



April 14, 2022

Laura Arp
The Nebraska Department of Insurance
PO Box 82089
Lincoln, Nebraska 68501-2089

Andrew Schallhorn
Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105

Re: Model 171 Sections 1 through 7

Dear Ms. Arp and Mr. Schallhorn:

Thank you for soliciting comments. The Health Benefits Institute is a group of agents, brokers, insurers, employers, benefit platforms and others seeking to protect the ability of consumers to make their own health care financing choices. We support policies that expand consumer choice and control, promote industry standards, educate consumers on their options and foster high quality health outcomes through transparency in health care prices, quality, and the financing mechanisms used to pay for care.

Model 171

This model covers a variety of different products (disability insurance, hospital or other fixed indemnity insurance, specified disease, and short-term limited-duration health insurance) that operate very differently. What they have in common, however, is that these plans fill an important consumer need. With rising consumer cost sharing, and a low savings rate, it is more important than ever for consumers to have access to a variety of products that can help fill a financial need.

The subgroup has determined that short-term limited duration coverage will be treated differently since the product is very different from the others. Indeed both long-term care insurance and limited duration long-term care insurance have also been stripped out of the model.

For the remaining products, a minimum standards model continues to make sense. While it is often frustrating how different some of these products are from each other, abandoning the minimum standards model would delay implementation, and might take years to create a separate NAIC model. To paraphrase Winston Churchill's quote on democracy, this minimum standards regulation process may be the worst possible process, except for all of the others.

It is also important to note that some products are already covered by the IIPRC. The subgroup explored using IIPRC standards when discussing Model 170, and found significant issues including disagreement with existing state standards, and requirements that did not reflect minimum standards.

HBI believes regulators should tread carefully in defining the products by the minimum standards too narrowly. Model 171 should include flexibility for insurers to design new products without regulators being forced to either ban the product (due to the product not meeting any regulatory definition) or leave products without regulatory oversight. Indeed Models 642 and 643 covering limited long-term care were created as a result of narrow state definitions of long-term care that created a regulatory gap.

In short, HBI and its members continue to believe the current process makes the most sense.

Supplemental Products

Unlike major medical insurance, most of these products covered by this model provide direct financial assistance to the consumer. The products generally do not limit the consumer's use of the money, and indeed these direct payments to the consumer are used to help pay for many other expenses including travel, lost wages from missing work, and to help fill the gap from rising deductibles and other cost sharing.

Coordination of Benefits for Fixed and Hospital Indemnity Coverage

The subgroup had a long discussion regarding fixed and hospital indemnity. One of the proposed solutions was to require that all plans be coordinated with major medical plans. In our interpretation, this creates several problems. First, in order for Fixed Indemnity and Hospital Indemnity to qualify as an "excepted benefit" (i.e. not subject to regulation as health insurance under federal law), the plans are not allowed to coordinate benefits.

It is also important to note there may be a variety of reasons why consumers choose to purchase these coverage. Filling coverage gaps for the very high deductibles may be a prominent reason for coverage, there are likely others. For example, the delivery of some medical services to residents in rural areas may require significant travel which includes time off work, and travel expenses. These coverages can help fill all gaps – especially if a loved one is hospitalized. Similarly, many insurance coverages have significantly narrowed their networks over the last decade, and supplemental coverage can help provide some assistance for consumers who want to see an out-of-network provider.

Reference Based Pricing in Fixed and Hospital Indemnity Coverage

Traditional fixed and hospital indemnity products include a limited schedule of benefits that cover broad categories of services. These plans may cover "doctor" services without differentiating between the types of visits or services. These schedules of benefits often fit on one sheet of paper. Coverage amounts are limited, and usually provide consumers enough assistance to help offset co-pays for services. However, these plans may provide limited utility for consumers seeking to finance significant deductibles.

So-called reference-based pricing merely uses a larger fixed schedule usually to cover services based on a CPT code. Many are based on the RBRVS or Medicare pricing. Consumers are provided with a similar fixed schedule of benefits set for the policy term. These schedules are available in paper, online, or in other ways and are filed with insurance departments. In most of these policies, the total amount of benefit paid to the consumer are usually set by a fixed amount chosen by the consumer. These plans allow consumers the flexibility to fund some or all of their deductible or cost sharing liability. The key, of course, is that schedule is still fixed. The payment amount should be paid to the consumer regardless of the cost of the service and indeed may on rare occasions exceed the billed amount by the provider. Again, in addition to fixed benefits, these plans also provide fixed dollar coverage in total.

HBI members understand that reference-based pricing creates new challenges to regulators seeking to protect consumers. Consumer confusion – specifically concerns that consumers will believe they are purchasing major medical plans – is important. In the proposed drafting note, we suggest that regulators pair a review of reference-based pricing plans with the insurer marketing materials to ensure that insurers are not developing, marketing, or selling products as major medical replacements.

Proposed New Drafting Note

EB. Hospital ~~Confinement~~ Indemnity or Other Fixed Indemnity Coverage

- (1) “Hospital ~~confinement~~ indemnity or other fixed indemnity coverage” is a policy of ~~accident and sickness~~ supplementary health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than [\$40] per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy.
- (2) Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.
- (3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.

