

PRODUCT OUTLINE
INDIVIDUAL SPECIFIED DISEASE COVERAGE
NON-RECURRING (LUMP SUM)
As of 8/1/03

Table of Contents

I.	Overview of Specified Disease Coverage in New York State	1
II.	Key References	2
III.	Cover Page	2
IV.	Policy Schedule Page	4
V.	Table of Contents	4
VI.	Regulatory Requirements for Specified Disease Coverage- General Rules.....	4
VII.	Regulatory Rules Relating to Specified Disease Coverage Written on an Indemnity and Non-Recurring Basis	6
VIII.	Regulatory Rules Relating to the Content of Forms for Individual Insurance that Must be Applied to Specified Disease Coverage.....	9
IX.	Permissible Exclusions and Limitations on Coverage	10
X.	Mandatory Standard Contract Provisions	13
XI.	Optional Standard Provisions	15
XII.	Other Provisions	15
XIII.	Applications	16
XIV.	Conditional Receipts/Interim Insurance Agreements	19
XV.	Disclosure Form Requirements.....	20
XVI.	Marketing of Individual Specified Disease Coverage Using Group Methods	21
XVII.	Rating Procedures and Requirements	23

I. Overview of Specified Disease Coverage in New York State

A product outline dealing with specified disease coverage should explain the development of the coverage in New York State. The overview will attempt to explain for the reader how specified disease coverage came to be a recognized category of health insurance in New York State, where specified disease coverage fits in the health insurance market place of New York State and why it is regulated in the manner set forth in this product outline.

Coverage of one or a few illnesses or diseases began to be offered nationally on a more prevalent basis sometime during the middle of the 1970s. The trend spread to New York State during this time period, but New York State took the position that “stand alone” coverage of this nature did not meet the statutory requirements set forth in Section 3217(b)(5) of the Insurance Law. The provision of coverage for one or a few illnesses or diseases was considered too limited in scope and to be of no substantial economic value for policyholders/certificateholders. The health insurance consumer was considered much better off if he/she devoted his/her premium dollars toward more comprehensive coverages which covered any illness or disease or injury.

There were arguments at the time that specified disease coverage provided coverage for certain needs which every comprehensive coverage may not meet. For example, arguments were made that large deductible amounts or co-pays of comprehensive coverages could be defrayed by a specified disease coverage. Consequential expenses of a serious illness or disease not covered by a comprehensive coverage (e.g.- room and board expenses associated with family members accompanying an ill insured for treatments in distant cities, extended income losses of an insured or family member due to serious illnesses or diseases, catastrophic expenses of a serious illness or disease exceeding the limits of comprehensive coverages) could be covered by a specified disease coverage.

In view of the above arguments, the Department did permit coverage for specified diseases on a supplemental basis. In keeping with Section 3217(b)(5) the Department did not allow “stand alone” policies/certificates providing specified disease coverage. However, the Department was willing to allow specified disease riders or optional benefits to be attached to comprehensive coverage meeting at least the minimum benefit levels of Section 52.5 (basic hospital insurance), Section 52.6 (basic medical insurance) or Section 52.7 (major medical insurance) of Regulation 62. Thus, the treatment of specified disease coverage as strictly a supplemental health insurance coverage in New York’s regulations took root.

During the middle of the 1990s, the Department again undertook a review of specified disease coverage. The health insurance market place was very different from the 1970s. Individual health insurance coverage and small group health insurance coverage of a comprehensive nature were mandated to be open enrolled and community rated by the mid-1990s. In addition to the concerns raised above under Section 3217(b)(5), there was now an apprehension that underwritten specified disease coverage which was not community rated could serve as a way for healthier and younger insureds to obtain some coverage for more catastrophic diseases and avoid the open enrolled and community rated comprehensive health insurance markets. This avoidance of the community rated markets by healthier and younger insureds would adversely impact the community rates for more comprehensive coverages.

The draft regulations of the Department to allow specified disease coverage were controversial and even subjected to a legislative hearing. The eventual final regulations of the Department (Twenty-Second Amendment to Regulation 62 (11 NYCRR 52), Fifth Amendment to Regulation 145 (11 NYCRR 360), and Second Amendment to Regulation 146 (11 NYCRR 361)) took into account the concerns noted above.

The Twenty-Second Amendment to Regulation 62 contains provisions to aid in ensuring that specified disease coverage is only issued to persons covered by more comprehensive coverages (see Section 52.15(b)(12)(13)(14) of Regulation 62). The same amendment makes clear that specified disease coverage is an indemnity coverage which pays benefits on a basis unrelated to hospital, medical or surgical expenses incurred, and it contains provisions intended to ensure the consumer realizes the coverage is limited and covers only one disease or a few diseases (see Section 52.15 (b)(5)(9)(10)(15), (c) and (d). These provisions aid in assuring that younger and healthier lives in the health insurance market should only have specified disease coverage as an adjunct to open enrolled and community rated comprehensive health insurance. Also, specified disease coverage is regulated as a coverage supplemental to comprehensive health coverage.

Since specified disease coverage is regulated as supplemental coverage to comprehensive and open enrolled and community rated coverage, that fact is recognized in Regulation 145 (11 NYCRR 360 – Sections 360.2(c) and 360.2(f)) which sets standards for open enrolled and community rated coverages. That fact is also recognized in Regulation 146 (11 NYCRR 361 – Sections 361.2(j) and 361.2(p)) which sets standards for market stabilization mechanisms in the open enrolled and community rated health insurance markets.

II. Key References

Key Insurance Law Sections –3102, 3105, 3201 (form approval issues), 3216 especially 3216(d)(1) and (2) (standard provisions), 3204 (contract/application issues).

Key Applicable Regulations – Regulation 62 (11 NYCRR 52) minimum standards for form, content and sale of health insurance including Sections 52.2 (definitions), 52.15 (specified disease coverage), 52.16 (permissible exclusions), 52.17 (individual form content), 52.31 (form submission), 52.33 (submission letter), 52.40 (rate filing), 52.41 (gross premium differentials based on sex), 52.43 (experience maintenance standards), 52.44 (experience filing standards), 52.45 (minimum loss ratio standards), 52.47 (experience monitoring), 52.51 (applications), 52.53 (conditional receipts/interim insurance agreements), Sections 52.15(b)(5) and 52.66 (disclosure statement requirements), 52.70(a), (b) and (c) (special rules for franchise insurance); Regulation 169 (11 NYCRR 420) privacy of consumer financial and health information including Section 420.18

Key Circular Letters – Circular Letter No. 3 (1989), Circular Letter No. 5 (1997)

III. Cover Page

1. The cover page must prominently indicate the licensed New York insurer's name and full address. Full street address of the company's home office in prominent place (generally front and back of policy form) for disclosure purposes. No unlicensed entity in New York State should appear on the form. Section 3201(c)(1)
2. Include name of product as "Specified Disease Coverage" on the form within the defined category of Section 52.15(a) of Regulation 62.
3. Include as required by Section 52.15(b)(9) on the first page of the policy in boldface type in at least 14-point size, but not less than the size of type used for policy captions, a prominent statement as follows:

“This is a limited policy. It pays benefits for (name of specified disease) treatment only. Read it carefully with the Required Disclosure Statement.”

4. Include “free look” provision of 10-20 days within parameters of Section 3216(c)(10). A 30 day provision is acceptable since it is more favorable to the insured than the statute.
5. Unique form identification number in lower left-hand corner of form. Section 52.31(d)
6. Renewability provisions of form must be placed on the front page of the policy form. Sections 52.17(a)(1) and (2)
7. The policy must be “Guaranteed Renewable for Life”. The term “guaranteed renewable” as defined in Section 52.17(a)(6)(7) as modified by Section 52.15(b)(3) means the insured has the right to continue the policy in force for life by the timely payment of premiums. While the insured continues to timely pay premiums, 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.

