

Model 171 Benefits Overview

Presented to the NAIC Accident and Sickness Minimum Standards (B) Subgroup

Cindy Goff
ACLI
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Types of Products Regulated in Model 171

- HIPAA Excepted Benefits
 - Supplemental Benefits
 - Accident-only
 - Specified Disease
 - Critical Illness
 - Hospital indemnity or Other Fixed Indemnity
 - Expense-based Benefits
 - Dental
 - Vision
 - Income Replacement
 - Short-Term Disability Income
 - Long-Term Disability Income
- Non-HIPAA Excepted Benefits
 - Short-term Limited Duration Insurance (STLDI)

What are HIPAA Excepted Benefits?

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established “excepted benefits” as a broad category health insurance products that are regulated differently than major medical products
- These products are excepted from federal regulation and primary regulatory authority lies at the state level.
- HIPAA excepted benefits are not subject to the Affordable Care Act (other than pediatric dental and vision which are part of an essential benefit package)
- Congress and Federal Government define how benefits qualify as HIPAA and ACA-excepted
 - CMS for individual products
 - CMS, Treasury and Labor for group products

What Are HIPAA Excepted Benefits?

- 4(a) Benefits not considered health coverage:
 - **Accident-Only**
 - **Accidental death and dismemberment**
 - **Disability Insurance (short and long-term)**
 - General liability and supplemental to liability
 - Automobile medical
 - Worker's compensation
 - Credit-only insurance
 - On-site medical clinics
- 4(b) Limited-scope benefits:
 - **Limited-scope Dental**
 - **Limited-scope Vision**
 - Long-term Care
 - Health FSAs
- 4 (c) Non-coordinated benefits:
 - **Specified Disease/Critical Illness (e.g. cancer-only)**
 - **Hospital Indemnity or Other Fixed Indemnity**
- 4(d) Supplemental benefits:
 - Medigap
 - TRICARE Supplement
 - Employee Assistance Programs (new)
 - Wrap-Around Products (new)
 - Other "similar" coverage that supplements primary group health coverage

Differences Between Group and Individual

Group	Individual
Employer is often the primary purchaser and holds the group policy	Individual holds the policy
Employer issues “certificates” with benefit descriptions and “how to use” information to the employees as they on-board – often customized by the insurer at the employers request	Individual receives the policy and coverage documents directly from the insurer – customized for the requirements in their state of residence
Employees submit claims and interact directly with the insurer for claims, appeals, and coverage questions	Employees submit claims and interact directly with the insurer for claims, appeals, and coverage questions
Group certificates are issued based on the situs state of the employer. All employees of that group, regardless of residence, receive benefits specified in the certificate unless the employee lives in a state that has legal extra-territorial authority.	Individuals’ benefits are administered by the insurers according to the requirements of the state in which they live
Renew periodically (usually ever 1 – 2 years) Premiums and benefits can be altered upon renewal.	<i>Guaranteed Renewable</i> – As long as premiums are paid the policy remains in force and does not have a “renewal” date. Premiums can only be changed for the entire class of policyholders. <i>Non-cancellable</i> – most policies cannot be canceled by the insurer except for specific cases of non-payment of premium or fraud
Often a portion or all benefits Guaranteed Issue – insurer does not have the ability to assess risk of each employee on the front end	Individually underwritten – insurer can assess the risk of the individual when they apply

SUPPLEMENTAL BENEFITS

What's in a Name: Supplemental Benefits

- HIPAA defines “supplemental benefits” very differently than how they have been defined by the industry and state regulators
- Today, we will refer to “supplemental benefits” as those financial protection products that are triggered by health events but are not expense-based and are not specifically meant to replace income.
- Disability Income, Dental, and Vision coverage are often considered “supplemental” because they provide additional benefits not covered by major medical plans. For purposes of this discussion we are describing them separate from supplemental benefits in order to make it easier to understand their unique features.

Supplemental Benefits Product Categories

- **Accident-only:** Pays a benefit following an accident resulting in injuries requiring hospitalization or treatment. Depending on the type of policy the person has chosen, benefits are paid as a lump-sum or a fixed dollar amount for each eligible service trigger. These benefits help pay for unexpected out-of-pocket costs not covered by comprehensive medical insurance. (exemption found in 42 U.S.C. 300gg-91(c)(1)).
- **Specified Disease:** Provides added protection to existing medical coverage to help cover costs when an individual is diagnosed with a disease or condition specified in the policy. These plans pay benefits as a lump-sum (more common) or a fixed dollar amount for each eligible service trigger. (exemption found in 42 U.S.C. 300gg-91(c)(3)).
 - A subcategory of Specified Disease, **Critical Illness coverage** usually pays benefits in a lump sum when one is diagnosed with one or more major illnesses (e.g. cancer, stroke, MS, etc.) that are outlined in the policy at the time of sale.
- **Hospital Indemnity or Other Fixed Indemnity:** Pays a fixed amount when policy holders are admitted to a hospital or need outpatient or provider office-visit care. These plans often pay a daily benefit for each day of hospitalization and a fixed amount based on eligible medical event triggers. The “Other Fixed Indemnity” name was added in federal law to reflect that often people do not require overnight stays at the hospital and therefore allows for inclusion of outpatient and non-hospital service benefit triggers to be included. (exemption found in 42 U.S.C. 300gg-91(c)(3)).

