REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Aug. 3, 2019, Minutes
  Regulatory Framework (B) Task Force May 15, 2019, Minutes (Attachment One)
  Regulatory Framework (B) Task Force Amended 2019 Charges (Attachment One-A)
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  Working Draft Revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171), Draft Dated 5-31-19 (Attachment Three-A)
ERISA (B) Working Group Aug. 3, 2019, Minutes (Attachment Four)
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HMO Issues (B) Subgroup May 16, 2019, Minutes (Attachment Six)
HMO Issues (B) Subgroup April 29, 2019, Minutes (Attachment Seven)
  HMO Issues (B) Subgroup Draft Work Plan (Attachment Seven-A)
Pharmacy Benefit Manager Regulatory Issues (B) Subgroup July 18, 2019, Minutes (Attachment Eight)
The Regulatory Framework (B) Task Force met in New York, NY, Aug. 3, 2019. The following Task Force members participated: Michael Conway, Chair (CO); Scott A. White, Vice Chair, represented by Don Beatty (VA); Lori K. Wing-Heier represented by Jacob Lauten (AK); Jim L. Ridling represented by Steve Ostlund (AL); Allen W. Kerr represented by Mel Anderson (AR); Ricardo Lara represented by Tyler McKinney (CA); Stephen C. Taylor represented by Howard Liebers (DC); David Altmaier represented by Craig Wright (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Vicki Schmidt represented by Julie Holmes (KS); Nancy G. Atkins represented by John Melvin (KY); Gary Anderson represented by Matthew Veno and Kevin Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Steve Kelley represented by Melinda Domzalski-Hansen (MN); Chlora Lindley-Myers represented by Angela Nelson and Mary Mealer (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Chrystat Bartuska (ND); Bruce R. Ramge represented by Martin Swanson and Laura Arp (NE); John G. Franchini represented by Paige Duhamel (NM); Glen Mulready represented by Cuc Nguyen (OK); Andrew Stolfi represented by TK Keen (OR); Jessica Altman represented by Katie Dzurec (PA); Raymond G. Farmer represented by Diane Cooper and Gwen Fuller McGriff (SC); Larry Deiter represented by Jill Kruger (SD); Kent Sullivan represented by Rachel Bowden (TX); Mike Kreidler represented by Molly Nollette (WA); and Mark Afable represented by Nathan Houlde and Jennifer Stegall (WI). Also participating were: Derek Oestreicher (MT); Troy Oechsner (NY); and Marie Ganim (RI).

1. **Adopted its May 15 and Spring National Meeting Minutes**

   The Task Force met May 15 and April 6. During its May 15 meeting, the Task Force took the following action: 1) adopted amended 2019 charges to add a charge for the HMO Issues (B) Subgroup to, “[r]evise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520);” and 2) adopted the HMO Issues (B) Subgroup’s Request for NAIC Model Law Development to revise Model #430 consistent with its 2019 charge.

   Mr. Ostlund made a motion, seconded by Mr. Keen, to adopt the Task Force’s May 15 (Attachment One) and April 6 (see NAIC Proceedings – Spring 2019, Regulatory Framework (B) Task Force) minutes. The motion passed unanimously.

2. **Adopted its Subgroup and Working Group Reports**

   a. **Accident and Sickness Insurance Minimum Standards (B) Subgroup**

   Ms. Domzalski-Hansen said the Subgroup met July 8 and June 17. During these meetings, the Subgroup discussed its approach to revising the provisions of the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170). She said the Subgroup decided to use a NAIC working draft of the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) as a starting point for the Subgroup’s work to revise Model #171 and review and discuss potential revisions to this working draft section-by-section. She said the Subgroup also discussed adhering to certain general guidelines as it works to revise Model #171, such as not reopening issues discussed and settled during the Subgroup’s work revising Model #170 and not including topics not included in Model #170.

   Ms. Domzalski-Hansen said the Subgroup also discussed initial comments received from several stakeholders, including the American Council of Life Insurers (ACLI), America’s Health Insurance Plans (AHIP), the Association for Community Affiliated Plans (ACAP), the Blue Cross Blue Shield Association (BCBSA), and the Coalition to Preserve Health Plan Choices (HPC), on revising Model #171. She said those comments reflected several themes and suggestions for the Subgroup’s focus on revising Model #171, including: 1) excepted benefits or supplemental coverage is different from short-term, limited-duration (STLD) plan coverage; 2) updating Model #171’s terminology; 3) developing disclosures for each type of coverage; and 4) developing standards for group and individual coverage, and distinguishing between the two types of coverage, as necessary.

   Ms. Domzalski-Hansen said the Subgroup set a public comment period ending July 30 to receive comments on Sections 1–5 of Model #171. The Subgroup plans to begin its review and discussion of the comments received following the Summer National Meeting.
Ms. Mealer made a motion, seconded by Mr. Keen, to adopt the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its July 8 (Attachment Two) and June 17 (Attachment Three) minutes. The motion passed unanimously.

b. **ERISA (B) Working Group**

Mr. Wake said the ERISA (B) Working Group met Aug. 3. During this meeting, the Working Group adopted its April 6 minutes *see NAIC Proceedings – Spring 2019, Regulatory Framework (B) Task Force, Attachment Four*. He said the Working Group also discussed association health plans (AHPs), including state legislative and regulatory activity addressing multiple employer welfare arrangements (MEWAs). He also noted that the Working Group is continuing to hold regulator-to-regulator conference calls with the U.S. Department of Labor (DOL) concerning the AHPs and the federal rule. He said the Working Group heard that the MEWA Association of America will be holding its first annual meeting during the Fall National Meeting, and state insurance regulators and interested parties are invited to attend. He said the Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

Ms. Nollette made a motion, seconded by Ms. Dzurec, to adopt the report of the ERISA (B) Working Group (Attachment Four). The motion passed unanimously.

c. **HMO Issues (B) Subgroup**

Mr. Beatty said the HMO Issues (B) Subgroup met June 24, May 16 and April 29. During these meetings, the Subgroup adopted its 2019 charge. The Subgroup also adopted a Request for NAIC Model Law Development to revise Model #430 consistent with its 2019 charge. He noted that the Subgroup’s Request for NAIC Model Law Development is scheduled to be considered for adoption by the Executive (EX) Committee at the Summer National Meeting. He said the Subgroup also discussed initial comments related to its work to revise Model #430 consistent with its 2019 charge, and it agreed on a potential work plan for moving forward with its work. He said the Subgroup plans to begin its work via conference call after the Summer National Meeting.

Ms. Mealer made a motion, seconded by Mr. Swanson, to adopt the report of the HMO Issues (B) Subgroup, including its June 24 (Attachment Five), May 16 (Attachment Six), and April 29 (Attachment Seven) minutes. The motion passed unanimously.

d. **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup**

Mr. Keen said the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup met July 18. During this meeting, the Subgroup heard a presentation from NAIC staff on the history of pharmacy benefit managers (PBMs) and their functions and role. The presentation also included a discussion of state and federal legislation, laws regulating PBMs and their business operations, and legal challenges to state PBM laws. He said the presentation also discussed NAIC PBM activities to date, including the Subgroup’s appointment and its 2019 charge to consider developing a new NAIC model to establish a licensing or registration process for PBMs. As part of its 2019 charge, the Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency. Mr. Keen said the Subgroup will continue its information-gathering sessions via conference call in August.

Ms. Nollette made a motion, seconded by Ms. Duhamel, to adopt the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, including its July 18 minutes (Attachment Eight). The motion passed unanimously.

3. **Heard an Update on the CHIR’s Work Related to the ACA**

Justin Giovannelli (Center on Health Insurance Reforms—CHIR, Georgetown University Health Policy Institute) provided an update on the CHIR’s work related to the federal Affordable Care Act (ACA) and other issues of interest to state insurance regulators. He discussed the CHIR’s work related to the balance billing issue, particularly with respect to state activity, as reflected in a July CHIR report, supported by the Commonwealth Fund, “States Are Taking New Steps to Protect Consumers from Balance Billing, But Federal Action Is Necessary to Fill Gaps.” He also cited a recent report analyzing New York’s 2014 law on surprise billing. He said the CHIR’s analysis of the law’s impact to date is that it appears to have had significant benefits for consumers, but gaps remain with respect to self-funded plans.

Mr. Giovannelli also discussed a recent report in Health Affairs, “Successfully Splitting The Baby: Design Considerations For Federal Balance Billing Legislation,” which provides lessons and considerations for both federal and state policymakers with
Mr. Giovannelli also discussed the CHIR’s work analyzing state activity with respect to regulating products, such as AHPs, STLDP, and health care sharing ministries, outside the ACA-compliant individual market. Lastly, he discussed state reforms, particularly through the ACA’s Section 1332 waiver process, to improve the affordability of comprehensive coverage in the individual market. He also noted the resources the CHIR has for state insurance regulators, including its publications and blog.