A second option for the insurer would be to make the specified disease coverage “Noncancellable and Guaranteed Renewable for Life.” In that instance Section 52.15(b)(3) and Section 52.17(a)(5) would be relevant. This term means the insured has the right to continue the policy in force for life by the timely payment of premiums. While the insured continues to timely pay premiums, the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

Since Section 52.15(b)(3) does not require any specified disease policy to be “Noncancellable for Life”, a possible third option for the insurer would be to make the specified disease coverage “Noncancellable to Age 65 but Guaranteed Renewable For Life”. This term means the insured has the right to continue the policy in force for life by the timely payment of premiums. While the insured continues to timely pay premiums, 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 commencing with the policy anniversary on or after the insured's 65th birthday.

The Department recognizes that the policy may terminate by its own terms once the entire benefit under the policy has been paid. This occurrence is consistent with a policy which is “guaranteed renewable for life” so long as it is stated in the policy at issuance.

8. If the policy will be issued to persons eligible for Medicare (due to age or disability), the policy must have a notice printed on or attached to the first page of the disclosure statement delivered to insureds to comply with Section 52.66 or to the first page of the policy which notifies the buyer as follows:

“THIS POLICY 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”. Section 52.17(a)(33)(i).

The notice shall be in no less than 12-point type.

9. The signature of one or more company officers should appear on the face page to execute the contract on behalf of the company.
10. If the policy is participating, the cover page must contain a statement to that effect. Section 3216(c)(1)

IV. Policy Schedule Page

1. Complete with hypothetical data. Section 52.31(f)
2. Premium summary amounts should appear. Section 52.31(f) and Section 3216(c)(1)
3. Face amount choices, percentages of face amount payable for certain specified diseases, probationary period time provisions complying with Section 52.15(d)(2) and similar varying elements of the policy should be set forth. Section 52.31(f) and 3204(a).
4. Name of insured space. Section 52.31(f) and Section 3216(c)(3)
5. Spaces for effective date of insurance, renewal dates and renewal terms. Section 52.31(f) and Section 3216(c)(2)
6. Optional choices of insured regarding certain benefits and/or riders should be set forth – originates from Section 52.31(f) and Section 3204(a)(1)

V. Table of Contents

1. Table of Contents must be included when required. – Section 3102(c)(1)(G)

VI. Regulatory Requirements for Specified Disease Coverage- General Rules

The Twenty-Second Amendment to Regulation 62 which, in part, sets minimum benefit standards for specified disease coverage in New York State became effective on April 15, 1998. The portion of the Twenty-Second Amendment which contains the core requirements for specified disease coverage is found in Section 52.15 of Regulation 62.

1. Definition –Specified disease coverage is defined in Section 52.15(a). In that regulatory section, specified disease coverage is defined as a policy which pays benefits on an indemnity basis for the diagnosis and treatment of a specifically named disease or diseases, which are life threatening in nature and could cause a person to incur substantial financial out-of-pocket expenses for the diagnosis and treatment of a specifically named disease or diseases.

The Department views this definition as proscribing specified disease coverages which would attempt to cover illnesses or diseases of a more routine nature. For example, an insurer which attempted to design a policy for the common cold would not be designing coverage for a disease which is life threatening in nature and results in substantial financial out-of-pocket expenses. Usual comprehensive coverages would satisfactorily cover such an illness, and the need for a limited supplemental coverage to the comprehensive coverage would be questionable. Such a policy design would be contrary to Section 3217(b)(5) of the Insurance Law.

2. Section 52.15(b)(1) of Regulation 62 requires that all forms of the specified disease or diseases must be covered.

This requirement is intended to assure that the limited specified disease coverage does not become unduly fragmented by only covering certain types of a disease. This would be contrary to Section 3217(b)(5) of the Insurance Law.

3. Any specified disease policy that conditions payments upon pathological diagnosis of a covered disease, shall also provide that if such a pathological diagnosis is medically

inappropriate, a clinical diagnosis will be accepted in lieu thereof. Any type of medically appropriate diagnosis shall be accepted by the insurer.

In general, the Department requires a policy to contain this three tiered explanation of diagnoses. A specified disease insurer should not be able to deny benefits due to a fragmented definition of diagnoses. A method of diagnosis generally accepted by the medical community for a particular disease should be accepted by a specified disease insurer. (Section 52.15 (b)(2))

4. Section 52.15(b)(3) of Regulation 62 requires that an individual policy containing specified disease coverage must be at least guaranteed renewable for life.
5. Section 52.15(b)(4) of Regulation 62 requires that benefits for specified disease coverage will be paid regardless of other coverage, except for any policy provision regarding other insurance with the insurer. Section 3216(d)(2)(C) of the Insurance Law sets forth the optional standard provision for "Other Insurance in This Insurer". This regulatory section indicates the specified disease policy does not coordinate benefits with other group or individual specified disease coverage, and always pays its benefits regardless of what other comprehensive coverage an insured has. See XI.2 and 3 also.
6. Except in the case of direct response insurers, no specified disease policy will be delivered or issued for delivery in New York State unless the appropriate disclosure form in Section 52.66 of Regulation 62 describing the policy's benefits, limitations and exclusions, and expected benefit ratio is delivered to the applicant at the time application is made and written acknowledgement of receipt or certification of delivery of such disclosure form is provided to the insurer. Direct response insurers will deliver the requisite disclosure form at the time the policy is delivered. 52.15(b)(5)

Please note that Section 52.66 contains two disclosure statement formats. One format is for persons less than 65 years of age, and the other format is for persons who are age 65 or older. The format for persons less than age 65 clarifies that specified disease coverage does not provide basic hospital, basic medical or major medical coverage. The format for persons age 65 and older clarifies that specified disease coverage does not provide Medicare supplement insurance, long term care insurance, nursing home insurance only, home care insurance only or nursing home and home care insurance. The format for persons age 65 and older also indicates an applicant may contact the local Social Security Office or the insurer to obtain a copy of the Guide to Health Insurance for People with Medicare.

7. Section 52.15(b)(8) of Regulation 62 requires an insurer to file its overinsurance rules with the Insurance Department. Overinsurance is deemed to exist when an insured has more than one specified disease policy or certificate for the same specified disease whether it is with the same or a different insurer. Also, in no event may an insurer issue a specified disease policy to any person that will result in that person being covered for eight or more specified diseases. Therefore, the maximum number of specified diseases for which an individual may be covered is seven, regardless of the number of insurers. See XIII below for insurer requirements to inquire about these issues on the application form.
8. No advertisement of a policy will imply coverage beyond the terms of the policy. Synonymous terms will not be used to refer to any disease so as to imply broader coverage than is the fact. 52.15(b)(10)
9. A specified disease policy where a benefit is a lump sum payment for the diagnosis of a specified disease without further coverage for treatment of the disease can only be offered if

it meets the requirements set forth in Section 52.15(d) of Regulation 62. Such a lump sum policy must also meet the requirements of Section 52.15(a)(b).

10. Specified disease coverage will only be issued to persons who are covered by either at least major medical insurance as defined in Section 52.7 of Regulation 62 or at least basic hospital insurance and basic medical insurance as defined in Sections 52.5 and 52.6 of Regulation 62. 52.15(b)(12). See XIII below for insurer requirements to inquire about these issues on the application form.
11. No later than 30 days following delivery of the policy, the insurer must ask the insured person(s) in a written request whether the insured person(s) has in force at least major medical insurance or at least basic hospital insurance and basic medical insurance on the effective date of the specified disease coverage. Where the insured person(s) responds to the insurer in writing that such underlying coverage is not in force on the effective date of the specified disease coverage, the policy will be voided from its beginning with a full premium refund. The method by which the insurer implements these requirements must be approved by the Superintendent. 52.15(b)(14)

In reviewing the method used by any specified disease insurer to implement Section 52.15(b)(14), the Department requires that every insured person covered by the policy be asked in writing about underlying coverage in force on the effective date of the specified disease coverage. For example, where family coverage is issued under Section 3216(c)(3) of the Insurance Law, a spouse and dependent children as well as the primary policyholder must be asked in writing about underlying coverage in force on the effective date of the specified disease coverage. When underlying coverage is not in force for the primary policyholder on the effective date of the specified disease coverage, the policy will be voided from the beginning with a full premium refund. When the primary policyholder has underlying coverage in force but one or more dependents do not, the coverage for the dependents without underlying coverage in force on the effective date of the specified disease coverage will be voided with a commensurate premium refund.

