

Comments are being requested on this draft by ?. The revisions to this draft reflect changes made from the existing model. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.

ACCIDENT AND SICKNESS ANCILLARY HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

Table of Contents

Section 1.	Purpose
Section 2.	Applicability and Scope
Section 3.	Definitions
Section 4.	Standards for Policy provisions
Section 5.	Minimum Standards for Benefits
Section 6.	Disclosure Requirements
Section 7.	Preexisting Conditions
Section 8.	Administrative Procedures

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 and to provide~~ for full disclosure in the sale of ~~accident and sickness coverages, group supplemental health insurance and dental and vision plans~~ ancillary health insurance, as defined in this Act.

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” or “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 and certificates providing hospital indemnity or other fixed indemnity insurance, accident only, specified accident, specified disease, limited benefit health, disability income protection and short-term, limited duration insurance coverages, including limited scope dental and limited scope vision coverage, referred to collectively in Section 1 of this Act and hereafter, as “ancillary health insurance.”~~

Drafting Note: The term “individual” as used this Act corresponds to its use in the NAIC *Uniform Individual Accident and Sickness Policy Provisions Law (#180)*, 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 (#100)*.

Drafting Note: States should be aware that generally, Section 1251 of the federal Affordable Care Act (ACA) exempts coverage from most reforms in Subtitles A and C of Title 1 of the ACA if the coverage was in force as of March 23, 2010, the date on which the ACA was signed into law, and the terms of coverage have not materially changed. This coverage is known as “grandfathered health plan coverage.” However, Section 1251 of the ACA specifically applies certain provisions of the ACA from which such coverage would otherwise be exempt. Some of these provisions apply to all grandfathered health plans, while other provisions apply only to grandfathered group health insurance plans. To the extent provisions of the PHSA, ERISA and the Internal Revenue Code (IRC) do not apply as amended by the ACA to a grandfathered plan, the pre-ACA versions of those provisions will continue to apply. In general, grandfathered plans must also comply with all applicable state laws; the only express preemption provision in the ACA is the prohibition against states including

grandfathered plans in the rating pool for non-grandfathered plans. The standards for grandfathered plans, including the requirements for maintaining grandfathered status, are found in the interim final regulations on grandfathered plans (26 CFR 54.9815-1251T, 29 CFR 2590.715-1251 and 45 CFR 147.140), as published in the *Federal Register* June 17, 2010.

- B. This Act shall apply to limited scope dental plans coverage and limited scope vision plans coverage 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)~~(1) Medicare supplement policies subject to [insert reference to state law equivalent to the NAIC *Medicare Supplement Insurance Minimum Standards Model Act*];
 - ~~(4)~~(2) Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC *Long-Term Care Insurance Model Act*]; or

Drafting Note: The NAIC *Long-Term Care Insurance Model Act* (#640) 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~~the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).

NOTE TO THE SUBGROUP: SUBGROUP INTENDS TO RETURN TO DISCUSS TRICARE SUPPLEMENT INSURANCE POLICIES.

- ~~(5)~~(3) TRICARE formerly known as the Civilian Health and Medical Program of the Uniformed Services (Chapter 55, title 10 of the United States Code) (CHAMPUS) supplement insurance policies.

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

Section 3. Definitions

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

Drafting Note: The phrase ~~“accident and sicknessancillary health”~~ 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 sicknessancillary health~~ 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.~~

~~ED.~~ “Direct response solicitation” means a communication through a sponsoring or endorsing entity or individually through mail, telephone, the internet or other mass communication media.

~~FE.~~ “Form” means policies, certificates, contracts, riders, endorsements and applications as provided in [insert reference to state law regarding the filing and approval of ~~individual accident and sickness~~ancillary health 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.~~

~~F.~~ Hospital indemnity or other fixed indemnity insurance” refers to coverage that pays benefits in a fixed dollar amount on the basis of per day (or other fixed time period) and/or per service regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage.

Drafting Note: “Hospital indemnity or other fixed indemnity insurance” does not include any other type or category of insurance that is listed separately as an excepted benefit in Section 2791(c) of the federal Public Health Service Act (PHSA) (e.g., disability income protection coverage, specified disease coverage, etc.) regardless of whether benefits under such coverage are paid as a fixed dollar amount.

