2025

SUPPLEMENTAL HEALTH,
DI & LTC CONFERENCE



Cracking the Code of Regulatory Compliance in Tough States









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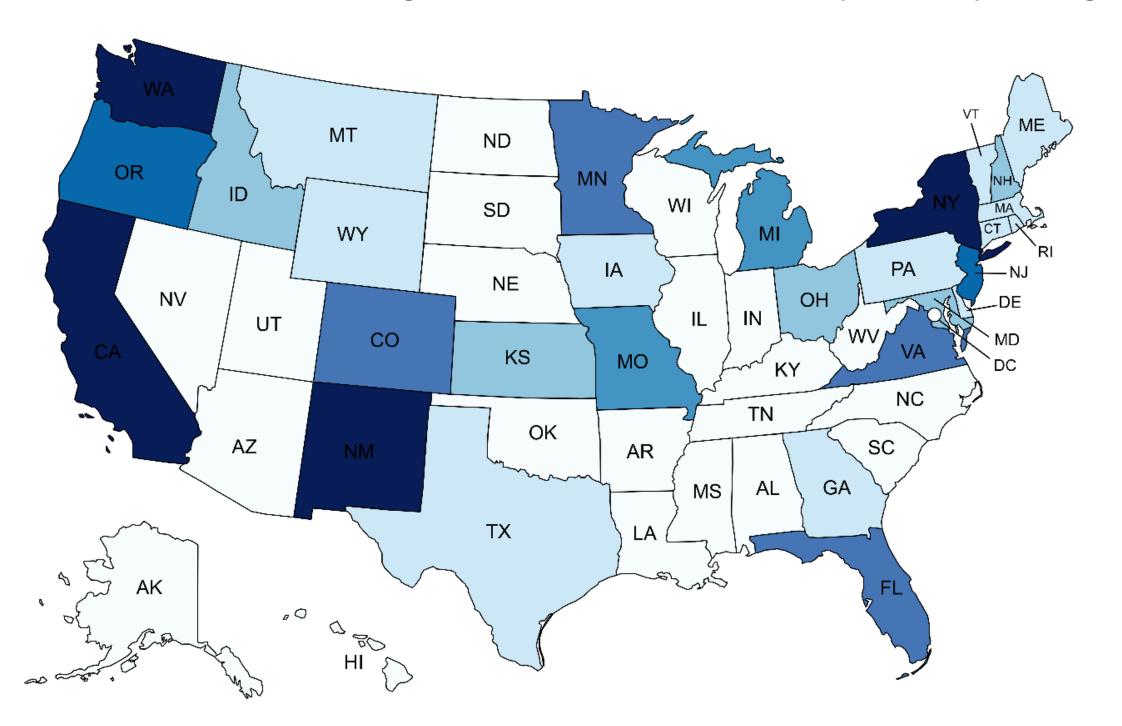
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Excepted Benefits Regulatory Landscape

In 2023, across Accident, Critical Illness, and Hospital Indemnity insurance carriers, California, New Mexico, New York, and Washington were mentioned most, followed by New Jersey and Oregon.