12. Reductions in specified disease benefits such as when certain events occur or ages are reached are not permissible. For example, the face amount cannot be reduced by 50% because the insured was age 70 at time of diagnosis. 52.15(b)(16)

VII. Regulatory Rules Relating to Specified Disease Coverage Written on an Indemnity and Non-Recurring Basis

1. Section 52.15(d)(1) of Regulation 62 requires dollar benefits to be offered only in even increments of \$1,000 but not to exceed \$500,000. In cases of clearly identifiable forms of diseases with significantly lower treatment costs, as long as the policy clearly indicates, lesser amounts may be offered, but in no event will such amounts be less than \$250.

In certain instances, Section 52.15(d)(1) is related to Section 52.15(b)(1) and its requirement that all forms of the specified disease or diseases be covered. For example, specified disease policies which cover cancer often attempt to exclude coverage for skin cancer. The Department has required that skin cancer be covered due to Section 52.15(b)(1). However, since skin cancer in its early stages often has significantly lower treatments costs, the Department has allowed coverage of skin cancer at amounts no lower than \$250.00 in a non-recurring specified disease policy. Insurers which claim that a form of the disease has significantly lower treatment cost and desire to offer lesser amounts for that form of the disease should be prepared to offer the Department an opinion statement from a medical professional to that effect. The Department would need such an opinion statement so there is

an appropriate medical basis for the regulatory action requested by the specified disease insurer.

2. Section 52.15(d)(2) indicates that no specified disease policy shall contain a probationary period greater than 30 days from the coverage effective date during which time period the insurer may void the policy from its beginning with a full premium refund to the insured when a specified disease is diagnosed within the initial 30 days of coverage.

This regulatory provision for a non-recurring specified disease policy is consistent with Section 52.16(d)(1) when the health insurance coverage is not required to be open enrolled under Section 3231 of the Insurance Law. However, it is the only probationary period allowed for use in a non-recurring specified disease policy.

Some specified disease insurers have indicated that a non-recurring policy format with face amounts of \$100,000 or more may be subject to insured manipulation. These specified disease insurers have stated that an applicant may not be truthful on an application, and/or he/she may know or suspect the presence of a specified disease before seeking medical treatment and apply for the specified disease policy before seeking medical treatment. These techniques may be particularly problematic in a specified disease coverage where medical underwriting is limited. Without some type of probationary period to protect against antiselection, some specified disease insurers have indicated fraud may be encouraged.

The Department considered this argument for a probationary period in view of the other alternatives a specified disease insurer may use to protect against anti-selection (e.g.-pre-existing condition limits-see IX.1. below-and the ability to extensively medically underwrite). A probationary period of no greater than 30 days from the coverage effective date was considered to be reasonable so that an insurer could void coverage with a full premium refund when a specified disease covered by the policy was diagnosed within the initial 30 days of coverage.

3. Section 52.15(d)(3) indicates that indemnity amounts for any one specified disease cannot be paid in more than two equal installments for any reoccurrence or spread of the same specified disease or a new primary occurrence of the same specified disease or the resulting death of the insured due to the same specified disease.

Before promulgating the Twenty-Second Amendment to Regulation 62, the Department became aware of problems in other jurisdictions which permitted the sale of “stand alone” specified disease coverage. One such problem appeared to be a specified disease policy design which allowed the insurer to withhold all or part of the benefits payable even after diagnosis of the specified disease. The specified disease insurer would make the entire benefit payment contingent upon reoccurrences or spread of a disease or a new primary occurrence of the disease or death of the insured. Other specified disease policy designs would make some partial payment upon diagnosis of the specified disease, but only make other payments when there were reoccurrences or spread of a disease or a new primary occurrence of the disease or death of the insured. From the perspective of the specified disease insurer, these benefit payment mechanisms were intended to make sure the specified disease was serious in nature before full benefits were paid. However, these mechanisms also allowed the insurer to pay less than the entire face amount at once upon diagnosis of a specified disease.

From the perspective of the consumer, these benefit payment mechanisms permitted an insurer to hold benefit payments and perhaps never pay them if the contingent events did not occur. In other jurisdictions, this apparently led to consumer inquiries as to why the entire face amount purchased for a non-recurring specified disease policy was not paid.

The Department had to balance these considerations in view of Section 3217(b)(2)(3)(5) of the Insurance Law. The insurer contention that full benefits should only be paid for serious occurrences of the specified disease as a type of anti-selection protection was viewed in light of the other anti-selection protections available to the specified disease insurer such as pre-existing condition limitations (Section 52.15(b)(6)), a probationary period (Section 52.15(d)(2)) and medical underwriting. Balancing the insurer and consumer concerns, the Department concluded in Section 52.15(d)(3) that no more than two equal installments could be utilized by the specified disease insurer in paying indemnity amounts for any one specified disease.

4. Section 52.15(d)(4) indicates that new probationary periods for any one specified disease cannot be instituted for any reoccurrences or spread of the same specified disease or a new primary occurrence of the same specified disease. This regulatory section also does not allow any additional probationary periods other than the one permitted by Section 52.15(d)(2). Section 52.15(d)(4) does recognize that the insurer can require reasonable and appropriate medical certification that an insured is afflicted with a specified disease covered by the policy.

Section 52.15(d)(4) proscribes a proliferation of probationary periods related to reoccurrences, a spread or a new primary occurrence of the same specified disease. This ability to have multiple probationary periods related to specified diseases enables the insurer to delay benefit payments as a specified disease progressively worsens. Depending upon the design of the multiple probationary periods, it might also allow a specified disease insurer to avoid benefit payments if reoccurrences, a spread or a new primary occurrence of a specified disease happened during one of the probationary periods. A specified disease insurer might claim these multiple probationary periods are necessary to protect against anti-selection and to be sure the specified disease is serious in nature.

From a consumer perspective, these multiple probationary periods would serve to delay or even terminate benefit payments when an insured is very sick from a serious disease. The specified disease insurer has the ability to avoid antiselection and/or be certain of the seriousness of a disease through medical underwriting, an initial probationary period allowed by Section 52.15(d)(2) and a preexisting condition limitation period allowed by Section 52.15(b)(6).

The Department again had to balance these considerations in view of Section 3217(b)(2)(3)(5) of the Insurance Law. Since the specified disease insurer has ample mechanisms to avoid antiselection and/or be certain of the seriousness of a disease, the Department concluded multiple probationary periods in addition to the one allowed by Section 52.15(d)(2) were violative of Section 3217(b)(2)(3)(5) of the Insurance Law.

5. Section 52.15(d)(5) indicates that benefit amounts payable for any one specified disease can be subject to a maximum policy benefit for all specified diseases covered under the policy. For example a policy may pay a lesser percentage of the policy benefit amount upon diagnosis of one of the insured conditions covered by a specified disease policy. Typically, the lesser percentage may be 25% of the overall policy benefit amount if an insured is diagnosed with one of the insured conditions covered by a policy. Once payment is made at the 25% level, the overall benefit amount is reduced by the payment made. The remainder of the overall benefit amount is then available for payment should the insured be diagnosed with one of the other insured conditions covered by the policy. Typically, the insured condition paid at the 25% level may have payment made for that condition only once during the life of the policy. Also typically, once payment is made at the 25% level, the premium payable for the policy will be reduced to reflect the lesser overall benefit amount remaining.

In reviewing minimum lesser percentages which may be paid for a particular insured condition, the Department would apply Section 3201(c)(3) of the Insurance Law. Miniscule percentages which provide no meaningful coverage of a particular insured condition would be unfair, unjust and inequitable for an insured within the meaning of Section 3201(c)(3). For guidance, the Department has routinely seen the 25% level as the lesser percentage payable, and we have approved it.