Commissioner Conway asked if, with respect to affordability of coverage in the individual market, the CHIR has studied subsidies. Mr. Giovannelli said the CHIR is still in the early stage of its analysis, but it is looking at legislation passed in California that increased subsidies. He said he believes that this increase could have a positive impact. He also noted reinsurance, which many states have used to reduce premium through the Section 1332 waiver process, to address affordability.

Ms. Duhamel asked if the CHIR has researched what Massachusetts has done through its wrap program with respect to affordability. Mr. Giovannelli said the CHIR has not specifically looked at Massachusetts, but he said this would be something that the CHIR can think about for a future project.

4. Heard a Presentation on the Montana PBM Legislation

Mr. Oestreicher discussed the history, purpose and provisions of Senate Bill 71 (SB71) to address issues related to PBMs, which passed in Montana but was ultimately vetoed. He said before drafting SB71, he considered two questions: 1) why prescription drug costs are so high; and 2) what state insurance departments can do to combat rising drug costs. He said to answer these questions, the Montana Department of Insurance (DOI) focused on obtaining information relevant to these questions from PBMs. He said after receiving this information, the Montana DOI focused on ways it could address the broken system. He said different approaches were considered, but ultimately, it was decided to develop a bill using the DOI’s current regulatory authority over health insurers to address the issue. He said SB71 comprised a list of best practices for insurers to include in their PBM contracts: 1) prohibit spread pricing; 2) require that all rebates be passed through the insurer; and 3) utilize rebate savings to directly lower premiums. He also discussed the opposition to SB71, which included claims that SB71 would: 1) prohibit mail order pharmacies; 2) increase administrative cost and manufacturer drug prices; and 3) cause insurers to violate the minimum loss ratio (MLR) under the ACA.

Mr. Oestreicher noted that the National Academy for State Health Policy (NASHP) adopted SB71 as model legislation. He said Maine recently enacted legislation, LD 1504, which is based on SB71. He pointed out that Maine’s legislation included a unique approach to spread pricing by permitting an insurer to allow spread pricing while requiring the insurer to account for the “spread” as an administrative cost for the purposes of the ACA’s MLR. He said the U.S. Senate Committee on Health, Education, Labor and Pensions (HELP) included provisions from SB71 in The Lower Health Care Costs Act of 2019 (S. 1895), Section 306. He also discussed continuing legal and regulatory actions against the Montana DOI.

Commissioner Godfread asked if SB71 would have required additional staffing resources. Mr. Oestreicher said the Montana DOI did not anticipate having to hire additional staff because SB71 relied on its regulatory authority over health insurers to enforce its PBM-related requirements. Mr. Keen asked if SB71 created a private right of action. Mr. Oestreicher said it did not. Mr. Oechsner asked Mr. Oestreicher if he thought prohibiting PBMs from spread pricing meant they would find another way to make up for the loss of this money. Mr. Oestreicher said he did think that was a possibility, which is why SB71 provided a global solution to address the issue of high prescription drug prices, not just relying on prohibiting spread pricing.

Commissioner Conway asked if the Montana DOI considered the cost-sharing component with respect to SB71’s pass-through provision. Mr. Oestreicher said the Montana DOI considered whether it should reduce premium or cost-sharing. He said ultimately, it decided to reduce premium.

5. Heard a Panel Presentation on State Activities Related to Mental Health Parity

The Task Force heard a panel presentation on state activities related to mental health parity. Andrew Sperling (National Alliance on Mental Illness—NAMI) said he believes the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) has been successful, but there remain issues, particularly with respect to non-quantitative treatment limits (NQTLs). He noted that the MHPAEA does not preempt state laws. He also noted that challenges remain with respect to enforcement because enforcement relies largely on complaints. He also said certain groups are trying to develop an accreditation tool to address some of these issues and challenges.
Debra Judy (Colorado Consumer Health Initiative) highlighted Colorado’s mental health parity activities. She discussed Colorado’s newly created Office of the Ombudsman for Behavioral Health Access (Office). She said the position operates independently and interacts directly with patients, families, providers, advocates and other stakeholders on complaints, concerns, and complex challenges related to behavioral health prevention, treatment and recovery. She said the Office is tracking stakeholder complaints and issues with the provision of mental health and substance use disorder services, and it will release its first report next year. However, because the Office started in 2018, the complaint data and other data in the report is probably not going to be robust. Ms. Judy also discussed the recent passage of Colorado’s “Behavioral Health Care Coverage Modernization Act” to address issues related to coverage of behavioral, mental health, and substance use disorder services under private health insurance and the state medical assistance program (Medicaid). She also discussed other activities, such as developing worksheets to assist with insurer compliance. She also urged the states to conduct market conduct examinations to gauge compliance. She discussed additional challenges, such as network adequacy. She noted that because of these network adequacy issues, consumers face challenges in obtaining initial appointments and follow up appointments. She said she anticipates the new Colorado helping with these challenges.

Laura Colbert (Georgians for a Healthy Future) said the states fall on a spectrum with respect to their activities on mental health parity. She said Georgia is at the initial stages, but it is making efforts to increase its activity in this area. She highlighted Georgia’s activities toward this goal: 1) participating in interagency work groups; 2) gathering data; and 3) more open communication with consumers and consumer groups.

Having no further business, the Regulatory Framework (B) Task Force adjourned.
The Regulatory Framework (B) Task Force met via conference call May 15, 2019. The following Task Force members participated: Michael Conway, Chair (CO); Scott A. White, Vice Chair (VA); Lori K. Wing-Heier represented by Sarah Bailey and Jacob Lauten (AK); Jim L. Ridling represented by William Rodgers, Steve Ostlund and Yada Horace (AL); Ricardo Lara represented by Sheirin Ghoddoucy (CA); David Altmaier represented by Chris Struk (FL); Doug Ommen represented by Andria Seip and Cynthia Banks-Radke (IA); Dean L. Cameron (ID); Vicki Schmidt represented by Julie Holmes (KS); Nancy G. Atkins represented by Bill Beagan (MA); Eric A. Cioppa represented by Robert Wake (ME); Steve Kelley represented by Kristi Bohn (MN); Chlora Lindley-Myers (MO); Mike Chaney represented by Bob Williams (MS); Mike Causey represented by Ted Hamby (NC); Jon Godfread represented by Crystll Bartuska (ND); Bruce R. Ramge represented by Martin Swanson (NE); John G. Franchini represented by Paige Duhamel (NM); Glen Mulready represented by Ron Kreiter (OK); Andrew Stolfi represented by TK Keen and Gayle Woods (OR); Jessica Altman represented by Alison Beam (PA); Raymond G. Farmer represented by Kendall Buchanan (SC); Kent Sullivan represented by Doug Danzeiser (TX); Todd E. Kiser represented by Jaakob Sundberg (UT); Mike Kreidler represented by Molly Nollette (WA); Mark Afable represented by Nathan Houdek (WI); and James A. Dodrill represented by Ellen Potter (WV).

1. **Adopted Amended 2019 Charges**

   Jolie Matthews (NAIC) explained that after the Health Insurance and Managed Care (B) Committee adopted the HMO Issues (B) Subgroup’s recommendation to open the *Health Maintenance Organization Model Act* (#430) for revision, the Subgroup adopted a 2019 charge during its April 29 conference call to “revise provisions in the *Health Maintenance Organization Model Act* (#430) to address conflicts and redundancies with the provisions in the *Life and Health Insurance Guaranty Association Model Act* (#520).” Commissioner Conway requested comments. There were no comments.

   Ms. Nollette made a motion, seconded by Mr. Wake, to adopt the Task Force’s amended 2019 charges, adding the Subgroup’s 2019 charge (Attachment One-A). The motion passed unanimously.

2. **Adopted the HMO Issues (B) Subgroup Request for NAIC Model Law Development**

   Commissioner Conway said that during the HMO Issues (B) Subgroup’s April 29 conference call, the Subgroup adopted a Request for NAIC Model Law Development to consider revisions to Model #430 to address conflicts and redundancies with provisions in Model #520. He requested comments.

   Mr. Wake asked if the Subgroup could consider additional revisions to Model #430 not related to Model #520. Commissioner Conway said he believes such revisions would be outside the scope of the Request for NAIC Model Law Development. As such, the Subgroup would have to request a change in the Request for NAIC Model Law Development and its 2019 charge, as well.

   Chris Petersen (Arbor Strategies, LLC) said he believes the Subgroup intentionally drafted the Request for NAIC Model Law Development narrowly in order for the Subgroup to expeditiously complete its work, given that the states are enacting the revised Model #520, which adds health maintenance organizations as members of the guaranty fund association. Mr. Wake agreed with Mr. Petersen’s comments.

   Ms. Nollette made a motion, seconded by Director Cameron, to adopt the Request for NAIC Model Law Development (Attachment One-B). The motion passed unanimously.

   Having no further business, the Regulatory Framework (B) Task Force adjourned.
2019 AMENDED CHARGES

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products and Services

1. The Regulatory Framework (B) Task Force will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority and structures.
   C. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2019.
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the ERISA (B) Working Group, monitor, report and analyze developments related to association health plans (AHPs).
   F. Monitor, analyze and report, as necessary, developments related to short-term, limited-duration coverage.

