F. “Form” means policies, contracts, riders, endorsements and applications as provided in [insert reference to state law regarding the filing and approval of individual accident and sickness insurance policy forms].

Drafting Note: This definition may be unnecessary if the term “form” is appropriately defined elsewhere, but it may be helpful to include it here with an appropriate cross-reference.

- G. “Group supplemental health insurance” means group accident and sickness insurance policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage.

- H. “Policy” means the entire contract between the insurer and the insured, including riders, endorsements and the application, if attached.
- I. Vision plan” means insurance written to provide coverage for vision care.

Section 4. Standards for Policy Provisions

- A. The commissioner shall issue regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of individual accident and sickness insurance and group supplemental health insurance. The commissioner may issue additional regulations to establish specific standards for the sale of dental and vision plans. This Act and any regulations issued pursuant to this Act shall be in addition to and in accordance with applicable laws of this state, including the [insert reference to state law equivalent to the NAIC Uniform Individual Accident and Sickness Policy Provisions Law], which may cover, but shall not be limited to:
 - (1) Terms of renewability;
 - (2) Initial and subsequent conditions of eligibility;
 - (3) Nonduplication of coverage provisions;
 - (4) Coverage of dependents;
 - (5) Preexisting conditions;
 - (6) Termination of insurance;
 - (7) Probationary periods;
 - (8) Limitations;
 - (9) Exceptions;
 - (10) Reductions;
 - (11) Elimination periods;
 - (12) Requirements for replacement;
 - (13) Recurrent conditions; and
 - (14) The definition of terms including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable and noncancellable.

Drafting Note: This section authorizes the commissioner to establish specific standards to facilitate public understanding of policy provisions. The section does not alter the requirements of the NAIC Uniform Individual Accident and Sickness Policy Provisions Law (UPPL) or other specifically applicable state laws dealing with individual policy provisions. Regulations adopted under this section should be consistent with the UPPL and other applicable state laws relating to the subject matter. The phrase “including standards of full and fair disclosure” provides the commissioner authority to establish standards that ensure policy provisions are technically accurate, in clear language and make the significance of policy provisions fully understandable.

- B. The commissioner may issue regulations that specify prohibited policies or policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to the policyholder, a person insured under the policy, or to a beneficiary of the policy.

Section 5. Minimum Standards for Benefits

- A. The commissioner shall issue regulations to establish minimum standards for benefits under specified categories of coverage of individual accident and sickness insurance and group supplemental health insurance.. to The regulation shall set minimum standards for benefits for the following categories of coverage:

- (1) Basic hospital expense coverage;
- (2) Basic medical-surgical expense coverage;
- (3) Basic hospital/ medical-surgical expense coverage;
- (4) Hospital confinement indemnity coverage;
- (5) Individual major medical expense coverage;
- (6) Individual basic medical expense coverage;
- (7) Disability income protection coverage;
- (8) Accident only coverage;
- (9) Specified disease coverage;
- (10) Specified accident coverage; and
- (11) Limited benefit health coverage.

Drafting Note: “Specified disease coverage” or “specified accident coverage” refers to coverage that contains exclusions, limitations, reductions, or conditions of such a restrictive nature that the payments of benefits under the policy or contract are limited in frequency or in amounts. An example of a specified disease or specified accident coverage would be a cancer only hospital indemnity policy or an automobile accident only policy. Act

- B. This section does not preclude the issuance of a policy or contract that combines two (2) or more of the categories of coverage enumerated in Paragraphs (1) through (11) of Subsection A.

Drafting Note: This subsection does not restrict reasonable combinations of the coverages in Paragraphs (1) through (11). For example, accident only coverage may be issued in conjunction with other categories. However, the section does not permit the combination of specified disease or specified accident coverages with other categories of coverage unless specifically permitted by a regulation adopted pursuant to this Act. In addition, it should be noted that the combination of coverages might raise Health Insurance Portability and Accountability Act of 1996 (HIPAA) creditable coverage issues; that is, certain combinations of coverages might not qualify as “excepted benefits” under HIPAA, thus making those combination policies subject to HIPAA requirements, such as guaranteed renewability.