6. Section 52.15(d)(6) requires that a specified disease policy specify the criteria that must be satisfied in order to trigger the payment of benefits. This regulatory section also requires that a benefit shall always be payable upon initial and medically appropriate diagnosis of the specified disease covered by the policy subject to the permissive probationary period stated in Section 52.15(d)(2)(see above).

In general, the Department approves specified disease policy language which clearly states that a benefit is payable upon initial and medically appropriate diagnosis of a specified disease covered by the policy. This language is consistent with the indemnity nature of a specified disease coverage as paying benefits unrelated to the necessity of incurring medical expenses for a specified disease but using the indemnity amount paid for consequential expenses arising from the specified disease (e.g.-travel, co-pays, etc.). Due to the indemnity nature of the specified disease policy, there is no purpose in requiring an insured to incur hospital, medical or surgical bills before specified disease payments will be made.

Only in extenuating circumstances will the Department consider slight variations from Section 52.25(d)(6). As an example of a slight variation, the Department has approved language concerning coronary artery disease which delays actual payment of the benefit for coronary artery disease until coronary artery bypass surgery is performed. Due to the specific definition of coronary artery disease in a particular specified disease policy, the insurer was concerned that payment of a large "lump sum" dollar amount upon diagnosis of the coronary artery disease would allow the insured to obtain the benefit and long delay any correction of the coronary artery disease all while continuing to live a normal lifestyle. There was some concern as to antiselection.

Even in this narrow circumstance, the Department approved language indicating the benefit for coronary artery disease was owing upon diagnosis of the coronary artery disease. The language went on to indicate that actual payment of the benefit would be delayed until coronary artery bypass surgery was performed as recommended by a doctor. The language also made clear that if death occurred prior to the performance of the coronary artery bypass surgery, the benefit would still be provided.

7. Section 52.15(d)(7) sets forth minimum loss ratios for specified disease policies. Those loss ratios are 60% in the case of individual insurance issued under the age of 65. In the case of individual insurance issued at ages 65 and over, the minimum loss ratio is 65% unless one rate is charged for all ages under 65 and 65 and over, and the policy is issued at all ages 25 and over, then the minimum loss ratio is 60%.

VIII. Regulatory Rules Relating to the Content of Forms for Individual Insurance that Must be Applied to Specified Disease Coverage

1. Reductions in benefits such as when certain events occur or ages are reached are not permissible. 52.15(b)(16)
2. Insurer must comply with Section 52.17(a)(9) of Regulation 62 and Sections 3216(c)(13) and (14) of the Insurance Law for insureds entitled to suspend coverage during periods of military

service. When the statute and regulation are read together, an insured is entitled to the right to resumption upon termination of military service of no longer than five years.

3. Family policies may provide a new contestable period for each new member added, but shall not provide for a new contestable period for the policy – Section 52.17(a)(10) of Regulation 62. For example, if a spouse is added as a dependent to an inforce specified disease policy, a new contestable period for the spouse runs from the later spousal issuance date, but not a new contestable period for the primary insured previously issued coverage.
4. Insurer attaching any rider or endorsement that reduces or eliminates coverage after policy issuance shall provide for signed acceptance by the insured – Section 52.17(a)(12) of Regulation 62. See also Section 52.16(e)(2), however, for waivers issued as a condition of issuance, renewal or reinstatement.
5. Riders or endorsements providing a benefit for which a specific premium is charged shall show the premium on the application, rider or elsewhere in the policy – Section 52.17(a)(14) of Regulation 62.
6. Policies based upon attained age shall include the applicable schedule of rates – Section 52.17(a)(29) of Regulation 62.
7. No specified disease insurer shall refuse to issue coverage, cancel coverage or decline to renew coverage because of the sex or marital status of the applicant or policyholder – Section 2607 of the Insurance Law.
8. Section 52.17(a)(30) requires that a family policy shall provide for coverage for adopted children and stepchildren dependent upon the insured on the same basis as natural children.
9. Section 52.17(a)(31) requires that a family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child’s adoption.
10. When applicable, Section 3216(c)(4)(C) of the Insurance Law contains requirements regarding coverage of newborns.

IX. Permissible Exclusions and Limitations on Coverage

The only permissible limitations or exclusions are those set forth in Sections 52.15(b)(6) and 52.16(c) of Regulation 62. In general, the exclusionary or limiting language can be no less favorable to the insured than these regulations.

1. The only permissible pre-existing condition limits are those that exclude coverage for no more than six months after the effective date of coverage under the policy for a condition for which medical advice was given or treatment was recommended by, or received from, a licensed health care provider within six months before the effective date of the coverage pursuant to Section 52.15(b)(6) of Regulation 62.

Some insurers have chosen to rely solely upon medical underwriting in specified disease coverage and not place any pre-existing condition limitations in policy language. The Department finds this approach acceptable.

Some insurers have desired to use the phrase “first diagnosed” or words of similar import when specifying policy criteria to trigger the payment of benefits. In brief, the words “first diagnosed” or similar terminology are used to indicate only diseases “first diagnosed” after

the policy effective date will be covered. The concept expressed by this terminology does not comply with Section 52.15(b)(6).

For example, suppose an insured received medical treatment for a condition one year before the coverage effective date. Then assume the insurer took no underwriting action concerning the condition based upon a truthful application of the insured (i.e. – the insurer did not ask about the condition or otherwise took no action) and issued coverage. Also assume the insured received no further treatment for the condition after the treatment one year before the coverage effective date. Then assume the insured received treatment again one year after the coverage effective date.

An insurer predicating benefit payments on “first diagnosis” would indicate the benefit trigger was not met. The insurer would equate the medical treatment one year before the coverage effective date with a diagnosis and deny benefits since the specified disease was not “first diagnosed” after the coverage effective date. However, this process does not comply with Section 52.15(b)(6). The treatment for the condition one year before the coverage effective date would be outside the six month time frame of Section 52.15(b)(6). The treatment for the condition one year after the coverage effective date would be outside the six month time frame of Section 52.15(b)(6). Thus, the condition would not be a “preexisting condition” and should be covered by the insurer. Insurers should use the term “diagnosed”, and rely upon wording in Section 52.15(b)(6) to have a permissible preexisting condition limitation.

2. Section 52.16(b) of Regulation 62 prohibits a specified disease policy from providing 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.
3. If an insurer chooses to place an exclusion or limitation on coverage for mental or emotional disorders, it must comply with Section 52.16(c)(2) of Regulation 62.
4. If an insurer chooses to place an exclusion or limitation on coverage for treatment arising out alcoholism or drug addiction it must comply with Section 52.16(c)(2) of Regulation 62 and Section 3216(d)(2)(K) as pertinent.
5. If insurer chooses to place an exclusion or limitation on coverage for pregnancy, it must comply with Section 52.16 (c)(3) of Regulation 62.
6. If an insurer chooses, it may place an exclusion or limitation on illness or medical condition arising out of:
 - war or act of war (whether declared or undeclared)
 - participation in a felony, riot or insurrection
 - service in the Armed Forces or units auxiliary thereto
 - suicide, attempted suicide or intentionally self-inflicted injury
 - aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline. These exclusions or limitations must comply with Section 52.16 (c)(4) of Regulation 62.

For felony participation, see also Section 3216(d)(2)(J) of the Insurance Law. For service in the armed forces, an insurer must also include a “suspension” provision complying with Sections 3216(c)(13)(14) of the Insurance Law and Section 52.17(a)(9).

