COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, MARCH 16, 2017

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

CASE NO. INS-2017-00032

Ex Parte: In the matter of Amending the Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies

ORDER TO TAKE NOTICE

Section 12.1-13 of the Code of Virginia ("Code") provides that the State Corporation Commission ("Commission") shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223 of the Code provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code.

The rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code are set forth in Title 14 of the Virginia Administrative Code. A copy may also be found at the Commission's website: http://www.scc.virginia.gov/case.

The Bureau of Insurance ("Bureau") recently received a proposal from American Family Life Assurance Company ("Aflac"), through its counsel, requesting that the Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies ("Rules") set forth in Chapter 120 of Title 14 of the Virginia Administrative Code be amended at 14 VAC 5-120-70. The Bureau has reviewed and is in agreement with the proposal to amend the Rules in accordance with Aflac's request.

The amendments to 14 VAC 5-120-70 are necessary to align the indemnity coverage benefits for various types of therapies used to treat cancer with a more flexible benefit and payment structure. Specifically, amendments to subdivisions 2 c (1) and (2) of section 70 of the Rules will reflect more up-to-date protocols and services for cancer treatment.

NOW THE COMMISSION is of the opinion that Aflac's proposal and the Bureau's request to amend the Rules at 14 VAC 5-120-70 should be considered for adoption.

Accordingly, IT IS ORDERED THAT:

(1) The proposed amendments to the "Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act with Respect to Specified Disease Policies," which amend the Rules at 14 VAC 5-200-70, are attached hereto and made a part hereof.

(2) All interested persons who desire to comment in support of or in opposition to, or request a hearing to consider the proposed amendments, shall file such comments or hearing request on or before May 5, 2017, with Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218. Interested persons desiring to submit comments electronically may do so by following the instructions at the Commission's website: http://www.scc.virginia.gov/case. All comments shall refer to Case No. INS-2017-00032.

(3) If no written request for a hearing on the proposal to amend the Rules as outlined in this Order is received on or before May 5, 2017, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposal, may adopt the Rules as submitted by the Bureau.

(4) The Bureau forthwith shall give notice of the proposal to amend the Rules to all insurers licensed by the Commission to write accident and sickness insurance in the Commonwealth of Virginia, as well as all interested persons.

(5) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the proposed amended Rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations.

(6) The Commission's Division of Information Resources shall make available this Order and the attached proposed amended Rules on the Commission's website: http://www.scc.virginia.gov/case.

STATE CORPORATION COMMISSION, BUREAU OF INSURANCE

Rules Governing Minimum Standards with Respect to Specified Disease Policies

14VAC5-120-70. Specified disease minimum benefit standards.

No specified disease policy shall be delivered or issued for delivery in this Commonwealth which does not meet the following minimum benefit standards. If the policy does not meet the required minimum standards, it shall not be offered for sale. These are minimum benefit standards and do not preclude the inclusion of other benefits which are not inconsistent with these standards.

1. Minimum benefit standards applicable to non-cancer coverage:

a. A policy must provide coverage for each person insured under the policy on an expense incurred basis for a specifically named disease(s). This coverage must be in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of $250, an overall aggregate benefit limit of not less than $5,000, a uniform percentage of covered expenses that the insurer will pay of not less than 20% in increments of 10%, no inside benefit limits and a benefit period of not less than two years for at least the following:

(1) Hospital room and board and any other hospital furnished medical services or supplies;

(2) Treatment by a legally qualified physician or surgeon;

(3) Private duty services of a registered nurse (R.N.);

(4) X-ray, radium and other therapy procedures used in diagnosis and treatment;

(5) Professional ambulance for local service to or from a local hospital;

(6) Blood transfusions, including expense incurred for blood donors;

(7) Drugs and medicines prescribed by a physician;

(8) The rental of an iron lung or similar mechanical apparatus;

(9) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

(10) 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

(11) May include coverage of any other expenses necessarily incurred in the treatment of the disease; or

b. A policy must provide coverage for each person insured under the policy for a specifically named disease(s) 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; or

c. A policy must provide lump-sum indemnity coverage of at least $1,000. It must provide benefits which are payable as a fixed, one-time payment made within 30 days of submission to the insurer of proof of diagnosis of the specified disease(s). Dollar benefits shall be offered for sale only in even increments of $100 (i.e. $1,100, $1,200, $1,300 . . .).