- C. A policy or contract shall not be delivered or issued for delivery in this state that does not meet the prescribed minimum standards for the categories of coverage listed in Paragraphs (1) through (11) of Subsection A or does not meet the requirements set forth in [insert reference to state law authorizing the commissioner to disapprove policy forms if the benefits provided in the policy forms are unreasonable in relation to the premium charged].
- D. The commissioner shall prescribe the method of identification of policies, certificates and contracts based upon coverages provided.

Section 6. Disclosure Requirements

- A. 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 delivered or issued for delivery in this state.
- B. If the sale of a policy described in Subsection A occurs through an agent, the outline of coverage shall be delivered to the applicant at the time of application or to the certificateholder at the time of enrollment.
- C. If the sale of a policy described in Subsection A occurs through direct response advertising, the outline of coverage shall be delivered no later than in conjunction with the issuance of the policy or delivery of the certificate.
- D. If the outline of coverage required in Subsections A and H and any regulations issued by the commissioner pursuant to this Act is not delivered at the time of application or enrollment, the advertising materials delivered to the applicant or enrollee shall contain all the information required in Subsection H and in any regulations issued by the commissioner pursuant to this Act.
- E. If the outline of coverage is delivered to the applicant or enrollee at the time of application or enrollment, the insurer shall collect an acknowledgment of receipt or certificate of delivery of the outline of coverage and the insurer shall maintain evidence of the delivery.
- F. If coverage is issued on a basis other than as applied for, an outline of coverage properly describing the coverage or contract actually issued shall be delivered with the policy or certificate to the applicant or enrollee.
- G. An outline of coverage for group supplemental health insurance, group dental plans and group vision plans shall not be required to be delivered by the insurer if the certificate contains a brief description of:
 - (1) Benefits;
 - (2) Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits;
 - (3) Renewability provisions; and
 - (4) Notice requirements as provided in the regulation promulgated pursuant to this Act.

Drafting Note: Advertisements can fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage under Subsection H and in the regulation promulgated pursuant to this Act.

- H. The commissioner shall prescribe the format and content of the outline of coverage required by Subsection A. “Format” means style, arrangement and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. The outline of coverage shall include:
- (1) A statement identifying the applicable category or categories of coverage as prescribed in Section 5 of this Act;
 - (2) A description of the principal benefits and coverage provided;
 - (3) A statement of the exceptions, reductions and limitations;
 - (4) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums; and
 - (5) A statement that the outline is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing policy provisions.

Drafting Note: Any possible conflict with Section 3A(1) of the NAIC Uniform Individual Accident and Sickness Policy Provisions Law can be avoided by enclosing and not attaching the outline at the time of policy or certificate delivery.

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

Section 7. Preexisting Conditions

- A. Notwithstanding the provisions of [insert reference to state law equivalent to Section 3A(2)(b) of the NAIC Uniform Individual Accident and Sickness Policy Provisions Law], if an insurer elects to use a simplified application or enrollment form, with or without a question as to the prospective insured’s health at the time of application or enrollment, but without any questions concerning the prospective insured’s health history or medical treatment history, the policy shall cover any loss occurring after twelve (12) months from any preexisting condition not specifically excluded from coverage by terms of the policy, and except as so provided, the policy or certificate shall not include wording that would permit a defense based upon preexisting conditions.

Drafting Note: States that have specific requirements with respect to waivers, exclusionary riders or evidence of insurability for group insurance should modify Subsection A by deleting references to “enrollment” and adding a new subsection addressing the requirements.

- B. Notwithstanding the provisions of Subsection A and the provisions of [insert reference to state law equivalent to Section 3A(2)(b) of the NAIC Uniform Individual Accident and Sickness Policy Provisions Law] an insurer that issues a specified disease policy or certificate, regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form, may not deny a claim for any covered loss that begins after the policy or certificate has been in force for at least six (6) months, unless the loss results from a preexisting condition that first manifested itself within six (6) months

prior to the effective date of the policy or certificate or was diagnosed by a physician at any time prior to that date. Except for rescission for misrepresentation, no other defenses based upon preexisting conditions are permitted.

Section 8. Administrative Procedures

The adoption of regulations pursuant to this Act shall be subject to the notice and hearing requirements set forth in [insert reference to state law relating to the adoption and promulgation of rules and regulations or state Administrative Procedures Act].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1974 Proc. I 12, 14, 405, 413, 414-418 (adopted).