7. If insurer chooses to place an exclusion or limitation on coverage for cosmetic surgery, must comply with Section 52.16(c)(5) of Regulation 62.
8. If insurer chooses to place an exclusion or limitation on coverage for foot care, must comply with Section 52.16(c)(6) of Regulation 62.
9. If insurer chooses to place an exclusion or limitation on coverage for care in connection with structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference must comply with Section 52.16(c)(7) of Regulation 62.
10. If insurer chooses, Section 52.16(c)(8) of Regulation 62 allows an insurer to place exclusions or limitations on coverage for any of the following:
 - Treatment provided in a government hospital;
 - Benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law;
 - Benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are covered or recoverable;
 - Services rendered and separately billed by employees of hospitals, laboratories or other institutions;
 - Services performed by a member of the covered person's immediate family;
 - Services for which no charge is normally made.
11. If insurer chooses to place an exclusion or limitation on coverage for dental care or treatment, must comply with Section 52.16(c)(9) of Regulation 62.
12. If insurer chooses to place an exclusion or limitation on coverage for eyeglasses, hearing aids, and exams for their prescription or fitting, must comply with Section 52.16(c)(10) of Regulation 62.
13. If insurer chooses to place an exclusion or limitation on coverage for rest cures, custodial care and transportation, must comply with Section 52.16(c)(11) of Regulation 62.
14. If insurer chooses to place an exclusion or limitation on coverage related to territorial restrictions, must comply with Section 52.16(c)(12) of Regulation 62. For Section 52.16(c)(12) compliance, insurer must provide coverage within the United States, its possessions and the countries of Canada and Mexico.
15. No specified disease policy will contain provisions establishing a probationary or similar period longer than 30 days. 52.16(d)(1) See above concerning Section 52.15(d)(2) as well.
16. For compliance with Sections 52.16(e)(2) and 52.2(i) of Regulation 62, insurers should note that Regulation 62 recognizes only aviation and its related activities and participation as a professional in sports as extra-hazardous activities which can be initially underwritten. These extra-hazardous activities may be excluded from coverage by means of prominently disclosed waivers (see Section 52.16(e)(2)) at coverage issuance or extra premium ("rate up") may be charged for coverage of such extra-hazardous activities or standard coverage may be issued when an applicant indicates participation in such extra-hazardous activities or coverage may be declined based upon participation in such extra-hazardous activities. Sections 52.16(e)(2) and 52.2(i) do not recognize any other avocations, vocations or activities as extra hazardous. Therefore, the insurer may only issue standard coverage or decline coverage for applicants participating in avocations, vocations or activities other than those defined in Section 52.2(i).

17. Individual accident and health coverages, including specified disease coverage, are not plans which can contain coordination of benefit provisions (Section 52.23(e)(3)(i)). Insurers have the ability to financially underwrite for other coverage before issuance. Under Section 52.15(b)(4), benefits for specified disease coverage must be paid regardless of other coverage, except for a policy provision regarding other insurance with the insurer, for which the optional standard provision of “Other Insurance in This Insurer” is set forth in Section 3216(d)(2)(C) to handle an excess insurance situation after issuance.

Please note specified disease insurers are precluded from issuing coverage when issuance would result in any insured having more than one specified disease policy or certificate for the same specified disease whether with the same or different insurer. Specified disease insurers must ask questions on their applications to elicit this fact. See Sections 52.15(b)(8) and (b)(15). Also see discussion above and below.

Please note specified disease insurers are precluded from issuing coverage when issuance would result in any insured being covered for eight or more specified diseases from all sources. Specified disease insurers must ask questions on their applications to elicit this fact. See Sections 52.15(b)(8) and (b)(15). Also see discussion above and below.

Please note specified disease insurers can only issue coverage when any specified disease insured is also covered by at least major medical insurance as defined in Section 52.7 of Regulation 62, or at least basic hospital insurance and basic medical insurance as defined in Sections 52.5 and 52.6 of Regulation 62. Specified disease insurers must ask questions on their applications to elicit this fact. Specified disease insurers must formulate a method to ascertain from any insured whether any insured has in force on the effective date of the specified disease coverage major medical insurance (Section 52.7), or at least basic hospital and basic medical insurance (Sections 52.5 and 52.6). See Sections 52.15(b)(12)(13)(14) of Regulation 62. Also see discussion above and below.

X. Mandatory Standard Contract Provisions

These provisions are required in each policy. The provision must be no less favorable to the insured than the following statutory provisions.

1. Must include a “Entire Contract; Changes” provision with no incorporation by reference to writings not part of the form – Section 3216 (d)(1)(A), Section 3204(a)(1).
2. In dealing with application misstatements, the specified disease insurer has two options as set forth in Section 3216(d)(1)(B)(i) of the Insurance Law. The first option allows the insurer to void the policy or deny a claim due to misstatements for “loss incurred” within the first two years of the policy issuance. For fraudulent misstatements in the application, there is no two year limit on the ability of the insurer to void the policy or deny a claim for “loss incurred” from the date of policy issuance. Since Section 52.15(d)(6) requires that a benefit be payable upon initial and medically appropriate diagnosis of a specified disease covered by the policy regardless of whether there is disability, the words “loss incurred” are the relevant words in Section 3216(d)(1)(B)(i) in determining the ability of the insurer to void the policy or deny a claim for application misstatements. A specified disease diagnosed within the first two years of policy issuance is a “loss incurred” for which benefits are payable, but such a claim can be denied or the policy voided if the policy was issued based upon application misstatements. A specified disease diagnosed after the first two years from the policy effective date is a “loss incurred” for which benefits are payable, and the claim cannot be denied or the policy voided

on the basis of application misstatements unless they were fraudulent misstatements.

The second option is available only for a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. This option is available because the specified disease policy must be “Guaranteed Renewable for Life” pursuant to Section 52.15(b)(3). This option requires the insurer to label the option “Incontestable” and not “Time Limit on Certain Defenses”. This option indicates that, once the policy has been in force for two years during the lifetime of the insured, the policy is incontestable as to any statements contained in the application. At the insurer’s option, the insurer may add a statutory phrase extending the calculation of the two year period by any period of disability of the insured.

Insurers are reminded these are two distinct statutory options, and the most favorable aspects for an insurer cannot be made into a third option not sanctioned by statute. For example, the fraudulent misstatement exception of the first option cannot be added to the second option.

3. Must include a “Grace Period” provision for premium payment in accordance with the statutory options.
4. Must include a “Reinstatement” provision in case of policy lapse in accordance with statutory options. Section 3216(d)(1)(D) of the Insurance Law makes reference to a conditional receipt when premium is tendered with an application for reinstatement. Insurers are reminded that the conditional receipt used for reinstatement of policies has its own statutory requirements for use in the reinstatement situation. For example, Section 3216(d)(1)(D) of the Insurance Law places a maximum 45-day time limit following the date of the conditional receipt for insurer action on a reinstatement application where the insurer or its agent issued a conditional receipt for premium tendered. The policy is reinstated on the 45th day following the conditional receipt date if the insurer has not approved or disapproved the reinstatement application in writing within that time period. - Section 3216(d)(1)(D).
5. Must include “Notice of Claim” provision in accordance with statutory options – Section 3216 (d)(1)(E).
6. Must include “Claim Forms” provision – Section 3216 (d)(1)(F).
7. Must include “Proofs of Loss” provision – Section 3216 (d)(1)(G).
8. Must include “Time of Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(H).
9. Must include “Payment of Claims” provision in accordance with statutory options – Section 3216 (d)(1)(I). Section 3216(d)(1)(I) contains several scenarios and/or options for the insurer. Each scenario and/or option chosen must be as favorable or more favorable than Section 3216(d)(1)(I).
10. Must include “Physical Examinations and Autopsy” provision – Section 3216 (d)(1)(J).
11. Must include “Legal Actions” provision – Section 3216 (d)(1)(K).
12. When applicable, must include “Change of Beneficiary” provision in accordance with statutory options – Section 3216 (d)(1)(L).

XI. Optional Standard Provisions

These provisions may be included, at the insurer's option; but, if they are included, they must be no less favorable to the insured than the following statutory provisions.