~~G.~~ “Limited scope dental coverage” means insurance that provides coverage substantially all of which is for treatment of mouth, including any organ or structure within the mouth, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

~~H.~~ “Limited scope vision coverage” means insurance that provides coverage substantially all of which is for treatment of the eye, which is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of a group benefit plan.

~~HJ.~~ “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.~~

NOTE TO THE SUBGROUP: THE FEDERAL AGENCIES IMPLEMENTING THE ACA PUBLISHED PROPOSED REGULATIONS IN THE *FEDERAL REGISTER*, JUNE 10, 2016, THAT WOULD REVISE THE DEFINITION OF “SHORT-TERM, LIMITED DURATION INSURANCE” REQUIRING THE COVERAGE TO BE LESS THAN THREE MONTHS IN DURATION, INCLUDING ANY PERIOD FOR WHICH THE POLICYHOLDER RENEWS OR HAS AN OPTION TO RENEW WITH OR WITHOUT THE ISSUER’S CONSENT.

~~J.~~ “Short-term, limited-duration insurance” means health insurance coverage provided pursuant to a contract with a health carrier that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the carrier’s consent) that is less than twelve (12) months after the original effective date of the contract.

Drafting Note: Some states may have different durations for the length of short-term, limited-duration insurance than the 12 months provided in the definition of “short-term, limited-duration insurance” above. States should review their definition for this term and change the duration length if necessary.

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~~ ancillary health insurance subject to this Act.

The commissioner may issue additional regulations to establish specific standards for the sale of limited scope dental and limited scope vision ~~plans~~coverage. 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, mental or nervous disorder, guaranteed renewable and noncancellable.

Drafting Note: States may want to consider reviewing issues surrounding post-claims underwriting possibly using their state unfair practices law or regulation, or other appropriate state law or regulation, to address issues, such as policy rescissions in instances of fraud and intentional misrepresentation.

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) (#180) 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~~ ancillary health insurance subject to this Act. ~~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)~~(1) Hospital ~~confinement~~ indemnity or other fixed indemnity coverage;
- ~~(5)~~ ~~Individual major medical expense coverage;~~
- ~~(6)~~ ~~Individual basic medical expense coverage;~~
- ~~(7)~~(2) Disability income protection coverage;
- ~~(8)~~(3) Accident only coverage;
- ~~(9)~~(4) Specified disease coverage;
- ~~(5)~~ Short-term, limited-duration coverage;
- ~~(10)~~(6) Specified accident coverage; and

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.

- ~~(11)~~(7) 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)~~ Subsection A. 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, as amended by the ACA, thus making those combination policies subject to HIPAA requirements as amended by the ACA, and ACA requirements, such as guaranteed availability, guaranteed renewability and premium rating restrictions. States may want to consider developing regulations on combination products and the potential for such products to confuse consumers that the combination coverage is equivalent to comprehensive, major medical coverage.

- 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, subject to this Act and limited scope dental plans coverage~~ and limited scope vision ~~plans coverage~~ 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 ancillary health insurance ~~group supplemental health insurance~~, group limited scope dental ~~plans coverage~~ and group limited scope vision ~~plans coverage~~ 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 Provision* Law (#180) 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].

NOTE TO THE SUBGROUP: THE FEDERAL AGENCIES IMPLEMENTING THE ACA PUBLISHED PROPOSED REGULATIONS IN THE *FEDERAL REGISTER*, JUNE 10, 2016, THAT WOULD REQUIRE ISSUERS TO DISPLAY PROMINENTLY IN THE CONTRACT AND ANY APPLICATION MATERIALS PROVIDED IN CONNECTION WITH ENROLLMENT IN SHORT-TERM, LIMITED-DURATION INSURANCE THE FOLLOWING: “THIS IS NOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.”

- J. For accident and sickness insurance providing hospital indemnity or other fixed indemnity coverage or short-term, limited-duration coverage an insurer shall display prominently in the application materials a notice reflecting that the coverage is not minimum essential coverage within the meaning of Section 5000A(f) of the Internal Revenue Code (IRC) and that the lack of minimum essential coverage could result in an individual tax penalty, as provided in Section 5000A(b) of the IRC.

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].

W:\Drafts\04 – Model Laws, Regulations & Guidelines#\# 170 – Accident and Sickness Insurance Minimum Standards Model Act\MO170-v1.docx