2. The Accident and Sickness Insurance Minimum Standards (B) Subgroup will:
   A. Review and consider revisions to the Accident and Sickness Insurance Minimum Standards Model Act (#170) and its companion regulation, the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171).

3. The ERISA (B) Working Group will:
   A. Monitor, report and analyze developments related to the federal Employee Retirement Income Security Act (ERISA), and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate and coordinate with the states and the U.S. Department of Labor (DOL) related to sham health plans.
   C. Monitor, facilitate and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the ACA that relate to ERISA.

4. The HMO Issues (B) Subgroup will:
   A. Revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520).

45. The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:
   A. Consider developing a new NAIC model to establish a licensing or registration process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.

NAIC Support Staff: Jolie H. Matthews/Jennifer R. Cook
REQUEST FOR NAIC MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: □ New Model Law or □ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:

HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force

2. NAIC staff support contact information:

Jolie Matthews jmatthews@naic.org

3. Please provide a brief description of the proposed new model or the amendment(s) to the existing model. If you are proposing a new model, please also provide a proposed title. If an existing model law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

The Subgroup has a charge to revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with provisions in the Life and Health Insurance Guaranty Association Model Act (#520).

4. Does the model law meet the Model Law Criteria? □ Yes or □ No (Check one)

(If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).

   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? □ Yes or □ No (Check one)

      If yes, please explain why

The revisions would provide guidance to those states that have adopted Model #430 and the revised Model #520, which added HMOs as members of the guaranty association, in addressing conflicts and redundancies in Model #430 with the revised Model #520.

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law? □ Yes or □ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?

   □ 1 High Likelihood □ 2 □ 3 □ 4 □ 5 Low Likelihood (Check one)

   Explanation, if necessary: The current subgroup would target completion of a model within one year.
6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?

☐ 1  ☒ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: State adoption of the anticipated revisions will depend on whether states have adopted the current Model #430 or its equivalent and adopted the revised Model #520.

7. What is the likelihood that state legislatures will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1  ☒ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood  Low Likelihood

Explanation, if necessary: State adoption of the anticipated revisions will depend on whether states have adopted the current Model #430 or its equivalent and adopted the revised Model #520.

8. Is this model law referenced in the NAIC Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup met via conference call July 8, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Adam Boggess (CO); Chris Struk (FL); Frank Opelka (LA); Mary Mealer, Molly White, and Amy Hoyt (MO); Martin Swanson (NE); Gayle Woods (OR); Jessica Altman and Alison Beam (PA); Kendall Buchanan (SC); Tanji Northrup (UT); Anna Van Fleet (VT); Michael Bryant and Andrea Philhower (WA); and Nathan Houdek (WI). Also participating were: Susan Jennette (DE); Weston Trexler (ID); John G. Franchini (NM); and Tyler Laughlin (OK).

1. Discussed June 28 Comments on Revisions to Model #171

Ms. Domzalski-Hansen reminded the Subgroup about what it discussed during its June 17 conference call. She said during that call, the Subgroup agreed to use the NAIC staff working draft as a framework for its work to revise the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). She also said the Subgroup agreed during its discussion of revisions that the Subgroup would adhere to these general guidelines: 1) not to reopen issues discussed and settled during the Subgroup’s work revising the Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) (formerly known as the Accident and Sickness Insurance Minimum Standards Model Act); 2) acknowledge that Model #171 sets minimum standards; 3) not include topics not included in Model #170; and 4) acknowledge the current supplemental market works and revise Model #171 in a manner to avoid market disruption.

Ms. Domzalski-Hansen said during the Subgroup’s June 17 conference call, it also set a June 28 public comment deadline to receive additional comments on potential revisions to Model #171. She said the Subgroup received comments from the American Council of Life Insurers (ACLI), America’s Health Insurance Plans (AHIP), the Association for Community Affiliated Plans (ACAP), the Blue Cross Blue Shield Association (BCBSA), the Coalition to Preserve Health Plan Choices (HPC), the NAIC consumer representatives, the Missouri Department of Insurance (DOI), and Jackson Williams. She summarized the comments noting several themes, including: 1) excepted benefits or supplemental coverage is different from short-term, limited-duration plan (STLDP) coverage; 2) updating Model #171’s terminology; 3) developing disclosures for each type of coverage; and 4) developing standards for group and individual coverage, and distinguishing between the two types of coverage, as necessary.

Chris Petersen (Arbor Strategies, LLC), representing AHIP, noted AHIP’s support of the principles for review as Ms. Domzalski-Hansen summarized. He said AHIP believes STLDPs are different than excepted benefit plans, and they should be treated differently in the Model #171 revisions. He said AHIP also believes in adequate and sufficient disclosures for each plan. However, he said the Subgroup should be aware that some provisions that may be included in a disclosure for one type of coverage may not be appropriate for another, such as disability income protection coverage. He also expressed support for eliminating the specific dollar amounts currently in Model #171 and replacing them with unspecified amounts.

Sarah Lueck (Center on Budget and Policy Priorities—CBPP) discussed the NAIC consumer representatives’ comments on Model #171. She said in their comments, the NAIC consumer representatives urge the Subgroup to revise the model such that it provides strong minimum standards to protect consumers and avoid fraud and abuse. She said the NAIC consumer representatives do not believe disclosure is enough, which is why they support the inclusion of strong minimum standards. She said the NAIC consumer representatives also suggest the Subgroup form a separate group to consider in-depth how disclosures can most clearly and simply communicate the information consumers need about supplementary and short-term health products. The Subgroup discussed whether it should form such a group. Mr. Struk suggested that forming such a group is unnecessary because the Subgroup would have to review whatever the group develops. In addition, he said because developing disclosures is a major part of the Model #171 revisions, most likely, most Subgroup members would want to be in the group. Mr. Laughlin suggested that forming such a group was premature. The Subgroup should wait until it finishes work on other sections. Ms. Philhower agreed. The Subgroup decided not to form such a group; but, if necessary, it will revisit the issue later.

The Subgroup discussed which sections it should review first. Superintendent Franchini suggested that it was important to work on the disclosure provisions first because of the urgency of providing consumers with sufficient information about these plans to avoid confusion and abuse. Mr. Laughlin agreed that consumer disclosure is an important issue, but the Subgroup needs to work on other provisions in Model #171 first to determine what language needs to be in the disclosures.
The Subgroup discussed the BCBSA comments, which suggest the Subgroup address an issue when STLDPs are sold through out-of-state discretionary groups and delivered to the purchaser as an individual policy. Because the policy was issued in another state, many states’ laws where the purchaser resides may not apply. Superintendent Franchini said this is an issue in New Mexico. Mr. Swanson said Nebraska is currently looking at this issue. Ms. Jennette said Delaware recently enacted legislation addressing this issue, and she agreed to share this information with the Subgroup. Mr. Trexler said Idaho has taken the same approach as Delaware. Ms. White asked if this issue was outside the scope of the Model #170 revisions. Ms. Lueck said she believed it was not because of the language included in the definition of “short-term, limited-duration insurance” in Section 3I.

Heather Foster (ACAP) expressed support for the BCBSA and AHIP comments. Ms. Domzalski-Hansen suggested the Subgroup include a new section to Model #171 on reporting with respect to STLDPs. Ms. Foster said the ACAP does not have a position on whether it should be a new section or included in an existing section. Mr. Swanson noted that the Market Analysis Procedures (D) Working Group is working on a data call related to STLDPs. He suggested that the Subgroup wait until this project is done before moving forward with possibly adding a reporting provision for STLDPs to Model #171.

2. Discussed its Next Steps

Ms. Domzalski-Hansen explained that during the Subgroup’s June 17 conference call, the Subgroup agreed to review Model #171 for potential revision section-by-section. She suggested that the Subgroup begin with Section 6. Ms. Philhower disagreed. She said the Subgroup needed to begin its review from the beginning. After discussion, the Subgroup set a public comment deadline ending July 22 to receive comments on Sections 1–5. The Subgroup will review any comments received during a conference call after the Summer National Meeting.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
The Accident and Sickness Insurance Minimum Standards (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call June 17, 2019. The following Subgroup members participated: Glen Mulready, Co-Chair (OK); Melinda Domzalski-Hansen, Co-Chair (MN); Adam Boggess (CO); Chris Struk (FL); Robert Wake (ME); Molly White and Amy Hoyt (MO); Martin Swanson and Laura Arp (NE); Gayle Woods (OR); Nicole McClain and Alison Beam (PA); Kendall Buchanan (SC); Jaakob Sundberg, Heidi Clausen and Nancy Askerlund (UT); Jamie Gile (VT); Andrea Philhower (WA); and Nathan Houdeke (WI).

1. Discussed Working Draft

Ms. Domzalski-Hansen said prior to the conference call, NAIC staff distributed a revised working draft of proposed revisions to the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) reflecting the recently adopted revised Supplementary and Short-Term Health Insurance Minimum Standards Model Act (#170) (formerly known as the Accident and Sickness Insurance Minimum Standards Model Act) (Attachment Three-A).