1. If insurer chooses to place a "Misstatement of Age" provision in the coverage, must comply with Section 3216 (d)(2)(B).
2. If insurer chooses to place an "Other Insurance in this Insurer" provision in the coverage, must comply with Section 3216 (d)(2)(C). However, please see Sections 52.15(b)(4),(8),(12),(13),(14), and (15), and the discussion in this outline concerning those sections.
3. If insurer chooses to place an "Insurance with Other Insurers" provision in the coverage, must comply with Section 3216 (d)(2)(E). However, please see Sections 52.15(b)(4),(8),(12),(13),(14), and (15), and the discussion in this outline concerning those sections. Section 3216(d)(2)(E) language is only permissible because it allows the insurer a remedy where the insurer has not been given written notice of other specified disease coverage prior to the occurrence or commencement of loss.
4. If insurer chooses to place an "Unpaid Premium" provision in the coverage, must comply with Section 3216 (d)(2)(G).
5. If insurer chooses to place a "Cancellation" provision in the coverage, must comply with Section 3216(d)(2)(H) of the Insurance Law.
6. If insurer chooses to place a "Conformity with State Statutes" provision in the coverage, must comply with Section 3216 (d)(2)(I).
7. If insurer chooses to place an "Illegal Occupation" provision in the coverage, must comply with Section 3216(d)(2)(J).
8. If insurer chooses to place an "Intoxicants and Narcotics" provision in the coverage, must comply with Section 3216(d)(2)(K).

XII. Other Provisions

1. Policy definition of "hospital" as used in an individual specified disease policy must comply with Section 52.2(m) of Regulation 62.
2. Policy definition of "pre-existing condition" must be meaningful as used in a specified disease policy, fair to the consumer and fully disclosed in the policy language – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) of Regulation 62. See also discussion above about Section 52.15(b)(6).
3. Reductions in benefits such as when certain events occur or ages are reached are not permissible. Section 52.15(b)(16)
4. Policy definition of "mental disorders" must be meaningful as used in a specified disease coverage policy, fair to the consumer, and fully disclosed in the policy language – originates from Sections 3201(c)(3), Sections 3217(b), 4224(b)(2) of the Insurance Law and Sections 52.1(c), 52.1(d), 52.16(c)(2) of Regulation 62.

5. Policy definitions of “physician” and similar terms cannot unduly limit access of the insured to benefits under the policy – originates from Sections 3201(c)(3), 3217(b) of the Insurance Law and Sections 52.1(c), 52.1(d) and 52.15 of Regulation 62.
6. Section 3216(d)(1)(K) is governed by “lead in” wording present in Section 3216(d)(1). The “lead in” wording proscribes approval of language which would be less favorable in any respect to an insured than the wording in Section 3216(d)(1)(K). Section 3216(d)(1)(K) sets forth parameters to allow an insured to bring an action at law or equity in a specified disease policy or any individual commercial accident and health insurance policy. Arbitration provisions set forth as a contractual right of an insurer generally preclude an insured from bringing an action at law or equity. Therefore, the Department is under a statutory constraint because arbitration provisions in a policy which preclude an insured from bringing an action at law or equity would be less favorable in many respects to an insured than the parameters set forth in Section 3216(d)(1)(K).

The Department addresses here its statutory inability to approve arbitration provisions in a specified disease policy. The Department does not address in this product outline other reasonable and appropriate mechanisms which an insurer may be able to use in its ongoing relationship with an insured.

7. Insurers are reminded of their obligations under Section 3228 of the Insurance Law regarding refund of premium upon death of insured and/or any covered dependents.
8. The Department has on occasion received individual non-recurring (lump sum) specified disease submissions which contain benefits additional to the specified disease coverage. For example, some specified disease insurers have wanted to add accident benefits and/or hospital confinement benefits.

Section 52.15(a) contains the definition of specified disease coverage. (See the discussion of this section in this outline.) That definition does not indicate that accident benefits, hospital indemnity benefits or any other benefit are part of a specified disease coverage. Adding benefits unrelated to specified diseases to a specified disease coverage gives the impression to a consumer the coverage is more comprehensive than it actually is. This is contrary to Section 3201(c)(3) of the Insurance Law. Giving the illusion of comprehensive benefits in such a limited policy would be contrary to the supplemental nature of the coverage, and it would be contrary to the requirements in Section 52.15(b) that a person have actual underlying comprehensive coverage in order to purchase the limited specified disease coverage. Such an illusion of comprehensiveness might convince an insured to lapse his/her actual underlying comprehensive coverage and keep only the specified disease coverage with “add-on” benefits. This would be contrary to Section 52.1(c) of Regulation 62 and Section 3217(b)(1)(2)(3) of the Insurance Law while adversely affecting the community rated pools of actual comprehensive coverages marketed in New York State.

XIII. Applications

1. If more than one application will be used, objective criteria is required to avoid unfair discrimination under Section 4224(b) of the Insurance Law. An example of unfair discrimination would be that, if two applications offer different levels of underwriting, two individuals would receive the same policy but undergo different levels of underwriting.

Insurers are reminded of their obligations under Section 4224(b)(1) as they pertain to the use of application forms with specified disease coverage policies. Objective and rational criteria must be used by the specified disease insurer to avoid unfair discrimination if the insurer is using multiple application forms so different applicants are subjected to different medical and

- financial underwriting in attempting to obtain coverage. When a submission is made of multiple application forms where the Department could reasonably inquire about such obligations, the insurer should provide a detailed and prominent explanation in the submission letter about the use of multiple application forms with a specified disease coverage product.
2. Section 52.51(a) of Regulation 62 requires that an application cannot contain questions as to race of the applicant.
 3. Section 52.51(b) of Regulation 62 requires that questions regarding past or present health of any person that refers to a specific disease or general health must be asked to the best of the applicant's knowledge and belief. Questions regarding factual information, such as doctor's visits or hospital confinements, do not require this qualification.
 4. Section 52.51(c) of Regulation 62 requires that no application will contain a provision that changes the terms of the policy to which it is attached.
 5. Section 52.51(d) of Regulation 62 requires that no application will contain a statement that the applicant has not withheld any information or concealed any facts.
 6. Section 52.51(e) of Regulation 62 requires that no application will contain an agreement that an untrue or false answer material to the risk shall render the contract void.
 7. Section 52.51(f) of Regulation 62 requires that no application will contain an agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except in conformity with Section 3204 of the Insurance Law.
 8. Section 52.51(g) of Regulation 62 requires that applications for conversion policies may not contain questions as to the health of the person or persons entitled to conversion.
 9. Section 52.51(h) of Regulation 62 requires that applications for policies subject to Section 3216(d)(2)(E), "Insurance with Other Insurers", will contain a question or questions requiring information with respect to such other insurance. However, please see Sections 52.15(b)(8),(12),(13),(14) and (15), and the discussion in this outline concerning those sections. Also see Section 52.15(b)(4), and the discussion in this outline about it. Also see the discussion of Section 3216(d)(2)(E) in the portion of this outline dealing with "Optional Standard Provisions".
 10. Section 52.51(i) of Regulation 62 requires that if an insurer includes in a policy the optional standard provision under Section 3216(d)(2)(C), "Other Insurance in this Insurer", a statement describing the provision in the policy must be included in the application, or provided at the time of application by separate notice. However, please see Sections 52.15(b)(4),(8),(12),(13),(14) and (15), and the discussion in this outline concerning those sections.
 11. Section 52.51(j) of Regulation 62 requires that if a policy contains a provision with respect to "pre-existing conditions", a statement describing the policy provision must be included in the application OR provided at the time of application by delivery of the disclosure statement required by Section 52.54.
 12. Section 52.15(b)(13) of Regulation 62 requires that an application form for specified disease coverage include a question designed to elicit information as to whether any applicant has at least major medical insurance or at least basic hospital insurance and basic medical insurance in force on the date of the application.