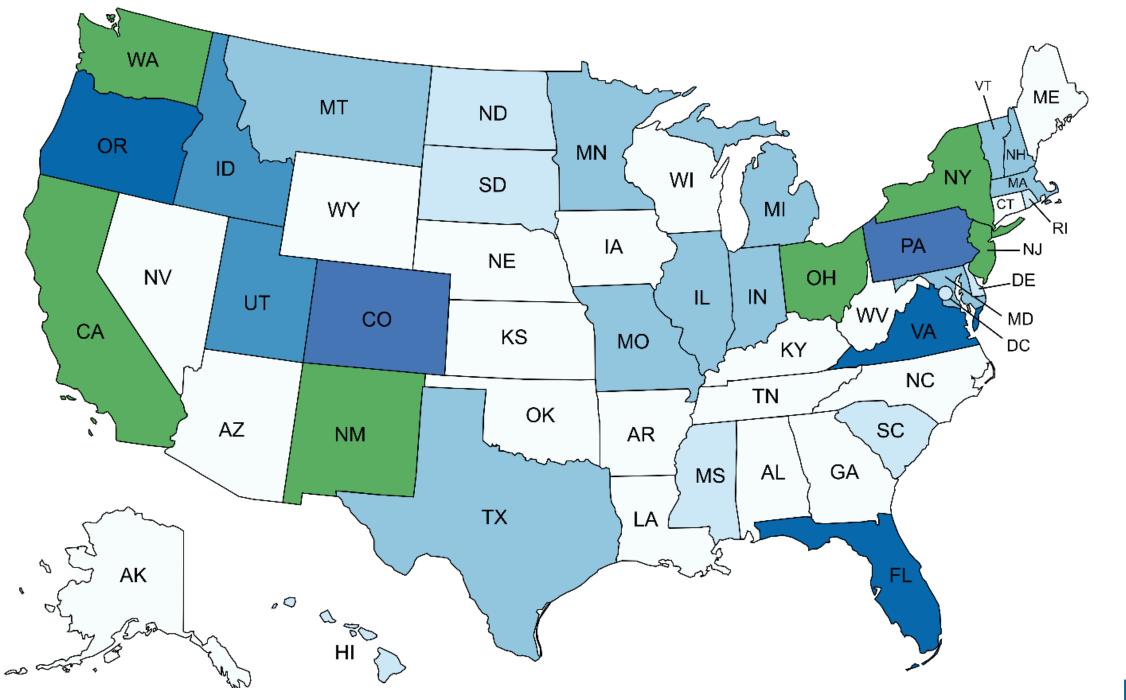


- □ 0 mentions
- 1-5 mentions
- 6-10 mentions
- 11-15 mentions
- 16-20 mentions
- 21-50 mentions
- 51+ mentions



Excepted Benefits Regulatory Landscape

In 2025, when asked if other states in addition to those most commonly mentioned in 2023 had become difficult to file supplemental products, Virginia, Florida, and Oregon were the most commonly cited.



- □ 0 mentions
- 1-2 mentions
- 3-4 mentions
- 5-6 mentions
- 9-10 mentions
- 11+ mentions
- Previously mentioned



Excepted Benefits Regulatory Landscape

- "No more easy states"
- Low concerns with Federal regulation, increasing concerns with state regulation
- Regulatory posturing is increasingly adversarial
- State regulatory bodies lean heavily on ambiguity and interpretive powers
- Landscape results in an often frustrating experience

• Let's ameliorate some of this frustration – one "tough" state at a time



Ohio – Involved and Precise Rate Regulation

- Full Rate Manual Required Recommend preparing Redacted and Non-Redacted Versions
 - Redacted ("For Public"): All claim costs and adjustment factor are afforded "Trade Secret" protections
 - Non-Redacted: Needs to supply average annual premium calculations. No rate guarantees beyond 3 years. For Issue-Age/Attained-Age rates reviewers will ask for an exhibit showing actuarial equivalence. Discretionary underwriting criteria must be explained in the manual as well as experience rating/credibility formula.
 - Technical quirk: anything submitted in Excel must have a "searchable PDF" submitted as well
- Forms, by contrast, are a breeze. Mandatory non-variable "Right to Examine" provision required.



New Mexico - Where Reason Goes to Die

- Restrictive minimum benefit standards or use the Major Medical exemption:
 - Major Medical Exemption: 13.10.34.23 NMAC if proof is provided, opportunity to offer more robust plan designs
- General Requirements:
 - Enrollment forms: clarify that "Eligibility for coverage or benefits is not based on sex, sexual orientation, gender, gender identity, race, religion, or national origin." 13.10.34.8(K) NMAC
 - Remove BWP: 13.10.34.8 (A) NMAC. Eligibility waiting periods are permitted.
 - Portability (Employer Group): Limit to 9 months maximum
 - Limit exclusions to those in 13.10.34.8 (E) NMAC. Any additional exclusions are likely to receive objections
 - Limited Variability OOC 13.10.34.8 (Y) NMAC
 - Expect and revise as needed general provisions to align with 59A-22-4 through 59A-22-15 ("individual" statutes)
- Specified Disease:
 - Use of ADLs Only require 2/6 ADLs (Advanced Alzheimer's)



New Mexico - Where Reason Goes to Die

Specified Disease:

- No more than 8 specified diseases (except employer) 13.10.34.13 (D) NMAC
- Various types/forms of diseases do not count against 8
- Only fixed-indemnity basis
- Use of ADLs Only require 2/6 ADLs (Advanced Alzheimer's)
- Objections to not life threatening: loss of sight, loss of speech, loss of hearing, stem cell or bone marrow transplant, occupational diseases such as occupational Hepatitis or HIV, infertility, cleft lip/cleft palate, down syndrome, and severe burns.
- Hospital Indemnity:
 - At least \$1,500 for initial confinement
 - Specific coverages allowed: being hospitalized, or receiving hospice, convalescent or extended care, hospital-treatment related ambulatory surgical center services, ambulance service to or from a covered confinement, hospital-affiliated outpatient services, anesthesia, surgery, emergency care leading to a hospital, convalescent or hospice confinement, lost wages during a period of hospital confinement, or expenses to travel to or from a hospital confinement.
 - Confinement Definition: "means any consecutive 24-hour period during which medical observation or services are provided on a continuous basis in a licensed medical facility, each immediately successive such period, and any period of time less than 24-hours on the date of discharge from any such society confinement"

California – Interpretation and Lawyerly Review

- Difficult to predict specific review requirements particularly for specified disease what is precedent?
- General Requirements:
 - Compulsory Uniform Provisions: T. 10 s 2232.16 Don't fight it. Do create a comparison chart
 - Discretionary Language: "acceptable to us", "appropriate", "in our discretion", "we determine."
 - Ambulance Benefits Ins 10352 language allowing to be paid directly to provider
 - Senior Insurance limit to employer or maximum issue age to 64
 - Definitions: Spouse + Domestic Partner, Child (remove "unmarried")
 - No specialists requirements
 - Proximate Causation: Exclusions using "contributed to by" language
 - Incurral Period Process of Nature rule allows as low as 180 day incurral period if extends longer "if the Covered Person can show that the manifestation of Injury relates back to the Covered Accident"



California – Interpretation and Lawyerly Review

- Specified Disease/Critical Illness
 - Cover cancer if you call it Critical Illness
 - Cancer coverage: highly visible disclosures for not covered cancers (cover page disclosure and definition)
 - Cancer coverage: definitions must not be "ambiguous" definitions should not cross exclude
 - Use of ADL's prohibited use other severity criteria (e.g., FAST Scale for Alzheimer's)
 - External References Use of DSM, reference to other medical standards, prohibited. Incorporate requirements into contract (e.g., Austism)
 - Occupational Diseases draft without accidental injury triggers or separate rider
 - Treatment based severity criteria (e.g., surgical requirements) remove/rephrase



Illinois/Pennsylvania – TOI Co-Mingling

- TOI Co-mingling: Filing different "type of insurance" benefits under one product roof. Certain states have rules/positions that control how to account for products that don't fit neatly into one TOI bucket.
- Illinois permits Co-mingling, but you have to cover every TOI your product touches with replica
 filings. Example: Group HI base plan with Cancer and AD&D riders. Filer will submit three separate
 filings one for each of the TOIs covered: H14G (Group Hospital Indemnity), H07G (Group Specified
 Disease), and H03G (Accidental Death and Dismemberment). Only one substantive review is
 performed, but revisions are made to each set of forms until approvals are obtained.
- Pennsylvania on the other hand, will permit certain Co-mingling of TOIs in group products, but any benefit deviations from the base plan TOI must be set apart in a rider and reviewed under any regulations pertinent to that TOI. TOI Co-mingling is not permitted, however, for individual products.
 Separate benefit categories = separately filed policies.



Idaho – Potatoes

- Idaho has become a particularly challenging state for group supplemental health products. The state (in 2019) restructured regulations applicable to supplemental health policies and released Bulletin 19-04 to explain its new positions. Accident-only, hospital indemnity, and specified disease coverages are excluded from the definition of "health benefit plan" under 41-4703(15) and thus considered "excepted benefits," but only if they meet the state's narrow interpretation of such products.
- Issues seem to be based on foundational understanding of excepted benefits
- Hospital Indemnity:
 - Idaho requires that hospital indemnity products be narrowly tailored to only provide "daily benefits for hospital confinement on an indemnity basis, meaning the benefit is a fixed dollar amount per day of confinement, regardless of the expenses incurred." (See IDAPA 18.04.08 s 10). Guidance from Bulletin 19-04 reaffirms that a plan which pays benefits "per service, per illness, per visit or on any basis other than per day of confinement does not meet this definition."