Jolie Matthews (NAIC) reviewed the working draft. She explained that her goal was not to make substantive revisions, but only to make proposed revisions for consistency with the revisions to Model #170, such as the name of the model. She also explained the inclusion of short-term, limited-duration plans (STLDPs) and the placeholder she included for the Subgroup to include specific requirements for this type of plan. Commissioner Mulready expressed his support for consumers having more options for their health care coverage, but he stressed the importance of disclosures, so the consumer understands what they are purchasing prior to purchase. The Subgroup discussed whether to use the working draft as a starting point for its work. Ms. White made a motion, seconded by Mr. Struk, to use the working draft as a starting point for the Subgroup’s work to revise Model #171. The motion passed unanimously. The Subgroup agreed that the language in the working draft is subject to change as the Subgroup moves through the model.

2. Discussed Subgroup Approach to Revising Model #171

Ms. Domzalski-Hansen said the Subgroup has at least two approaches it could take: 1) “section-by-section”; or 2) another approach, such as “topic-by-topic.” Chris Petersen (Arbor Strategies, LLC) urged the Subgroup to consider certain underlying principles no matter what approach it takes. He outlined his suggested underlying principles, including: 1) the Subgroup should not “relitigate” what was decided during its discussions related to the Model #170 revisions, such as not including STLDPs; and 2) the Subgroup should acknowledge that Model #171 sets minimum standards for the types of coverages subject to its requirements, not “maximum” requirements. Mr. Petersen discussed the likelihood that the Subgroup, in reviewing existing or developing new disclosure requirements for the various coverages subject to Model #171, would most likely have to vary the disclosure language depending on the type of coverage. J.P. Wieske (Horizon Government Affairs) agreed. After additional discussion, the Subgroup agreed to review Model #171 section-by-section. The Subgroup also agreed to keep in mind Mr. Petersen’s suggested principles as it works to revise Model #171. The Subgroup set a public comment period ending June 28 to receive comments on the working draft. The Subgroup plans to begin reviewing those comments during its July 8 conference call.

Having no further business, the Accident and Sickness Insurance Minimum Standards (B) Subgroup adjourned.
Comments are being requested on this draft by June 28, 2019. 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.

MODEL REGULATION TO IMPLEMENT THE ACCIDENT AND SICKNESS SUPPLEMENTARY AND SHORT-TERM HEALTH INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Purpose

The purpose of this regulation is to implement [insert reference to state law equivalent to the NAIC Accident and Sickness Supplementary and Short-Term Health Insurance Minimum Standards Model Act] (the Act) to standardize and simplify the terms and coverages of individual accident and sickness insurance policies and group accident and sickness policies and certificates providing hospital confinement indemnity, accident only, specified disease specified accident or limited benefit health coverage (hereafter referred to as “group supplemental health insurance”). This regulation is also intended to facilitate public understanding and comparison of coverage, to eliminate provisions contained in individual accident and sickness insurance policies and group supplemental health insurance that may be misleading or confusing in connection with the purchase of the coverages or with the settlement of claims; and to provide for full disclosure in the marketing and sale of individual accident and sickness insurance policies and group supplemental health insurance supplementary and short-term health insurance, as defined in the Act. This regulation is also intended to assert the commissioner’s jurisdiction over limited scope dental coverage and limited scope vision plan coverages, and to provide for disclosure in the sale of those plan coverages.

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

Section 2. Authority

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

Section 3. Applicability and Scope

A. This regulation applies to all individual accident and sickness insurance policies and group supplementary health insurance policies and certificates providing hospital indemnity or other fixed indemnity, accident only, specified accident, specified disease, limited benefit health and disability income protection, referred to collectively in Section 1 of the Act and hereafter, as “supplementary health insurance,” delivered or issued
for delivery in this state on and after [insert effective date] that are not specifically exempted from this regulation. This regulation also applies to short-term, limited-duration health insurance coverage delivered or issued for delivery in this state on and after [insert effective date], which, unless otherwise specified, is included in the definition of “short-term health insurance” under the Act.

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

C. This regulation shall not apply to:

1. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this regulation;
2. Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;
3. Medicare supplement policies subject to [insert reference to state law equivalent to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act];
4. Long-term care insurance policies subject to [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Act]; or
5. TRICARE formerly known as 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.

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

Section 4. Effective Date

This regulation shall be effective on [insert a date not less than 120 days after the date of adoption of the regulation].

Section 5. Policy Definitions

A. Except as provided in this regulation, an individual accident and sickness insurance policy or group supplemental health insurance policy, supplementary or short-term health insurance policy delivered or issued for delivery to any person in this state and to which this regulation applies shall contain definitions respecting the matters set forth below that comply with the requirements of this section.

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

(2) The definition shall not be more restrictive than the following: “injury” or “injuries” means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.
(3) The definition may provide that injuries shall not include injuries for which benefits are provided under workers’ compensation, employers’ liability or similar law, or under a motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

CB. “Convalescent nursing home,” “extended care facility,” or “skilled nursing facility” shall be defined 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 benefits or be qualified to receive approval for payment of Medicare 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 may provide that the term shall not be inclusive of:
   (a) A home, facility or part of a home or facility used primarily for rest;
   (b) A home or facility for the aged or for the care of drug addicts or alcoholics; 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 law may be required in structuring this definition.

C. “Disability” or “disabled” shall be defined as due to injury or sickness.

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

(1) The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital:
   (a) Be an institution licensed to operate as a hospital pursuant to law;
   (b) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
   (c) Provide twenty-four-hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term “hospital” may state that the term shall not be inclusive of:
   (a) Convalescent homes or, convalescent, rest or nursing facilities;
(b) Facilities affording primarily custodial, educational or rehabilitory care;
(c) Facilities for the aged, drug addicts or alcoholics; or
(d) A military or veterans’ hospital, a soldiers’ home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services.

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

E. (1) “Injury” shall be defined as bodily injury resulting from an accident, independent of disease or bodily injury, which occurs while the coverage is in force.

(2) An insurer may indicate that the “injury” shall be sustained independent of sickness.

(3) The definition shall not use words such as “external, violent, visible wounds” or similar words of characterization or description.

(4) The definition may state that the disability shall have occurred within a specified period of time (not less than thirty (30) days) of the injury, otherwise the condition shall be considered a sickness.

(5) The definition may provide that “injury” shall not include an injury for which benefits are provided under workers’ compensation, employers’ liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

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

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

G. “Nurse” may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “nurse,” “trained nurse” or “registered nurse” are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

H. “One period of confinement” means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

I. “Partial disability” shall be defined in relation to mean that, due to a disability, an individual:

(1) the individual’s inability is unable to perform one or more but not all of the “major,” “important” or “essential” duties of the individual’s employment or existing occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation; and

(2) is in fact engaged in work for wage or profit.
JK.  “Physician” may be defined by including 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.

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

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

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

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

M. “Sickness” shall not be defined to be more restrictive than the following: “Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person.” The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker’s compensation, occupational disease, employers’ liability or similar law.

N. “Total disability”
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.

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.

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.


A. Except as provided in Section 5K, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting from disease or condition related to hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six-month exception shall not be applicable where the specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

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

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

C. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than twelve (12) months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.

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

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

Drafting Note: This provision is optional and the desirability of its use should be reviewed by the individual states.
E. Policies providing hospital confinement indemnity or other fixed indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

F. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

1. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

2. Mental or emotional disorders, alcoholism and drug addiction;

3. Pregnancy, except for complications of pregnancy, other than for policies defined in Section 247C 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. 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 of a covered dependent child that has resulted in a functional defect;

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

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

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

8. Treatment provided in a government hospital; 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;

(10) Eye glasses, hearing aids and examination for the prescription or fitting of them;

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

(12) Territorial limitations.

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

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

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

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

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

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. An individual accident and sickness insurance policy or group supplemental 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 SLSH 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 5A and B and C of the NAIC Accident and Sickness Supplementary and Short-Term Health Insurance Minimum Standards Model Act].

A. General Rules

(1) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual accident and sickness supplementary or short-term health 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.

(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 8A(1).

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

c) An individual **accident and sickness supplementary or short-term health 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 only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.

d) 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 **accident and sickness supplementary or short-term health policy** covering both husband and wife, 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:** For Paragraphs (2) and (3) above, coverage as defined under HIPAA or applicable state law must be guaranteed renewable except for reasons stated in Part B Section 2742 of Title XXVII (Public Health Service Act) as amended by HIPAA or applicable state law, unless it is an excepted benefit as described in Part B Sections 2721, 2763 and 2791 of Title XXVII as amended by HIPAA, the ACA or applicable state law.

4) When accidental death and dismemberment coverage is part of the individual **accident and sickness supplementary or short-term health insurance coverage** offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

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

6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

7) Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

8) In individual **accident and sickness supplementary or short-term health insurance policies**, coverage shall continue for a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child’s coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.
A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

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.

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

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

An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

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

A policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations.