13. Section 52.15(b)(15) of Regulation 62 requires that application forms for specified disease coverage include questions designed to elicit:
- whether, as of the date of the application, any applicant (includes primary applicant and all dependents) has in force or application(s) pending for another specified disease policy or certificate for the same specified disease with the same or a different insurer, and
 - the number of specified diseases for which either any applicant (includes primary applicant and all dependents) has coverage in force as of the date of application or application(s) pending as of the date of application.
14. Previous HIV test results are NOT questioned, sought or used per Sections 3217(b) and 52.1 of Regulation 62. Information regarding the diagnosis or treatment of AIDS or ARC may be sought and used. Also, the insurer has the right to conduct its own medical tests as part of the underwriting process
15. Individual insurers are reminded of their obligations under Section 2611 of the Insurance Law and Section 2782 of the Public Health Law regarding written informed consent, authorization and disclosure of confidential information when the insurer uses an HIV antibody test in underwriting. Circular Letters No. 3 (1989) and No. 5 (1997) are relevant.
16. If this filing contains a reference to a telephone or in-person interview, the interview is conducted in the following manner:
- Any questions raised during the interview are limited to those questions appearing on the application (i.e., questions over the phone would be no different than those being asked in the application).
- The applicant will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview.
- Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with Section 3204 of the Insurance Law.
17. If an Investigative Consumer Report will be prepared or procured, the insurer complies with Section 380-c of the General Business Law by providing notice in the application or in a separate form.
18. If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with Section 321 of the Insurance Law.
19. Section 420.18(b) of Regulation 169 requires that an authorization to disclose nonpublic personal health information specifies the length of time the authorization will remain valid (maximum 24 months).
20. Section 403(d) of the Insurance Law requires a fraud warning on the application form.
21. Section 3204 of the Insurance Law contains requirements that apply to application forms for individual specified disease coverage policies. An insurer may make insertions for administrative purposes only as long as the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without his written consent.

XIV. Conditional Receipts/Interim Insurance Agreements

Section 52.53 of Regulation 62 requires that, if premium is paid prior to policy delivery and the insurer requires a determination of insurability as a condition precedent to the issuance of a policy, an insurer must issue either a conditional receipt or interim insurance agreement. In general, Section 52.53 sets forth two permissible methods for money to be accepted with an application – conditional receipt or interim insurance agreement. A “determination of insurability” means a determination by the insurer as to whether the proposed insured is insurable under its underwriting rules and practices for the plan and amount of insurance applied for and at the insurer’s standard premium rate. Section 52.53(c) sets forth the meaning of “determination of insurability”.

1. A conditional receipt sets an effective date for the policy if the applicant successfully completes the underwriting process. The conditional receipt shall contain an agreement to provide coverage subject to any reasonable limit regarding the amount of insurance specified in the receipt, contingent upon insurability, and provides that such insurability be determined as of a date no later than:

The date of completion of all parts of the application, including completion of the first medical examination if one is required by the company’s underwriting rules,
AND

The required premium has been paid.

Completion of a second medical examination may be required as a condition precedent to coverage if initially required by the company’s underwriting rules because of the amount of insurance applied for or the age of the proposed insured.

If the proposed insured is insurable as of the above date, coverage under the issued policy begins not later than such date, except as provided in paragraph 4 below. Section 52.53(a) of Regulation 62

2. Although the proposed insured dies, undergoes a change in health or otherwise becomes uninsurable according to the insurer’s underwriting standards for the insurance plan for which application was made after the date provided in paragraph 1 above but before the application is approved or rejected and before the expiration of any time limit specified in the receipt, an insurer may determine that the proposed insured is not insurable only as of the date stated in paragraph 1. Information relating to an event or physical condition that is the subject of a question in any part of the application cannot be considered for underwriting purposes if the event or accident occurred or sickness first manifested itself after completion of that part of the application. Adverse changes in insurer underwriting rules after the date stated in paragraph 1 cannot be taken into account when such adverse changes in underwriting rules take effect after the date stated in paragraph 1 but before the application is approved or rejected and before the expiration of any time limit specified in the receipt. (In summary, policy underwriting can only be based on the insured’s health status as of the date provided for in paragraph 1.) Section 52.53(e) of Regulation 62.

Suppose a specified disease applicant pays premium with his/her application, and the insurer issues a conditional receipt to the applicant on December 1, 2002. The applicant completes all parts of the application truthfully on December 1, 2002, and the applicant awaits the insurer's underwriting decision. Then assume on January 1, 2003 (which is before the expiration of a 60 day time limit in the receipt), the applicant is diagnosed with a severe condition which would be covered under the specified disease policy applied for (but not yet issued because the insurer is in the process of underwriting). Then assume the applicant dies on January 27, 2003. The insurer would be using its underwriting rules in effect on December 1, 2002, and the insurer would be

assessing the insured's health as of December 1, 2002 based upon a truthful application submitted by the applicant on December 1, 2002. The insurer would issue a specified disease policy dated effective December 1, 2002. The insurer would be obligated to pay for the specified disease diagnosed on January 1, 2003 because it is past any 30 day probationary period the policy might have as (Section 52.15(d)(2)) measured from December 1, 2002. This might all occur retrospectively if the insurer used the full 60 day period mentioned in the conditional receipt and did not issue the specified disease policy with a December 1, 2002 effective date until January 29, 2003.

3. An interim insurance agreement provides some type of immediate limited insurance coverage as of the application date. The agreement provides coverage in accordance with the policy and plan of insurance described in the application subject to any reasonable limit regarding the amount or duration of insurance specified in the agreement. Coverage is provided as of the application date and must provide at least 60 days coverage unless:

The policy applied for is issued prior to the end of the 60 days, OR

The applicant receives actual notice that coverage under the agreement is cancelled because the application has been declined. If notice is given by mail, it may be deemed received on the fifth day after mailing such notice to the applicant. Section 52.53(b) of Regulation 62

4. An insurer may honor a written request from the applicant that coverage begins as of a specified date later than the date provided for in the conditional receipt or interim insurance agreement. In other than replacement situations, the applicant's written request for a later effective date must contain a statement signed by the applicant that he/she understands that he/she may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement. Section 52.53(f) of Regulation 62
5. If coverage is provided under a conditional receipt or interim insurance agreement for two or more proposed insureds, the coverage must be determined separately for each proposed insured, except, however, all proposed insureds may be rejected in the event of fraud or material misrepresentations. Section 52.53(d)
6. If a policy is not issued within the time specified in the conditional receipt or interim insurance agreement, the application will be deemed rejected and all premiums will be refunded. Section 52.53(i) of Regulation 62
7. In mail order cases only, an insurer may postpone the effective date of coverage to the date of issuance of the policy. Section 52.53(g) of Regulation 62
8. In franchise cases, the coverage under the conditional receipt or interim insurance agreement may be made contingent upon meeting specified participation requirements. Section 52.53(h) of Regulation 62

The Department will entertain reasonable alternatives to Section 52.53 requirements. The insurer cannot take the most favorable aspects of a conditional receipt and interim insurance agreement for an insurer and submit a hybrid form that is not as favorable for an insured as under Section 52.53. Any alternative must be as favorable for an insured as Section 52.53 requirements.

XV. Disclosure Form Requirements

1. Sections 52.15(b)(5) and 52.66 of Regulation 62 set forth the disclosure requirements for specified disease coverage policies. Section 52.15(b)(5) of Regulation 62 requires that,

except in the case of direct response insurers, no specified disease policy will be delivered or issued for delivery in New York State unless the appropriate disclosure form in Section 52.66 of Regulation 62 describing the policy's benefits, limitations and exclusions, and expected benefit ratio is delivered to the applicant at the time application is made and written acknowledgement of receipt or certification of delivery of such disclosure form is provided to the insurer. Direct response insurers will deliver the requisite disclosure form at the time the policy is delivered. See also discussion above about Section 52.15(b)(5).

XVI. Marketing of Individual Specified Disease Coverage Using Group Methods

The individual specified disease coverage checklist contains items pertaining to whether a filing is individual, "list bill" or franchise. The requirements for each category are listed in the checklist, and those requirements will not be repeated here. However, this individual specified disease coverage product outline will explain the necessity of including these items on the individual specified disease coverage checklist.