1977 Proc. I 26, 28, 49-53, 317, 325 (amended and reprinted).

1979 Proc. I 44, 47, 373, 385, 394-396 (amended).

1980 Proc. II 22, 26, 588, 591, 594, 634 (amended).

1989 Proc. II 13, 23-24, 467-468, 518-519, 544-548 (amended to remove references to Medicare supplement insurance).

1998 Proc. 4th Quarter 16, 17, 652, 654, 655-660 (amended and reprinted).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO CURRENT ACTIVITY	
Alaska	NO CURRENT ACTIVITY	
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas		18 ARK. CODE R. (1981/2003).
California		CAL. INS. CODE § 10291.5; §§ 10600 to 10609 (1974/2013).
Colorado	NO CURRENT ACTIVITY	
Connecticut	CONN. GEN. STAT. §§ 38a-505 (1976).	
Delaware	DEL. CODE ANN. tit. 18, §§ 3601 to 3608 (1983/2013).	
District of Columbia	NO CURRENT ACTIVITY	
Florida	FLA. STAT. §§ 627.643 (1982/1992).	
Georgia	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho	IDAHO CODE ANN. §§ 41-4201 to 41-4207 (1975).	
Illinois		215 ILL. COMP. STAT. 5/355a (1980/2014).
Indiana	NO CURRENT ACTIVITY	
Iowa	IOWA CODE §§ 514D.1 to 514D.9 (1980).	
Kansas	KAN. STAT. ANN. §§ 40-2216 to 40-2220 (1976).	
Kentucky	NO CURRENT ACTIVITY	
Louisiana	NO CURRENT ACTIVITY	
Maine	NO CURRENT ACTIVITY	
Maryland		MD. CODE ANN. INS. § 12-102 (1963/1997).
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota	NO CURRENT ACTIVITY	
Mississippi	NO CURRENT ACTIVITY	
Missouri	NO CURRENT ACTIVITY	
Montana	NO CURRENT ACTIVITY	
Nebraska	NO CURRENT ACTIVITY	
Nevada	NO CURRENT ACTIVITY	
New Hampshire	N.H. REV. STAT. ANN. §§ 415-A:1 to 415-A:6 (1975/2005).	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
New Jersey		N.J. STAT. ANN. § 17B:26-45 (1979); N.J. ADMIN. CODE §§ 11:22-5.1 to 11:22-5.11 (2006/2009).
New Mexico	NO CURRENT ACTIVITY	
New York		N.Y. INS. LAW § 3217 (1984).
North Carolina	NO CURRENT ACTIVITY	
North Dakota	NO CURRENT ACTIVITY	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	NO CURRENT ACTIVITY	
Oklahoma		OKLA. STAT. tit. 36, §§ 3611 (1982); OKLA. ADMIN. CODE §§ 365:10-5- 170 to 365:10-5-177 (1997/2011).
Oregon		OR. REV. STAT. §§ 743.010(1) (1979) (Commissioner empowered to make regulations).
Pennsylvania	40 PA. CONS. STAT. §§ 776.1 to 776.7 (1976).	
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island		R.I. GEN. LAWS §§ 27-18-1 to 27-18- 82 (2012).
South Carolina		S.C. CODE ANN. §§ 38-71-510 to 38-71-540 (1988).
South Dakota	NO CURRENT ACTIVITY	
Tennessee	NO CURRENT ACTIVITY	
Texas		TEX. INS. CODE ANN. §§ 1201.101 to 1201.154 (2005/2013); § 1202.051 (2005).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Utah	UTAH CODE ANN. §§ 31A-22-605 to 31A-22-606 (1986/2005).	
Vermont	NO CURRENT ACTIVITY	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	VA. CODE ANN. §§ 38.2-3516 to 38.2-3520 (1986/2013).	
Washington	WASH. REV. CODE ANN. §§ 48.20.450 to 48.20.480 (1975).	
West Virginia	W. VA. CODE §§ 33-28-1 to 33-28-5; §§ 33-28-6 to 33-28-7 (1974).	
Wisconsin	NO CURRENT ACTIVITY	
Wyoming	NO CURRENT ACTIVITY	

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Drafting on the model began with the goal of providing state insurance regulators with the authority to promulgate comprehensive minimum standards for accident and sickness insurance policies. **1974 Proc. I 414.**