**B. Basic Hospital Expense Coverage**

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

1. Daily hospital room and board in an amount not less than the lesser of:
   a. $100
   b. [80%] of the charges for semiprivate room accommodations or
   c. [$3,000] or [ten] times the daily hospital room and board benefits;

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

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

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

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

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

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

C. Basic Medical-Surgical Expense Coverage

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

(1) Surgical services:

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

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

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

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

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

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

D. Basic Hospital/Medical-Surgical Expense Coverage

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

E. Hospital Confinement Indemnity or Other Fixed Indemnity Coverage

(1) "Hospital confinement indemnity or other fixed indemnity coverage" is a policy of accident and sickness supplementary health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $40 per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy.
(2) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

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

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

F. Individual Major Medical Expense Coverage

(1) “Individual major medical expense coverage” is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $500,000; coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out of pocket maximum after any deductibles shall not exceed ten thousand dollars ($10,000) per year, a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed five percent (5%) of the aggregate maximum limit under the policy for each covered person for at least:

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

(b) Miscellaneous hospital services;

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services;

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

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

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

(ii) Convalescent nursing home care;

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

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

(v) Artificial limbs or eyes, casts, splints, trusses or braces;
(vi) Treatment for functional nervous disorders, and mental and emotional disorders; or

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

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

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

G. Individual Basic Medical Expense Coverage

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

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

(b) Miscellaneous hospital services;

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services;

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

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

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

(ii) Convalescent nursing home care;
(iii) Diagnosis and treatment by a radiologist or physiotherapist;
(iv) Rental of special medical equipment, as defined by the insurer in the policy;
(v) Artificial limbs or eyes, casts, splints, trusses or braces;
(vi) Treatment for functional nervous disorders, and mental and emotional disorders;
(vii) Out-of-hospital prescription drugs and medications.

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

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

**Disability Income Protection Coverage**

“Disability income protection coverage” is a policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(1) Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62);

(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;

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

(4) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.
**4D. 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 [$1,000] and a single dismemberment amount shall be at least [$500].

**4E. 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:

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

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

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

   d. Individual accident and sickness supplementary or short-term health insurance policies containing specified disease coverage shall be at least guaranteed renewable.

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

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

(h) Except for the NAIC uniform provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage.

Drafting Note: Specified disease coverage is recognized as supplemental coverage. Any specified disease coverage, therefore, must be payable in addition to and regardless of other coverage. The same general rule should apply so that group insurance cannot reduce its benefits because of the existence of specified disease coverage. Section 3H(4) of the Group Coordination of Benefits Model Regulation states that the definition of a “plan” (for the purpose of coordination of benefits) “shall not include individual or family insurance contracts.” States should consider using this language to prevent benefit reductions that could otherwise occur because of the existence of specified disease coverage purchased by the insured.

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

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

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

(l) Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than six (6) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded.

(m) Hospice Care.

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

(I) For terminally ill patients whose life expectancy is less than six (6) months;

(II) Provided on an inpatient or outpatient basis; and

(III) Directed by a physician.

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

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

(II) A fixed-sum payment of at least $50 per day; and

(III) A lifetime maximum benefit limit of at least $10,000.
(iii) Hospice care does not cover nonterminally ill patients who may be confined in a:

(I) Convalescent home;
(II) Rest or nursing facility;
(III) Skilled nursing facility;
(IV) Rehabilitation unit; or
(V) Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers.

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

(a) Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of [$250] and an overall aggregate benefit limit of no less than [$10,000] and a benefit period of not less than [two (2) years] for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;
(ii) Treatment by a legally qualified physician or surgeon;
(iii) Private duty services of a registered nurse (R.N.);
(iv) X-ray, radium and other therapy procedures used in diagnosis and treatment;
(v) Professional ambulance for local service to or from a local hospital;
(vi) Blood transfusions, including expense incurred for blood donors;
(vii) Drugs and medicines prescribed by a physician;
(viii) The rental of an iron lung or similar mechanical apparatus;
(ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;
(x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
(xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than [$25,000] payable at the rate of not less than [$50] a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges,
with a deductible amount not in excess of [$250], and an overall aggregate benefit limit of not less than [$10,000] and a benefit period of not less than three (3) years shall provide at least the following minimum provisions:

(a) Treatment by, or under the direction of, a legally qualified physician or surgeon;
(b) X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;
(c) Hospital room and board and any other hospital furnished medical services or supplies;
(d) Blood transfusions and their administration, including expense incurred for blood donors;
(e) Drugs and medicines prescribed by a physician;
(f) Professional ambulance for local service to or from a local hospital;
(g) Private duty services of a registered nurse provided in a hospital;
(h) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, Subparagraphs (a), (b), (d), (e) and (g) plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed twenty percent (20%) of covered charges when rendered on an out-patient basis;
(i) Braces, crutches and wheelchairs deemed necessary by the attending physician for the treatment of the disease;
(j) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

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

(I) It is primarily engaged in providing home health care services;
(II) Its policies are established by a group of professional personnel (including at least one physician and one registered nurse);
(III) A physician or a registered nurse provides supervision of home health care services;
(IV) It maintains clinical records on all patients; and
(V) It has a full time administrator.

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

(ii) Home health includes, but is not limited to:
Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;

Physical, occupational or speech and hearing therapy; and

Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.

Physical, speech, hearing and occupational therapy;

Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

Prosthetic devices including wigs and artificial breasts;

Nursing home care for noncustodial services; and

Reconstructive surgery when deemed necessary by the attending physician.

Drafting Note: Policies that offer transportation and lodging benefits for an insured person should not condition those benefits on hospitalization.

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

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

A fixed-sum payment equal to one half the hospital in-patient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and

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

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

A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days.

A fixed-sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days.

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

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

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

(a) These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $1,000.

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

(b) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

Drafting Note: The purpose of requiring equal coverage for all subtypes of a specified disease is to ensure that specified disease policies actually provide what people reasonably expect them to. In approving skin cancer or other exceptions, commissioners should consider whether a specified disease policy might mislead if it treats a subtype of a disease differently from the rest of the specified disease.

K. Specified Accident Coverage

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

L. Limited Benefit Health Coverage

(1) “Limited benefit health coverage” is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, C, D, E, and F, G, I, and K. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 8L8H 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 4J7E 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 benefit health insurance policies.
insurance plans, and should be subject to the NAIC Accident and Sickness Insurance Minimum Standards Model Act and implementing regulation Limited Long-Term Care Insurance Model Act (#642) and its implementing regulation, the Limited Long-Term Care Insurance Model Regulation (#643).

H. Short-Term, Limited-Duration Health Insurance Coverage


A. General Rules

(1) All applications for coverages specified in Sections 7B, C, D, E, F, G, I, J, K and L and H shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant’s signature block on the application as follows:

“The [policy] [certificate] provides limited benefits. Review your [policy] [certificate] carefully.”

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

“The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully.”

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

“The [policy] [certificate] provides vision benefits only. Review your [policy] [certificate] carefully.”

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

(5) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirements in this paragraph apply to group supplemental health insurance certificates only where the certificateholder also pays the insurance premium.

(6) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate.
(7) A policy or certificate that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(8) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as “Preexisting Condition Limitations.”

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

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

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

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

Drafting Note: This section should be included only if the state has legislation granting authority.

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

(12) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be “Conversion Privilege” or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(13) (a) Outlines of coverage delivered in connection with policies defined in this regulation as hospital confinement indemnity or other fixed indemnity (Section 7E7B), specified disease (Section 7E7F), or limited benefit health coverages (Section 7L7G) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections FD and JF, the following language, which shall be printed on or attached to the first page of the outline of coverage:

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.
An insurer shall deliver to persons eligible for Medicare any notice required under [insert reference to state law equivalent of Section 17D of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act].

(14) Insurers, except direct response insurers, shall give a person applying for specified disease insurance a Buyer’s Guide approved by the commissioner at the time of application enrollment and shall obtain all recipients’ written acknowledgement of the guide’s delivery. Direct response insurers shall provide the Buyer’s Guide upon request but not later than the time that the policy or certificate is delivered.

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

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

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

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

(b) For all “hospital indemnity or other fixed indemnity” products sold in the individual market, a notice must be displayed prominently in the application materials in at least 14 point type that has the following language: “THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.”

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

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

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

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

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

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

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

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

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

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

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

“Notice to Buyer: This [policy][certificate] provides dental benefits only.”

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

“Notice to Buyer: This [policy][certificate] provides vision benefits only.”

B. Outline of Coverage Requirements

(1) An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual accident and sickness insurance, group supplemental and short-term health insurance, limited scope dental plan coverage and limited scope vision plan coverage as required in Section 6 of the Act.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name:

“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon [application][enrollment], and the coverage originally applied for has not been issued.”
(3) The appropriate outline of coverage for policies or contracts providing hospital coverage that only meets the standards of Section 7B shall be that statement contained in Section 8C. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 7B and C shall be the statement contained in Section 8E. The appropriate outline of coverage for policies providing coverage which meets the standards of both Sections 7B and E or Sections 7C and E or Sections 7B, C, and E shall be the statement contained in Section 8G.