Idaho – Potatoes

Accident:

- Biggest issue is with hospitalization benefits
- Department position that an accident product that covers hospital confinement is a hospital confinement product – subject to those regulations (including no per service/treatment)
- Doesn't allow to be "combined" citing Bulletin 19-04
- Consider identifying these benefits differently
- General Requirements:
 - Automatic newborn child coverage must define "placed/placement"
 - Congenital Anomaly definition mandated whether or not used. Incorporate
 - Spouse definition limited to spouse domestic and civil union partners separate
 - Pre-existing condition limitation 6 months IDAPA 18.04.08 s 011(10)



Minnesota - Continuation and Interpretation

- Recent experience New interpretations
- Dependent coverage:
 - Must include both spouse and children. Do not allow policyholder to limit to one or the other 62A.3021
 - Coverage for grandchildren required 62A.042 Subd. 2(a)
 - Definition of Child should be separate from definition of dependent and separate from definition of disabled child.
 - Newborn/Newly adopted coverage no notification can be required. Deduct premium at time of claim
- Continuation:
 - Continuation for Survivors 62A.146
 - Continuation for Former Spouse and Children 62A.21
 - Continuation of Family Coverage 62A.20
 - Portability and general broad continuation provisions not accepted.
 - Applicability challenges hospital or medical expense



Texas – Wait then Hurry Up

- Objection Response TAT is oppressive 5 days, regardless of depth, volume, Holidays or time zones
- Initial objection letters always include stock objections. So, don't fret over a 30+ point objection letter, many (probably most) of them are easily discharged. Example: "Is this filing submitted to roll out a new program or initiative? If yes, explain the new..." Recommend budgeting the time for thorough objection responses in advance of submission
- Technical quick: Different group types require separate filings. So, if your business model revolves
 around Association business, you'd lead with this filing and fast follow with Employer Group and/or
 Discretionary Group (Trust) filings. DON'T file in tandem this will invariably result in annoying
 discrepancies between the group type forms. Instead, fast follow with an "Exempt" filing for the other
 group type forms.
- Other Texas "thangs": Benefits can't available 365 days or its LTC. Payment to Texas Health and Human Services Commission provision.

Florida – Value Added Benefits

- Florida's position is that value-add benefits are not "insurance" benefits and therefore, cannot be included in the insurance contract. In a recent filing that included such benefits, the reviewer stated the following:
 - "Pursuant to Section 626.9541(1)(h)(4.)(a.), the Company may provide 'a value-added product or service at no or reduced cost when such product or service is not specified in the life or health insurance policy,' The Company may provide Value Added Services, however, it may not become part of the Policy."
- A number of our clients have tried filing VAB within the contract or as a rider not approved
- Argued that VAB are also allowed if "plainly expressed in the insurance contract."
- Offered outside contract, not filed. Remove language and provide extracontractually
- Aligns with NAIC Model 880



Colorado – Standardized Syntax, Lexicon, and Rate Regulation

- Forms and Rate materials in Colorado must follow a prescribed order AND utilize precise stator nomenclature for section headings. See 700 CO Code Regs 3 CCR 702-4-2-34-7 for forms. Use 4-2-11 Act Memo template.
- Plan title example: GROUP ACCIDENT CERTIFICATE OF INSURANCE [WITH WELLNESS BENEFITS]. Schedule example: "Who Pays What."
- This is annoying. You will have to move pieces or whole provisions from one section to another to fit the state's form schematics.
- Don't fall for the fast form approval trap most of the substantive forms regulation comes via the rigorous review of the rate materials.



Virginia – Unwellness

- Virginia has taken a firm stance on the inclusion of wellness benefits in supplemental health products.
- The state's published wellness guidance, which became effective on July 1, 2025:
 - Prohibits wellness in: accident only, group hospital indemnity, and disability income policies.
 - Possibly allowed: critical illness, *individual* hospital indemnity, and limited scope dental, vision, or hearing plans if the benefit functions in a certain way.
- Critical Illness wellness must be:
 - related to the disease for which coverage is being provided; AND
 - the monetary amount provided to the insured for receiving the service must be related to the cost of the service (i.e., the payment functions as a partial reimbursement). It must NOT be a "reward" (i.e., a monetary amount unrelated to the cost of the service).
- Other General Issues:
 - Excepted benefit disclosure, separate definition domestic partner, no marital status requirement for children, no Unpaid Premiums provision, very detailed review



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- Full Rate Manual Required
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Washington – Variability

- Both "macro-level" variability and specific pieces of variable language are problematic for Washington regulators
- Washington takes umbrage with "too much variability" as a threshold issue you'll wait for months
 just to receive this ambiguous push back
- No real success in providing go-to-market plan designs
- General rule: Variability must be justifiable within the rate materials e.g. each piece of variable language must have an associated rate factor
- Reccomendation: Trim your variability WAY DOWN before filing. Not going through this exercise is akin to wasting 3-4 months