A representative from a trade association argued that minimum standards legislation was neither necessary nor desirable. The reasons he gave included: 1) if the standards were too rigid, progress in product development would be restricted; 2) if benefit minimums were too high, some people might be priced out of the market altogether. Since the proposed model bill left much detail to the regulation that would accompany it, he could not determine the far-reaching effects. **1974 Proc. I 418-419.**

The first model contained provisions only applicable to individual policies. An interested party commented in support of this decision because there were already procedures and practices in place to adequately inform an employee or member of a group as to the scope and extent of group coverage. **1974 Proc. I 424.**

When a group was appointed in 1997 to review the model, the members proposed amendments in several areas. They discussed the addition of group insurance provisions to the NAIC Individual Accident and Sickness Insurance Model Act and Regulation, extension of disclosure requirements, addition of clarifying drafting notes, adjustment to the models necessitated by the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and modernization of model language. In addition, the group discussed updating minimum benefit standards. **1997 Proc. 3rd Quarter 1278.**

Section 1. Purpose

The drafting group reviewed the model act and regulation and sought to standardize the use of the word “group.” The goal was to clarify that the model act and regulation covered individual major medical and supplemental policies and group supplemental policies. The model act and regulation were not intended to govern group major medical products. A regulator had expressed concern that basic hospital and surgical coverages were being sold through associations in a way that misled consumers into thinking the products provided more benefits than they actually covered. This issue was addressed in the draft model regulation through required disclosures in the outline of coverage for group basic hospital and surgical products. **1998 Proc. 1st Quarter 807.**

Section 2. Applicability and Scope

Staff noted that these were older models and that NAIC staff will try to bring these drafts up to more modern standards. In particular, she suggested the addition of a new “Applicability and Scope” section, and suggested that the exclusion of coverage be moved from the “Purpose” section to the new section. The working group agreed with this suggestion. **1998 Proc. 1st Quarter 807.**

B. The issue of whether dental plans should be excluded from the models was considered by the drafting group. Staff said that there were no other model acts that addressed minimum standards for dental plans. A regulator said that dental plans were gaining in importance and, short of setting

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Section 2B (cont.)

up a new dental plan working group, he recommended including them in these models. Another regulator observed that dental plans had not caused much concern. She felt that they fit here and they might as well be left in. **1998 Proc. 1st Quarter 807.**

The issue was discussed again prior to the next meeting, and the drafters agreed that dental and vision plans were not susceptible to the same kinds of problems as other limited benefit health plans; that is, consumers were generally aware of the scope of their coverage and did not suffer from the misconception that they had comprehensive health coverage. However, since these forms of coverage were not regulated elsewhere, the group decided to keep dental and vision plans within the scope of this model act. The group agreed that the disclosure requirements for limited benefit health plans were not appropriate for dental or vision plans and, therefore, decided to exempt these plans from the specific notice requirements of the act and regulation. However, these plans would still be required to provide outlines of coverage. **1998 Proc. 2nd Quarter II 756.**

C. A regulator suggested that the working group should consider specifically excluding long-term care insurance and credit insurance from the model. **1997 Proc. 4th Quarter II 836.**

At the next meeting, the group reported that the Minimum Standards Act and Regulation specifically excluded products that were regulated under the NAIC Long-Term Care Insurance Model Act and Regulation. This raised the question as to whether the Long-Term Care Insurance Model Act and Regulation included policies that covered home health care (including stand-alone home health policies) or policies that covered less than one year of benefits. Staff reported that stand-alone home health coverage was included under the Long-Term Care Insurance Model Act and Regulation as long as the duration of the coverage was at least 12 months. With respect to coverage with a duration of less than 12 months, the drafting group agreed that it would be considered limited benefit health coverage under the Minimum Standards Act and Regulation. Some members of the group indicated that a stand-alone home health benefit (or any “long-term care type coverage”) of less than 12 months would not be allowed because it did not meet the definition of long-term care insurance; others indicated that it would be regulated as limited benefit health coverage. The group agreed to include a drafting note in the Minimum Standards Act and Regulation indicating that if a state allowed a long-term care product of less than one year, then it should be considered a limited benefit health plan. **1998 Proc. 2nd Quarter II 756.**