(4) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

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

C. Basic Hospital Expense Coverage (Outline of Coverage)

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

[COMPANY NAME]

BASIC HOSPITAL EXPENSE COVERAGE

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

OUTLINE OF COVERAGE

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

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

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

(a) Daily hospital room and board;
(b) Miscellaneous hospital services;
(c) Hospital out-patient services; and
(d) Other benefits, if any.]
Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

(5) [A description of policy provisions respecting renewability or continuation of coverage, including any reservation of right to change premiums.]

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

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

[COMPANY NAME]

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

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

OUTLINE OF COVERAGE

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

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

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

(a) Surgical services;
(b) Anesthesia services;
(c) In-hospital medical services; and
(d) Other benefits, if any]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]
(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.]

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

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

[COMPANY NAME]

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

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

OUTLINE OF COVERAGE

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

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

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

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Hospital outpatient services;

(d) Surgical services;

(e) Anesthesia services;

(f) In-hospital medical services; and

(g) Other benefits, if any.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]
FD. Hospital Confinement Indemnity or Other Fixed Indemnity Coverage (Outline of Coverage)

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

[COMPANY NAME]

HOSPITAL CONFINEMENT INDEMNITY [OR OTHER FIXED INDEMNITY] COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS

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

OUTLINE OF COVERAGE

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

(2) Hospital confinement indemnity or other fixed indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement services and any additional benefit described below.

(3) [A brief specific description of the benefits in the following order:

(a) Daily benefit payable during hospital confinement; and

(b) Duration of benefit described in (a).]

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

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Paragraph (3) above.]

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

(6) [Any benefits provided in addition to the daily hospital benefit.]

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

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

[COMPANY NAME]
INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

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

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

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

(a) Daily hospital room and board;
(b) Miscellaneous hospital services;
(c) Surgical services;
(d) Anesthesia services;
(e) In-hospital medical services;
(f) Out of hospital care;
(g) Maximum dollar amount for covered charges; and
(h) Other benefits, if any.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

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

H. Individual Basic Medical Expense Coverage

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

[COMPANY NAME]

INDIVIDUAL BASIC MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

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

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

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

(a) Daily hospital room and board;
(b) Miscellaneous hospital services;
(c) Surgical services;
(d) Anesthesia services;
(e) In-hospital medical services;
(f) Out of hospital care;
(g) Maximum dollar amount for covered charges; and
(h) Other benefits, if any.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

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

IE. Disability Income Protection Coverage (Outline of Coverage)

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

[COMPANY NAME]

DISABILITY INCOME PROTECTION COVERAGE

OUTLINE OF COVERAGE

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

(2) Disability income protection coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) [A brief specific description of the benefits contained in this policy.]

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

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

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

JF. Accident-Only Coverage (Outline of Coverage)

An outline of coverage in the form prescribed below shall be issued in connection with policies meeting the standards of Section 717D of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

ACCIDENT-ONLY COVERAGE

THIS [POLICY][CERTIFICATE] PROVIDES LIMITED BENEFITS

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

OUTLINE OF COVERAGE

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

(2) Accident-only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) [A brief specific description of the benefits.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

(4) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]
(5) [A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.]

KG. 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 7E and KF of this regulation. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE

THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS

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

OUTLINE OF COVERAGE

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

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

(3) [Specified disease][Specified accident] coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of [specified diseases] or [specified accidents]. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) [A brief specific description of the benefits, including dollar amounts.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

LH. Limited Benefit Health Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Sections 7B, D and GC, DE, E, F, G, I and K of this regulation. The items included in the outline of coverage must appear in the sequence prescribed:

[COMPANY NAME]

LIMITED BENEFIT HEALTH COVERAGE

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

OUTLINE OF COVERAGE

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

(2) Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.

(3) [A brief specific description of the benefits, including dollar amounts.]

Drafting Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits that vary according to accidental cause shall be made in accordance with Section 7A(13) of this regulation.

(4) [A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (3) above.]

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

MI. Limited Scope Dental Plans Coverage (Outline of Coverage)

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

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

(2) [A brief specific description of the benefits.]

(3) [A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Paragraph (1) above.]

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

NJ. Limited Scope Vision Plans Coverage (Outline of Coverage)

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

(1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY][CERTIFICATE] CAREFULLY!
Section 9. Requirements for Replacement of Individual Accident and Sickness Insurance Supplementary and Short-Term Health Insurance Coverage

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

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

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection C below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Subsection D below. In no event, however, will the notices be required in the solicitation of the following types of policies: accident-only and single-premium nonrenewable policies.

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS SUPPLEMENTARY OR SHORT-TERM HEALTH INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness supplementary or short-term health insurance and replace it with a policy to be issued by [insert company name] Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

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

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as...
though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

________________________________________
(Date)

________________________________________
(Applicant’s Signature)

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

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND SICKNESS INSURANCE SUPPLEMENTARY OR SHORT-TERM HEALTH INSURANCE

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing accident and sickness supplementary or short-term health insurance and replace it with the policy delivered herewith issued by [insert company name] Insurance Company. Your new policy provides thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) [To be included only if the application is attached to the policy]. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

Section 10. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected thereby.
The ERISA (B) Working Group of the Regulatory Framework (B) Task Force met in New York, NY, Aug. 3, 2019. The following Working Group members participated: Robert Wake, Chair (ME); Ryan James (AR); Kate Harris (CO); Howard Liebers (DC); Andria Seip (IA); Julie Holmes (KS); Frank Opelka (LA); Melinda Domzalski-Hansen (MN); Angela Nelson and Mary Mealer (MO); Laura Arp and Martin Swanson (NE); Ted Hamby (NC); Laura Miller (OH); Cuc Nguyen (OK); Jill Kruger (SD); Tanji Northrup (UT); and Toni Hood (WA). Also participating were: Weston Trexler (ID); Erica Baily (MD); David Cassetty (NV); and Tashia Sizemore (OR).

1. Adopted its Spring National Meeting Minutes

Ms. Nelson made a motion, seconded by Mr. James, to adopt the Working Group’s April 6 minutes (see NAIC Proceedings – Spring 2019, Regulatory Framework (B) Task Force, Attachment Four). The motion passed unanimously.

2. Discussed AHPs

Mr. Wake asked for information on state activities regarding multiple employer welfare arrangements (MEWAs) and association health plans (AHPs) since the District Court for the District of Columbia issued its opinion in New York v. U.S. Department of Labor, vacating critical portions of the U.S. Department of Labor’s (DOL) final rule on AHPs. Mr. Bader said the North Carolina legislature was drafting MEWA legislation, and the department of insurance (DOI) has been asked to provide technical assistance. Ms. Hood said in Washington, the DOI was working on a regulation to clarify what it means to be a “bona fide association.” Mr. James said Arkansas was exposing a MEWA rule for public comment that is a hold-over from an attempt years ago to specifically regulate MEWAs. Mr. Wake said Maine was again looking at stop loss insurance requirements after a hiatus from considering changes.

William F. Megna (MEWA Association of America—MAA) said his organization is made up of MEWAs that have gathered to protect the existing infrastructures in which they operate and lower health care costs for small business and their employees. He said the MAA promotes market regulatory changes to open new markets to existing MEWAs through the development of uniform standards for regulation and solvency protections for self-funded MEWAs. He said the MAA would like to work with state insurance regulators on these standards. He said the MAA will be holding its first annual meeting during the 2019 Fall National Meeting in Austin, TX, and everyone is welcome to attend. Mr. Wake said it was unlikely, given the differing perspectives of the states, that the NAIC would support a uniform approach to the regulation of MEWAs, but a forum for hearing what other states are doing might be interesting.

Having no further business, the ERISA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations which may involve either the NAIC or any member in any capacity), paragraph 3 (specific companies, entities or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.
The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call June 24, 2019. The following Subgroup members participated: Don Beatty, Chair, and Doug Stolte (VA); Nichole Boggess (CO); Toma Wilkerson (FL); Robert Wake (ME); Martin Swanson (NE); Ron Pastuch (WA); Jennifer Stegall (WI); and Joylynn Fix (WV).

1. Discussed the Coalition Comment Letter and Next Steps

Mr. Beatty said that in response to the Subgroup’s request for comments from stakeholders on which provisions in the Health Maintenance Organization Model Act (#430) should be considered for revision, the Subgroup received a comment letter from a coalition of health insurers (Coalition)—Aetna, Anthem, Cigna, Health Care Service Corporation (HCSC) and UnitedHealthcare.

Chris Petersen (Arbor Strategies LLC), representing the Coalition, reviewed the Coalition’s comments. He explained that the Coalition’s overarching comments urge the Subgroup to only make the minimum changes necessary to Model #430 and to not adopt revisions that would either weaken or eliminate its consumer and solvency protections. He discussed the Coalition’s detailed comments on some of the sections identified in the 2018 NAIC staff memorandum to the Subgroup for potential revision in light of the revisions to the Life and Health Insurance Guaranty Association Model Act (#520) adding health maintenance organizations (HMOs) to the guaranty association. Those sections include: Section 14—Continuation of Benefits; Section 18—Deposit Requirements; Section 19—Hold Harmless Provision Requirements for Covered Persons; Section 20—Uncovered Expenditures Deposit; and Section 31—Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations.