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

Drafting Note:

Fixed and Hospital Indemnity plans provide consumers with a fixed schedule of benefits regardless of the amount billed by the provider, or covered by other insurance plan. Traditional plans have provided a limited schedule of benefits, for example one amount tied to a doctor visit. Many newer plans – filling the gap for consumers with high

deductible plans – have used a broader schedule of benefits with fixed amounts varying based on specific procedure codes. The schedule is still fixed regardless of what the provider charges and is often based on some other reference like Medicare’s RBRVS. Similar to other fixed indemnity, the plans also limit coverage to annual maximum. Regulators have taken different positions on whether referenced-based pricing constitutes fixed indemnity coverage and this is a policy difference between the states. In states allowing reference-based pricing and indeed all supplemental coverage, regulators should ensure that the insurer is not developing, marketing, or selling the plan as a replacement for major medical coverage through a required certification by the insurer and market conduct exams when consumer complaints highlight significant compliance issues.

Marketing

States have taken a variety of positions on the marketing of the plans in part over the concern that consumers are sold some or all of these plans as replacement for major medical coverage. We agree that these plans, with the exception of short-term limited duration coverage, should be treated as supplemental plans.

HBI continues to support appropriate consumer disclosures and requirements that consumers certify on the application that the proposed coverage is not major medical coverage, and will not meet the federal government’s minimum essential coverage requirements.

HBI also supports a requirement that insurers certify with the filing that these plans are not developed, marketed, or sold as major medical replacement plans.

Short-Term, Limited-Duration Health Insurance Coverage

Short-term limited duration health insurance coverage is important coverage for hundreds of thousands of consumers across the U.S. It fills an important need for consumers who need to fill the time between coverage periods (i.e. those who do not have access to job-based coverage and have not enrolled in ACA coverage during an open enrollment period) and lack affordable alternatives. Anyone who has not secured coverage during open enrollment will be ineligible to buy ACA qualified coverage unless qualified for an SEP. Short-term limited duration coverage is necessary to fill that gap.

It is also important to note that there is wide expectation that the Biden administration will resurrect the Obama administrations limits on short-term limited duration to three months. HBI continues to believe this provides a significant disservice to consumers who will lose coverage. In some cases, consumers may no longer be able to meet underwriting standards of a new insurer needed to secure coverage for the balance of the year. In other cases, the consumer will be forced to meet a new deductible on a new plan.

HBI believes the model law generally struck a reasonable balance that reflects a rational approach and allows state flexibility, and it is important for the subgroup not to continually re-litigate issues that have been decided. HBI and its members have worked to create an appropriate level of standards for all states, but we understand the upcoming disclosure section will be equally important. As minimum standards, HBI would suggest the following concepts are important:

Definition

The model law does not define the standards for short term, limited duration health insurance and does not take a position on limiting the time frame of coverage. To be perfectly clear, the Institute supports a model standard based on the federal rule which permits contracts of up to 364 days and renewals of up to three years. However, we have all agreed with the principle that settled issues should not be relitigated. To that end, we suggest the following definition:

“Short Term, Limited Duration Health Insurance Plan” means a policy of health insurance that provides hospital, medical and surgical expense coverage for a fixed period of time defined in [state law].

Covered services

As the subgroup has discussed in the past, short term plans do not typically provide coverage for all of the ACA’s 10 categories. The intent of the plans is to provide flexible coverage tailored to what individuals need during a gap, and given the nature of the coverage, it is unlikely the additional services would meet underwriting standards. The Institute supports the proposed NCOIL model definition of mandatory coverage categories:

- (1) Ambulatory patient services;
- (2) Hospitalization;
- (3) Emergency services; and
- (4) Laboratory services

These services are already covered by the typical short-term plans and are what a consumer should expect from a short-term plan.

Benefits

Consumers should be able to expect a minimum standard of benefits for short-term plans that differentiate them from fixed indemnity coverage. We would propose that the requirements below as minimum standards for short term health insurance and that are met by most insurers are providing in the market:

1. Annual or lifetime limit of [\$500,000]
2. Coinsurance of no more than 50% of covered charges
3. Family out-of-pocket maximum of not more than [x] per year.

Drafting Note: The annual and lifetime limit and out-of-pocket limits should vary depending on the specific state interests. For states that have severely limited coverage time frames with limited renewals/extensions, smaller annual and out-of-pocket maximums should apply. For states allowing coverage up to the federal maximum of three years, states may want to consider different limits.

Pre-existing conditions / Underwriting

The group has had extensive discussions on the use of pre-existing condition exclusions. We would suggest the proposed model adopt the following standards for short-term plans.

Short term health insurance plans may provide a look back period for underwriting purposes of not more than 2 years.

After issuance of a short-term insurance plan, the insurer may not require underwriting until all renewal periods elected for that coverage have ended;

Network Standards

Some short term health insurance plans offer coverage through preferred provider plans, and in some areas the short term health insurers provide access to broader networks than the individual market plans. While it makes little sense to require ACA standards to these plans, regulators need an appropriate standard. HBI would suggest inclusion of the following language:

Any preferred provider plan is sufficient in number and types of providers to assure covered individuals' access to all covered health care services without unreasonable delay.

We hope you find these comments helpful. Please do not hesitate to contact me if you have further questions at jpwieske@thehealthbenefitsinstitute.org or (920) 784-4486.

Sincerely

A handwritten signature in green ink, appearing to read "JP Wieske", with a long horizontal flourish extending to the right.

JP Wieske
Executive Director