An interested party asked that Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS) plans be excluded from applicability from the models. He stated that these products were similar in structure to Medicare supplement insurance, and they should be treated as such. The working group recommended that the exclusion be placed in the next draft. **1997 Proc. 4th Quarter II 836.**

At its prior meeting, the drafting group had decided to exclude CHAMPUS supplement insurance from the models. However, the regulators wanted to confirm that these products were subject to some regulation. They researched the issue and discovered that CHAMPUS supplement insurance was not regulated on the federal level. In many instances, states regulated them as group products

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Section 2C (cont.)

through filing requirements. An interested party stated that members of his association were of the opinion that CHAMPUS supplement plans were regulated as group plans, the products were filed with state insurance departments, and the products were primarily sold through associations of CHAMPUS-eligible individuals. Because there had been few reports of problems with CHAMPUS supplement plans, the drafters recommended excluding these products from the drafts and suggested that states be alerted to this issue through a drafting note. There were no objections to the drafting note from the working group or interested parties. **1998 Proc. 1st Quarter 807.**

Section 3. Definitions

- A. The definition of accident and sickness insurance was modified during the drafting of amendments in 1998. **1998 Proc. 4th Quarter II 656.**
- B-E. These definitions were added in 1998. **1998 Proc. 4th Quarter II 656.**
- F. The definition was included in the original model in nearly the same form. **1974 Proc. I 415.**
- G. This definition first appeared in 1998. **1998 Proc. 4th Quarter II 656.**
- H. The definition was included in the original model in nearly the same form. **1974 Proc. I 415.**
- I. This definition first appeared in 1998. **1998 Proc. 4th Quarter II 656.**

Section 4. Standards for Policy Provisions

A. The group drafting amendments in 1997–1998 added a specific reference to group products to Section 4. One member remarked that he had noticed over the last several years a new marketing aspect incorporating work site marketing. Another regulator noted that these products were sold as individual products, and the purchasers enjoyed the portable aspects of the products, while still being able to receive something close to group premium rates. An insurer representative said that some of the products could be sold as group products. A regulator stated that group products used to mean that the employer made most of the decisions; but this new trend provided significant motivation to include group products in the model act and regulation. **1997 Proc. 4th Quarter II 836.**

An interested party objected to the language in Section 4A of the draft of the Accident and Sickness Insurance Minimum Standards Model Act that would allow the commissioner to “issue additional regulations to establish specific standards for the sale of dental and vision plans.” The association she represented did not want the commissioner to set standards for those products. The regulators agreed that the commissioner should have that authority and retained the language. **1998 Proc. 3rd Quarter 578.**

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Section 4 (cont.)

B. This subsection was included in the original model and remains substantially the same. **1974 Proc. I 416.**

Section 5. Minimum Standards for Benefits

A. When the model was amended in 1976, Paragraph (11) was added to require minimum benefit standards for limited benefit plans. **1977 Proc. I 51.**

B. An interested party asked about the rationale behind the grouping of types of policies together in a single policy, and more specifically, the prohibition of allowing specified disease, specified accident and limited benefit plans from being included in the grouping of policies. A regulator replied that specified disease policies were deemed to be experimental when the model originally was developed. There seemed to be a movement to split the coverages up into different contracts and the coverages were being spun out of major medical policies. On the other hand, if combinations are allowed, the consumer stood to lose due to duplication of per policy costs. He said that he would encourage combination of coverage as long as adequate disclosure was given to the policyholder. Another group member asked if some combination of coverage should be considered excepted coverage in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A federal representative replied that HIPAA was specific as to what was considered creditable coverage. She said that she was concerned as to what was considered excepted coverage in the statute, but she would not be concerned if the products were offered separately. In the areas of Medicare supplement insurance, specific disease and fixed indemnity, she was concerned with regard to the applicability of creditable coverage. **1997 Proc. 4th Quarter II 836.**

The decision to allow specified disease and specified accident coverage to be combined with other types of coverage raised issues with respect to HIPAA as these combined coverages may no longer be considered excepted benefits under HIPAA. The working group decided to address the issue of grouping of several limited benefits coverage in one policy by adding a drafting note alerting insurers that the combination of coverages might raise HIPAA creditable coverage concerns. Concerns were raised with respect to the wording of the drafting note and at the next meeting staff reported that the language in the drafting note had been refined. **1998 Proc. 2nd Quarter II 756.**