The Subgroup discussed the Coalition’s comments and the rationale for its position that the provisions in these sections should remain unchanged and/or maintained. Mr. Petersen pointed out the Coalition’s suggestion to amend or delete Section 21—Open Enrollment and Replacement Coverage in the Event of Insolvency because the federal Affordable Care Act (ACA) requires all insurers and HMOs to offer guaranteed issue coverage to individuals who lose their health insurance coverage. As such, it would not be necessary for the state insurance commissioner to order an open enrollment period through other HMOs for those individuals affected by their HMO’s insolvency.

Mr. Petersen reiterated his comment to the Subgroup during its June 17 conference call that the states should continue to seek to enact the revised Model #520 and not wait until the proposed revisions to Model #430 are complete. He pointed out the Coalition’s suggestion to add a drafting note on the issue. Mr. Beatty said he is uncomfortable with the Coalition’s drafting note suggestion, which is designed to provide guidance to other state insurance departments. He asked for Subgroup comments on the suggested drafting note for discussion during the Subgroup’s next conference call. Mr. Stolte noted that he was one of the members that worked on the revisions to Model #520 suggesting that there be a national uniform approach to reviewing Model #430 for revision.

Mr. Beatty asked Subgroup members how they would like to proceed with the Subgroup’s work. Mr. Stolte said Virginia is working on a series of recommendations related to Model #430. He said he would share the memorandum discussing those recommendations with the Subgroup when it is complete. After discussion, Ms. Stegall made a motion, seconded by Ms. Wilkerson, to have the Subgroup move forward with its work by reviewing and considering revisions to Model #430 section-by-section and, as part of its work, consider the recommendations in the Virginia memorandum and the 2018 NAIC staff memorandum to the Subgroup. The motion passed unanimously.

Having no further business, the HMO Issues (B) Subgroup adjourned.
The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call May 16, 2019. The following Subgroup members participated: Don Beatty, Chair (VA); Toma Wilkerson (FL); Robert Wake (ME); Ronald Pastuch (WA); and Jennifer Stegall (WI).

1. Discussed its Next Steps

Mr. Beatty said the Regulatory Framework (B) Task Force adopted the Subgroup’s 2019 charge and its Request for NAIC Model Law Development during its May 15 conference call. He said the purpose of this conference call is to discuss the Subgroup’s next steps to complete its 2019 charge to “revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with the provisions in the Life and Health Insurance Guaranty Association Model Act (#520).”

Mr. Beatty said that prior to the conference call, NAIC staff distributed several documents, including a 2018 memorandum to the Subgroup highlighting potential sections in Model #430 the Subgroup might consider for revision. He suggested Subgroup members review the memorandum. He also pointed out the Subgroup’s work plan, which was discussed during the Subgroup’s April 29 conference call. He provided an overview of the work plan. He said he believes the Subgroup can finish its work by the Fall National Meeting, as the work plan specifies.

Chris Petersen (Arbor Strategies, LLC) asked if the Subgroup plans to discuss which sections of Model #430 should be revised before it begins its work.

The Subgroup discussed whether to ask for comments. After discussion, the Subgroup set a June 10 public comment deadline to receive comments from stakeholders on which sections of Model #430 should be considered for revision and specific suggestions on what those revisions should entail. The Subgroup said the 2018 memorandum to the Subgroup should be used to assist stakeholders in preparing their comments.

The Subgroup next discussed how it should approach drafting the revisions, such as designating specific Subgroup members to draft specific sections or another approach. Mr. Beatty said he would consider the matter and make a recommendation later.

Mr. Petersen reminded the Subgroup that the states should continue to seek to enact the revised Model #520 and not wait until the proposed revisions to Model #430 are complete.

Having no further business, the HMO Issues (B) Subgroup adjourned.
The HMO Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call April 29, 2019. The following Subgroup members participated: Don Beatty, Chair (VA); Toma Wilkerson (FL); Jennifer Reif (IL); Patrick O’Connor (KY); Robert Wake (ME); Jessica Schrimpf (MO); Martin Swanson and Laura Arp (NE); Doug Hartz (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix (WV).

1. **Adopted its 2019 Proposed Charge**

   Mr. Beatty said that prior to the conference call, NAIC staff distributed the following draft 2019 proposed charge: “revise provisions in the Health Maintenance Organization Model Act (#430) to address conflicts and redundancies with the provisions in the Life and Health Insurance Guaranty Association Model Act (#520).” He requested comments.

   Mr. Hartz said he participated in the discussions related to the Model #520 revisions adding health maintenance organizations (HMOs) as members of the guaranty association.

   Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) asked if the charge includes having the Subgroup revise the Model Regulation to Implement Rules Regarding Contracts and Services of Health Maintenance Organizations (#432). Mr. Beatty said it does not. He explained that the appropriate time to determine if Model #432 should be revised would be after the revisions to Model #430 are completed.

   Mr. Swanson made a motion, seconded by Ms. Wilkerson, to adopt the Subgroup’s 2019 proposed charge. The motion passed unanimously.

2. **Adopted a Request for NAIC Model Law Development**

   Mr. Beatty said that prior to the conference call, NAIC staff also distributed a draft Request for NAIC Model Law Development, which is consistent with the Subgroup’s just adopted 2019 charge to revise Model #430. He asked for comments on the document. There were no comments.

   Ms. Wilkerson made a motion, seconded by Mr. Swanson, to adopt the Request for NAIC Model Law Development (see NAIC Proceedings – Summer 2019, Regulatory Framework (B) Task Force, Attachment One-B). The motion passed unanimously.

3. **Discussed Draft Work Plan**

   Mr. Beatty said that prior to the conference call, NAIC staff also distributed a draft work plan for the Subgroup to complete its work by the Fall National Meeting (Attachment Seven-A).

   Jolie Matthews (NAIC) said the draft work plan includes a few caveats. One of those caveats is when the Subgroup can actually begin drafting revisions to Model #430. She explained that the Subgroup can discuss the revisions it envisions making to Model #430, but it cannot begin drafting those revisions until the Health Insurance and Managed Care (B) Committee adopts its Request for NAIC Model Law Development. She also noted that following the Health Insurance and Managed Care (B) Committee’s adoption, the Executive (EX) Committee would also have to adopt the Request for NAIC Model Law Development, but the Subgroup can begin drafting until that happens. She also said the Regulatory Framework (B) Task Force plans to meet May 15 via conference call to consider adoption of the Subgroup’s 2019 proposed charge and its Request for NAIC Model Law Development.

   Ms. Matthews said the Subgroup is scheduled to meet May 16 via conference call to begin discussing the revisions it needs to make to Model #430.

   Having no further business, the HMO Issues (B) Subgroup adjourned.

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HMO Issues (B) Subgroup

WORK PLAN

**April 29, 2019:** Subgroup holds conference call to discuss and consider adoption of its 2019 charge and Request for NAIC Model Law Development and forwards both to the Regulatory Framework (B) Task Force for its consideration and adoption. Subgroup also discusses draft work plan.

**May 2019:**

*Note: Subgroup will have to wait until Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee adopt the Request for Model Law Development before drafting revisions. However, the Subgroup can discuss the revisions it thinks should be made.*

May 16, 2019: Subgroup holds conference call to discuss potential revisions to the HMO model consistent with its 2019 charge and Request for NAIC Model Law Development.

*TBD:* Subgroup holds additional conference call(s) in May or June to discuss potential revisions to the HMO model consistent with its 2019 charge and Request for NAIC Model Law Development.

**June 2019:** Subgroup begins drafting revisions to the HMO Model assuming the Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee have adopted its Request for NAIC Model Law Development.

**July 2019:** Subgroup completes an initial draft of revisions to HMO Model and distributes for comment with a public comment deadline ending after the Summer National Meeting.

**August 2019:** Subgroup discusses via conference call the comments received on the first draft and develops a revised draft based on that discussion.

**September 2019:** Subgroup completes work on a second draft and distributes for comment with a public comment deadline ending sometime in October 2019.

**October 2019:** Subgroup discusses via conference call the comments received on the second draft and completes a third final draft of revisions to the HMO model. Subgroup considers adoption of the draft and forwards to the Regulatory Framework (B) Task Force for its consideration either prior to or at the Fall National Meeting.
The Pharmacy Benefit Manager Regulatory Issues (B) Subgroup of the Regulatory Framework (B) Task Force met via conference call July 18, 2019. The following Subgroup members participated: TK Keen, Chair (OR); Martin Swanson, Vice Chair (NE); Chris Murray (AK); Yada Horace (AL); William Lacy (AR); Bruce Hinze (CA); Stephen C. Taylor and Howard Liebers (DC); Johanna Nagel (IA); Vicki Schmidt (KS); Patrick O’Connor (KY); Jeff Zewe (LA); Al Redmer Jr. and Mary Kwei (MD); Chad Arnold (MI); Andrew Kleinendorst and Melinda Domzalski-Hansen (MN); Chlora Lindley-Myers and Mary Mealer (MO); Derek Oestreicher and Marilyn Bartlett (MT); Gale Simon (NJ); Renee Blechner (NM); Michael Humphreys and Rachel Jade-Rice (TN); Eric Lowe and Yolanda Tennyson (VA); Jennifer Kreitler and Ron Pastuch (WA); Nathan Houdek (WI); Al Redmer Jr. and Mary Kwei (MD); and Ellen Potter (WV).