Where coverage is advertised or otherwise represented to offer generic coverage of a disease(s) (e.g., "heart disease insurance"), the same dollar amounts must be payable regardless of the particular subtype of the disease. However, in the case of clearly identifiable subtypes with significantly lower treatment costs, lesser amounts

may be payable so long as the policy clearly differentiates that subtype and its benefits.

2. Minimum benefit standards applicable to cancer only or cancer combination coverage:

a. A policy must provide coverage for each person ensured under the policy 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 that are ordered or are prescribed by a physician as necessary for the treatment of cancer. This coverage must be in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of $250, an overall aggregate benefit limit of not less than $10,000, a uniform percentage of covered expenses that the insurer will pay of not less than 20% in increments of 10%, no inside benefit limits and a benefit period of not less than three years for at least the following:

(1) Treatment by, or under the direction of, a legally qualified physician or surgeon;

(2) X-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

(3) Hospital room and board and any other hospital furnished medical services or supplies;

(4) Blood transfusions, and the administration thereof, including expense incurred for blood donors;

(5) Drugs and medicines prescribed by a physician;

(6) Professional ambulance for local service to or from a local hospital;

(7) Private duty services of a registered nurse (R.N.) provided in a hospital; and

(8) May include coverage of any other expenses necessarily incurred in the treatment of the disease; or

b. A policy must provide benefits for each person insured under the policy for the following:

(1) Hospital confinement in an amount of at least $100 per day for at least 500 days;

(2) Surgical expenses not to exceed an overall lifetime maximum of $3,500; and

(3) Radium, cobalt, chemotherapy, or X-ray therapy expenses as an outpatient to at least $1,000. Such therapy benefit shall be restored after an insured is treatment or hospitalization free for at least 12 months; or

c. A policy must provide ~~per diem~~ indemnity coverage.

(1) Such coverage must provide covered persons:

(a) A fixed-sum payment ~~of at least $100~~ for each day of hospital confinement for at least 365 days; ~~and~~

(b) A fixed-sum payment ~~equal to at least ½ the hospital inpatient benefit~~ for ~~each day of hospital or non-hospital~~ inpatient or outpatient surgery~~, chemotherapy and radiation therapy for at least 365 days of treatment~~; and

(c) A fixed-sum payment made on the basis of a specified period of time for any chemotherapy, radiation therapy or other similar therapy used to treat the disease.

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

(a) A fixed-sum payment ~~equal to at least ¼ the hospital inpatient benefit~~ for each day of skilled nursing ~~home~~ facility confinement for at least 100 days;

(b) A fixed-sum payment ~~equal to at least ¼ the hospital inpatient benefit~~ for each day of home health care for at least 100 days;

(c) Notwithstanding any other provision of this chapter, any restriction or limitation applied to the benefits in subdivisions 2c(2)(a) and 2c(2)(b) above, whether by definition or otherwise, shall be no more restrictive than those under Medicare; or

d. A policy must provide lump-sum indemnity coverage of at least $1,000. It must provide benefits which are payable as a fixed, one-time payment made within 30 days of submission to the insurer of proof of diagnosis of the specified disease(s). Dollar benefits shall be offered for sale only in even increments of $100 (i.e., $1,100, $1,200, $1,300 . . .).

Where coverage is advertised or otherwise represented to offer generic coverage of a disease(s) (e.g., "cancer insurance"), the same dollar amounts must be payable regardless of the particular subtype of the disease (e.g., lung or bone cancer). However, in the case of clearly identifiable subtypes with significantly lower treatment costs (e.g., skin cancer), lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.