These items are a recognition of how individual insurance is generally sold in the New York State marketplace by insurers and their agents, brokers or other representatives. In the sale of individual accident and health insurance, including specified disease coverage, it is generally recognized that individual sales on a "one to one" basis are the most time consuming and costly to administer. There is no ability to know beforehand the characteristics of the insureds who will purchase the individual product (as contrasted with true group coverage where, as an example, one knows the type of employer or association purchasing---e.g. coal miners vs. librarians). True individual sales only occur by individual solicitation where not many insureds are purchasing at a particular point of sale. The medical underwriting, if any, is generally detailed to obtain and process. Due to such factors, the minimum loss ratios in Regulation 62 for such coverage are generally lower than for group coverages or coverages where many sales are made at one time or where group characteristics are apparent. Similarly, the individual sale is usually an adhesion contract situation where the insurer retains most of the bargaining leverage at point of sale, and the insurer retains that superior bargaining position concerning various issues such as claim processing after individual coverage is in force. This situation aids in explaining why many of the Insurance Law provisions pertaining to individual accident and health coverages (such as standard provisions) are more detailed and protective of the individual insured. This same situation aids in explaining why many of the Regulation 62 provisions pertaining to individual accident and health coverage are also more detailed and protective of the individual insured.

Over the years, however, insurers have developed mechanisms in the individual accident and health insurance marketplace which are not solely individual sales. These mechanisms seek to market or offer the individual product using group or quasi-group type methods. Often, however, the insurer does not want to pass on all or some of the savings or advantages of marketing an individual product in a group or quasi-group type manner. Thus, insurance regulations become necessary to protect the consumer. In addition, even when the insurer seeks to pass on some of the savings or advantages, the group or quasi-group type arrangement is not present forever. Sometimes the individual product group-type sales arrangement does not meet statutory requirements in New York State. Statutory and regulatory requirements can determine whether the group or quasi-group type marketing methods for an individual product are appropriate, and how much of the advantage of those methods should be passed on to the insured and for how long. The integrity of the New York statute recognizing groups is important when considering the appropriateness of marketing or offering an individual product with group or quasi-group methods. The integrity of that statute is important so the public is not misled into believing an individual product (without all or some of the advantages of a group product) is a group product as recognized by law with the consequential advantages of a group product.

Based upon the foregoing, the individual specified disease coverage checklist has set forth the mechanisms through which individual specified disease coverage products can be marketed using group or quasi-group methods. The first method which is a step toward group or quasi-group methods is a

payroll deduction arrangement. When this arrangement is used for premium payments with no discounts at all and no other type of group or quasi-group methods, the individual specified disease product remains subject to regulation as an individual product. No group or quasi-group savings or advantages to any significant degree are claimed by the insurer, and the individual insured has the convenience of payroll deduction as long as the employer is willing to provide that convenience. Here the insurer will accept premium payments directly from an insured should the insured lose the convenience of payroll deduction or choose not to use payroll deduction to pay premiums.

The second method, which is the next step toward group, or quasi-group methods is “list bill.” One will not find this method as a statutory or regulatory exception to the statute that recognizes permissible groups in New York State. It has been a method recognized by the Insurance Department as an accommodation to insurers for over 30 years.

Essentially, insurers desiring to use this method must differentiate it from franchise insurance (see below) to retain the exclusive treatment as an individual product, including but not limited to the generally lower individual minimum loss ratio more favorable to the insurer. The Insurance Department views this method as the sale of very few individual policies at a common site or address (usually an employer or some association) with no exclusivity granted to the insurer, no sponsorship by the employer or association, no mass marketing (i.e. - agent or representative engages in the “one on one” sale) and no contribution of premiums by the employer or association. The employer or association may remit or not remit premiums through the sending of a single bill to the common address of the employer or association where the few individual insureds work or have a membership. Generally, this situation goes further than the payroll deduction arrangement because there are a few sales at a small employer or association site, and the insurer provides actuarial justification to the Insurance Department that the “list bill” arrangement is worth some small discount.

It is important to note that the “list bill” discount is dependent upon the factual circumstances noted here for its continued existence. Since the “list bill” arrangement as understood by the Insurance Department provides such marginal savings and advantages of a group or quasi-group nature and a rather small discount, the Insurance Department regulates the individual specified disease coverage product as still an individual product with the generally more favorable individual minimum loss ratio. However, due to the marginal savings and advantages, the Insurance Department requires that the small discount revert to the higher individual premium if the “list bill” situation goes out of existence, and the insured continues to pay his/her premium on a direct bill basis. Once the “list bill” situation goes out of existence and the marginal savings and advantages also do not exist, the insured is a usual individual insured who should pay the undiscounted individual rate like other individual insureds to avoid “unfair discrimination” under Section 4224 (b)(1) of the Insurance Law. Prominent disclosure in the form of the increased rate when the “list bill” situation ends must occur.

The third method which is the last method and the most expansive method of marketing or offering individual specified disease coverage products with group or quasi-group savings or advantages is franchise insurance. Sections 52.2 (k), 52.19 and 52.70 of Regulation 62 (11NYCRR52) should be consulted. Generally, individual specified disease coverage products are distributed on a mass merchandising basis, administered by group methods and provided with or without evidence of insurability. Sponsorship by an employer or association occurs and exclusivity in the marketing of the individual products is granted to a particular insurer. The individual contract mechanism is retained. So the legal relationship is directly between the insured and insurer with no group policy being issued to a group policyholder. However, the insurer is generally able to know beforehand the characteristics of the insureds (e.g. – bar association, medical society, etc.), and the insurer is generally able to obtain a significant number of insureds due to the sponsorship of the employer or association, exclusivity granted to the insurer in marketing the individual specified disease coverage product and more sizeable discounts for the insured. We are just short of marketing the product as group under New York law, but the employer or association does not enter the direct legal relationship of the insurance contract and is not the group policyholder.

In the franchise situation, the agent or insurer representative usually does less work because of the sponsorship and exclusivity. The insurer achieves economies of acquisition and administration as well as knowing there is some affinity or relationship among all the insureds purchasing the franchise individual product. Therefore, the Insurance Department requires that these factors accrue to the insured's benefit in the regulation of the franchise individual product. A higher minimum loss ratio is required, and the insurer can allow the discount on the franchise product to remain if the franchise arrangement ends because of the sizeable savings and advantages occurring at point of sale which can be recognized over the lifetime of the franchise form. (These sizeable savings and advantages do not occur with the first two methods either resulting in no discount or the reversion to the higher individual rate. The Department will allow an insurer to charge the higher individual rate upon termination of the franchise arrangement for any reason if the insurer provides actuarial justification as to why the franchise savings and advantages do not warrant continuation of the discount upon termination of the franchise arrangement. In that instance, prominent disclosure of the higher rate in the form is necessary as with the "list bill" arrangement.)

XVII. Rating Procedures and Requirements

1. Section 52.40 (a) of Regulation 62 sets forth general procedures and requirements that apply to the rating of individual specified disease coverage policies.
2. Section 52.40 (b) of Regulation 62 sets forth prohibited rating practices that may be applicable to individual specified disease coverage policies.
3. Section 52.40 (c) of Regulation 62 sets forth requirements applicable to individual specified disease coverage policies.
4. Section 52.40 (d) of Regulation 62 sets forth requirements applicable to individual specified disease coverage policies.
5. Section 52.41 of Regulation 62 sets forth gross premium differentials based on sex, which apply to individual specified disease coverage policies.
6. Section 52.43(a) of Regulation 62 sets forth standards for maintaining experience data that apply to individual specified disease coverage policies.
7. Sections 52.44(a) and (b) of Regulation 62 set forth monitoring standards that apply to individual specified disease coverage policies.
8. Section 52.45(j)(2) of Regulation 62 sets forth minimum loss ratio standards that apply to individual specified disease coverage policies written on a non-recurring basis (lump sum).