1. Discussed the Subgroup’s Next Steps

Mr. Keen described the Subgroup’s anticipated work over the next few months. He said that beginning with today’s conference call, the Subgroup plans to hold information-gathering sessions based on the information Subgroup members have requested to hear as the Subgroup works to develop the new NAIC model law on pharmacy benefit managers (PBMs). He said the purpose of these sessions is to hear from representatives of the pharmaceutical industry and health insurance industry, consumer representatives, and various experts on issues the Subgroup anticipates needing to discuss as it makes progress on its charge to develop the new NAIC model.

Carl Schmid (The AIDS Institute) asked who would be speaking during the other information-gathering sessions. Mr. Keen said the other planned presenters are individuals and groups Subgroup members specifically wanted to speak. He said after the Subgroup hears from these individuals and groups, the Subgroup most likely will take a pause on its conference calls to process the information presented and decide if it wants to hear from additional speakers. He suggested Mr. Schmid and other stakeholders contact NAIC staff of their interest in presenting to the Subgroup.

2. Heard a Presentation on an Overview of the PBM Industry, State and Federal PBM Legislation, Legal Challenges, and NAIC PBM Activities

Jolie H. Matthews (NAIC) said during today’s Subgroup conference call, she and Holly Weatherford (NAIC) will provide an overview of the PBM industry, state and federal PBM legislation, legal challenges, and NAIC PBM activities. She explained that neither Ms. Weatherford nor herself are experts on PBMs. The goal of the presentation is to provide a high-level overview of the PBM industry in order to provide the Subgroup with general information related to PBMs in anticipation of experts providing more detailed information during the Subgroup’s next information-gathering sessions.

Ms. Matthews said that historically, PBMs started out as third-party administrators (TPAs) of prescription drug programs. Over time, and possibly due to the rise of managed care, PBMs began providing more services to insurers and other entities, some of which are meant to control prescription drug costs. Those services include: 1) claims processing; 2) drug formulary development; 3) mail order pharmacy operation; and 4) retail pharmacy network development. She noted PBMs also began negotiating and obtaining rebates from drug manufacturers in return for inclusion and low-cost designation of their drugs on the plan’s formularies. She discussed the consolidation and acquisition of PBMs over the last decade, which has resulted in three PBMs accounting for more than 70% of the market: Express Scripts, CVS Caremark and OptumRx. She touched on how the states regulate PBMs, noting many states regulate PBMs based on their function. She explained that Ms. Weatherford would provide additional detail on this during her part of the presentation.

Ms. Matthews next discussed PBM core functions. Those functions include: 1) claims administration; 2) pharmacy network management; 3) negotiation and administration of product discounts, including manufacturers’ rebates; 4) mail-order service pharmacy; and 5) specialty pharmacy services. She said PBMs provide a range of services to insurers and other entities related to their core functions designed to improve the value of their clients’ prescription drug benefits. She described a few of those services and PBM strategies and tools with respect to those services.

Ms. Weatherford discussed current PBM laws and recent state and federal PBM legislative activity. She said that in response to PBM practices and influence on consumers, state legislatures enacted limitations under which PBMs could operate. As of
April 2019, 35 states require some form of registration or licensure for operations in the state. Nine states require PBMs to obtain a license from the state department of insurance (DOI). Ten states require PBMs to register with the state DOI in order to operate in the state. Three states require registration or licensure from a department other than insurance. Thirteen states capture PBM registration or licensure under TPA laws.

Ms. Weatherford said during 2019, 119 bills to regulate PBM activities were filed. Of those bills, 22 became law. She discussed the trends in recent legislation filed and ultimately enacted affecting PBM business practices, such as “claw-backs,” retroactive fees and “gag” clauses. A “claw-back” is the practice of charging a co-payment that exceeds the cost of drug to the insurer or PBM, where the PBM then pockets the extra dollars. Retroactive fees, often known as direct and indirect remuneration fees, are fees not known at the point of sale that are billed to the pharmacy later. “Gag” clauses in contracts between PBMs and pharmacies restrict pharmacists from informing customers of cheaper options for purchasing the prescriptions. She said 25 states have laws related to “claw-backs.” She noted that the U.S. Congress passed The Patient Right to Know Drug Prices Act (S. 2554) and The Know the Lowest Price Act (S. 2553) in October 2018 restricting gag clauses at the federal level. She noted the recent rise in state legislative activity related to restricting gag clauses at the state level.

Ms. Weatherford also discussed the National Conference of Insurance Legislators’ (NCOIL) Pharmacy Benefits Manager Licensure and Regulation Model Act adopted in 2018. She said the NCOIL model provides a basic legislative framework for the regulation and licensing of PBMs. She explained that as initially introduced, the NCOIL model included provisions regulating other aspects related to PBMs, but those provisions were removed prior to adoption and included in a drafting note for the states to consider providing to the state insurance commissioner as guidance in adopting regulations.

Mr. Oestreicher asked if the NAIC has taken a position on Section 306, Health Plan Oversight of Pharmacy Benefit Manager Services, in the Lower Health Care Costs Act (S. 1895). Ms. Matthews said the NAIC has not taken a position on S. 1895. Mr. Oestreicher also suggested the Subgroup, as part of its work, review the provisions in Maine’s law LD 1504 “An Act to Protect Consumers from Unfair Practices Related to Pharmacy Benefits Management.” He also discussed Montana’s legislation, SB 71, and its approach taken to regulate PBMs and their business operations. Montana’s SB 71 takes the approach to regulating PBMs indirectly through the insurer by requiring the insurer to monitor and be responsible for any of the activities of entities, including a PBM, the insurer contracts with to carry out its responsibilities. The Maine law includes a specific PBM registration and licensing process, but also includes aspects of SB 71 in indirectly regulating a PBM through a carrier that contracts with the PBM to carry out its responsibilities under the law. However, the Maine law does specifically reference PBMs and their responsibilities under the state law as well. The Maine law also specifically provides that a carrier that contracts with a PBM to perform any activities related to the carrier’s prescription drug benefits is responsible for ensuring that, under the contract, the PBM acts as the carrier’s agent and owes a fiduciary duty to the carrier in the PBM’s management of activities related to the carrier’s prescription drug benefits.

Mr. Oestreicher suggested the Subgroup should review these different approaches taken by the states with some directly regulating the PBM and its business operations and other states regulating the PBM and its business operations indirectly through the insurer that has contracted with the PBM to carry out some of its responsibilities under the state law.

Mr. Oestreicher asked if the Subgroup should review these different approaches taken by the states with some directly regulating the PBM and its business operations and other states regulating the PBM and its business operations indirectly through the insurer that has contracted with the PBM to carry out some of its responsibilities under the state law.

Ms. Matthews discussed legal challenges to state PBM legislation. She said most of the legal challenges have centered on state statutes and provisions involving “maximum allowable cost” (MAC) pricing. The legal challenges centered on federal Employee Retirement Income Security Act (ERISA) preemption and the provisions of Medicare Part D. She focused on two such cases: Pharmaceutical Care Management Association v. Gerhart, Pharm. Care Mgmt. Ass’n v. Gerhart, 852 F.3rd 722 (8th Cir.2017) and Pharmaceutical Care Management Association v. Rutledge. Pharm. Care Mgmt. Ass’n v. Rutledge, 891 F.3rd 1109 (8th Cir.2018). She discussed the specific laws challenged and the court’s rulings in both cases finding the laws preempted by ERISA and the provisions of Medicare Part D.

Ms. Matthews discussed the NAIC’s PBM activities to date. She explained that during its discussions of revisions to the Health Carrier Prescription Drug Benefit Management Model Act (#22), the Model #22 (B) Subgroup discussed whether to include specific provisions in Model #22 regulating PBMs. She said after numerous discussions, the Subgroup decided that including such provisions most likely did not fit into the scope of the Subgroup’s work, deciding to continue to regulate entities an insurer may contract with to carry out its responsibilities under Model #22 indirectly through the insurer. She said the Regulatory Framework (B) Task Force was asked to discuss further the issue of PBM regulation during the Executive (EX) Committee and Plenary’s discussion and adoption of the revisions to Model #22 in March 2018. She said the Regulatory Framework (B) Task Force discussed the issue and established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup in 2018 and adopted a 2019 charge for the Subgroup to: “Consider developing a new NAIC model to establish a licensing or registration...
process for pharmacy benefit managers (PBMs). The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency.” She said earlier this year, the Subgroup adopted a Request for NAIC Model Law Development (Request) to develop a new NAIC model to establish a licensing or registration process for PBMs. The Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee adopted the Request at the Spring National Meeting. She said the Executive (EX) Committee is to consider adoption of the Request at the Summer National Meeting.

Having no further business, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup adjourned.

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