New York - If You Can Make Here, You Can Make It Anywhere



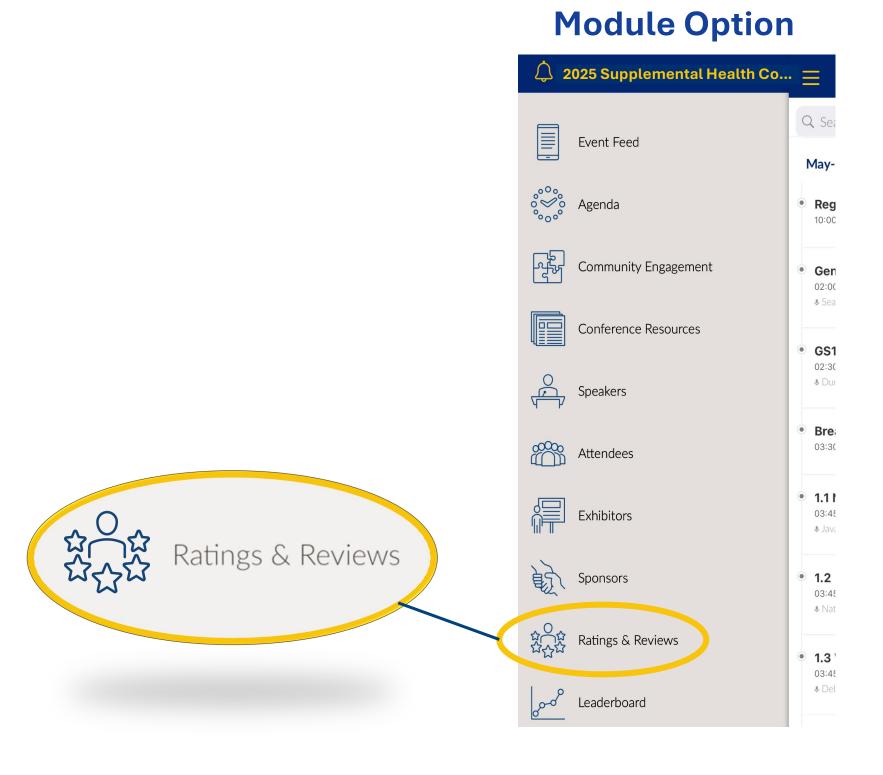
Questions



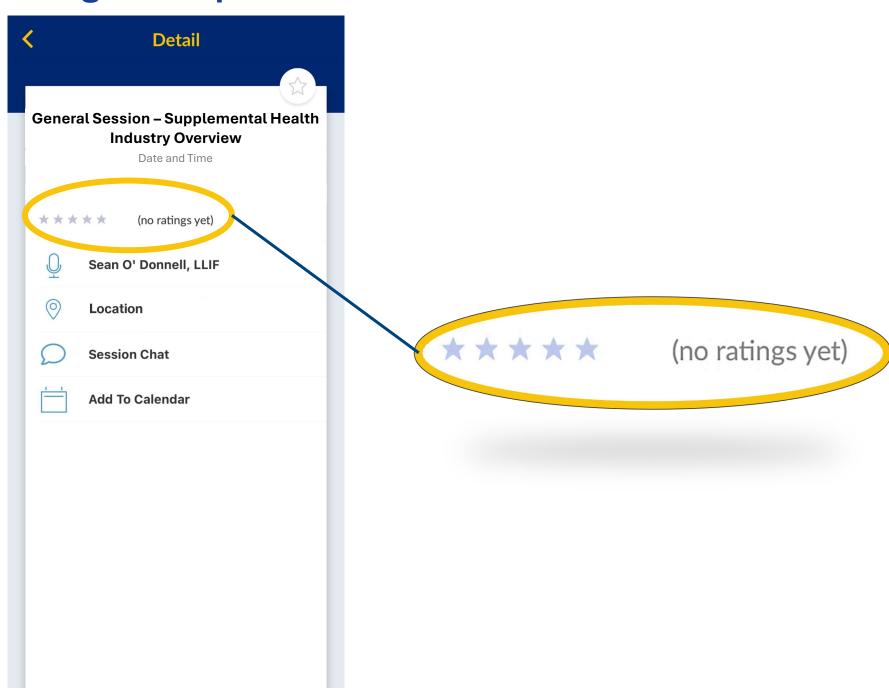




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