C. As originally drafted in 1973, this subsection imposed on the commissioner the burden of finding affirmatively that each policy was in the public interest, thereby endorsing any policy he approved. An interested party opined that the commissioner would not want to be placed in that position. As a solution he suggested that the commissioner only needed to find that the policy was not contrary to the public interest. **1974 Proc. I 419.**

D. The provisions adopted in 1973 have been the subject of technical amendments, but remain substantially the same as that in the first model. **1974 Proc. I 417.**

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Section 6. Disclosure Requirements

A. The model adopted in 1973 included a requirement for delivery of the outline of coverage that did not comport with the manner of doing business utilized by nonprofit plans. They urged a broader provision. **1974 Proc. I 424.**

New language for Section 5A was included in the draft being reviewed in late 1997, requiring the delivery of an outline of coverage. The proposed language at the beginning of Section 6 stated that the outline of coverage should be delivered either at the time of application or at the deliverance of the policy. A regulator questioned the timing of delivery, suggesting that the time of policy delivery might be too late. The chair of the drafting group also stated that the language allowed for the waiver of the requirement for group supplemental health insurance if the certificate contained the same or similar information as the outline of coverage. **1997 Proc. 4th Quarter II 836.**

The entire Subsection A from the original model was deleted in 1998 and replaced with different text. **1998 Proc. 4th Quarter II 658.**

B. The drafters revised the model act so that the outline of coverage would be delivered to the enrollee at the time of application if an agent sold the coverage to a person. However, if the policy was sold through direct response advertising, the outline of coverage would be delivered at the time of delivery of the policy. The chair explained that the group had looked at Medicare supplement insurance and long-term care insurance requirements, both of which contained this timing. The group agreed that this timing made sense since an agent should have the necessary information at the time of sale, while the coverage might change between the time of response to direct mail advertising and the actual delivery of the policy. **1998 Proc. 1st Quarter 808.**

C-F. The text of Subsections A through F was all new in 1998. **1998 Proc. 4th Quarter II 658-659.**

G. Since the model regulation was changed to require delivery of the outline of coverage at policy application for coverage issued through an agent, the issue was raised as to whether advertising material that contained the same information as the outline of coverage could fulfill this requirement. The drafting group agreed that if the advertisement contained exactly the same information in the same format (order, prominence, etc.) as required in the outline of coverage, then it could be used in place of the outline of coverage. Industry representatives pointed out that this was already allowed under the current model. The model was revised to include a drafting note after the new Subsection G clarifying that point. **1998 Proc. 2nd Quarter II 757.**

H. The text of Subsection H is nearly identical to that in the first model adopted in 1973. **1974 Proc. I.**

I. In 1978 a task force was appointed to review issues related to Medicare supplement insurance. That group decided to amend the model act to add a definition of Medicare and some disclosures regarding Medicare supplement policies. **1979 Proc. I 394-396.**

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Section 6 (cont.)

In 1989 technical amendments to the model were made to delete obsolete references to Medicare supplement. A separate model on Medicare supplement policies had been adopted. **1989 Proc. II 518-519.**

Reference to the Medicare supplement regulation was added in 1998. **1998 Proc. 4th Quarter 659.**

Section 7. Preexisting Conditions

A. Subsection A remains substantially the same as when it was originally adopted in 1973. **1974 Proc. I 418.**

B. This subsection was added in 1980, without discussion. **1980 Proc. II 634.**

Section 8. Administrative Procedures

When the first version of the model was being considered for adoption, an interested party urged regulators to include a delayed effective date of at least 180 days to allow time for the drafting, submission and approval of policies affected by the regulation, which had not yet been developed. The model as adopted did not include that wording. **1974 Proc. I 418-419.**

Chronological Summary of Actions

December 1973: Model adopted.

December 1976: Some amendments were adopted.

December 1978: Added reference to Medicare supplements.

June 1980: Added Section 7C.

June 1989: Removed provisions related to Medicare supplement insurance, in recognition of the extensive models specific to that type of coverage.

March 1998: Model extensively amended. Group limited benefit plans included. Updated in response to the federal Health Insurance Portability and Accountability Act (HIPAA).