What Supplemental (Acc, HIP, SD/CI) Benefits ARE

- Financial protection products that help pay costs not covered by medical insurance
- Not allowed to “coordinate” with other types of insurance
- Pay fixed amounts of benefits triggered by a medical event
- Usually pay directly to the insured
 - Can be used for any purpose determined by the policyholder
- Mostly sold through the worksite (group or individual) - employers often make them available as part of a broader benefits package
 - 96% of policies are made available through employers as part of the employer’s benefits enrollment process
 - group products
 - individual products sold through the worksite
 - 4% of policies are sold with no employer involvement, mostly through direct mail or independent agents

What Supplemental (Acc, HIP, SD/CI) Benefits Are NOT

- Not comprehensive medical coverage or intended to be sold as such
- Do not pay directly for medical expenses or claims
- Cannot pay benefits on expense-incurred basis
- Cannot vary benefits based on other insurance coverage
- Short-term limited duration insurance (STLDI) or Health Care Sharing Ministries (HCSM)
- “Mini-meds” or other types of medical expense insurance eliminated under the ACA
- “Junk insurance” that leaves policyholders vulnerable to uncovered medical costs

Supplemental Benefits Are Popular

There are well over 33,028,221 active supplemental individual policies and group certificates in the country, many of which cover multiple members of a household:

Policy Type	Number of Policies and Certificates*
Hospital Indemnity	4,246,838
Accident-Only	18,141,614
Specified Disease/Critical Illness	10,639,768

**Survey of ACLI Members, April 2021. Note that this number is undercounted because several national Supplemental Benefits carriers are not ACLI members.*

Satisfaction with Supplemental Benefits Is Very High

A 2020 Global Strategy Group survey of 500 supplemental insurance (Accident-only, Hospital and Other Fixed Indemnity, and Specified Disease/Critical Illness) beneficiaries found:

- 98-99% satisfaction with the service they received
- 94-95% satisfaction rate depending on product type
- 90% satisfaction with claims filing, timeliness of benefits, and ability to communicate with the insurer
- 89% found benefits easy to understand and use
- 90% feel their plan was there when they needed it
- 90% believe they received value for their premium
- 89% agree that the purchase of the plan was a valuable investment

Supplemental Benefits Are Important

A few statistics on the fragility of household budgets :

- Over the past five years, the average annual deductible among all covered workers has increased **53%**. – *The Kaiser Family Foundation*
- **45%** of respondents say they have \$0 in savings. An additional **24%** said they only have \$1000 in savings. – *GOBankSavings Survey, 2019*
- About **50%** of consumers with a high deductible plan say it would be hard to afford the deductible. – *PwC Health Research*
- **86%** of surveyed employees see a need for “Supplemental” insurance and **93%** of employees stated they chose to enroll these products because they believe the policies “help protect their financial security.” – *Aflac WorkForces Report, 2020*
- **62%** of respondents who reported having trouble with medical bills were covered by health insurance, and **75%** of insureds (with both high and low deductible plans) reported an inability to afford copays, deductibles, and co-insurance – *KFF and New York Times survey*

DENTAL AND VISION

Dental Insurance

- 262.7 million Americans (80% of the population) have dental coverage.
 - Employer sponsored = 161 million +
 - Government sponsored = 85 million +
 - Individual = 16 million +
- Coverage through employers or other groups accounts for nearly 90% of private dental coverage.
 - In the group space, employers pay a portion of the premiums around 60% of the time.
- Dental is usually sold separate from medical insurance.
- Dental benefits are the most requested health benefit after medical and pharmacy coverage

Dental Insurance

- Characteristics of Dental Coverage
 - Often network-based – expense-based payments to the in-network dental providers/payments to insured or provider for out-of-network
 - Coverage generally at 100% for preventive services (exams, x-rays, cleanings, sealants, etc.)
 - Coverage at varying percentages for non-routine services (fillings, extractions, soft tissue treatments, root canals, crown, bridges, dentures, orthodontics, emergency services and anesthesia)
 - Average premium \$35/mo (could vary by region)
 - Average annual deductible \$50 - \$100
 - Average annual maximum benefit \$1500 - \$2500

Vision Insurance

- Characteristics of Vision Coverage
 - Network-based
 - Our-of-network coverage based on reimbursement amounts
 - Annual eye exams covered in full after copay
 - Eyeglass lenses covered in full after copay
 - Eyeglass frame and contact lens allowances between \$130 - \$200 (every 12 – 24 mo)
 - Discounts for lens coatings and sunglasses; discounts for corrective surgery
 - Average premium \$11/mo
 - Average copays \$0 - \$25

INCOME PROTECTION

Short-Term Disability Income Insurance

Replaces a portion of a person's salary when they must take time off from work due to a serious illness or injury

- 40% of the workforce currently has short-term disability through their employer (62 million workers – this does not count workers that pay the premium entirely themselves)
- Employers often pay all or a portion of the premium for short-term disability insurance
- Premiums tend to average \$4 - \$5 per week
- On average, the private insurance industry processes 2,002,000 claims annually
- Typical benefits
 - 22 – 26 weeks of paid leave
 - 60 – 70% of wages replaced (there are also indemnity-type products that sell coverage in dollar increments)
 - Trained medical and vocational experts to assess and assure appropriate leave duration and resources are available to the worker
 - Assistance in transitioning to different types of leave (e.g. maternity to bonding, short-term disability to long-term)
 - Return-to-work programs (e.g. special accommodations, workspace modifications, work re-entry plans, prevention of re-injury plans)
- Claims are reviewed to assure they meet disability eligibility criteria. 88.2% of claims are approved upon first review.

Long-Term Disability Income Insurance

Replaces a portion of a person's salary when they are unable to work for an extended period of time (after short term disability is used)

- Approximately 37% of the workforce currently has long-term disability through their employer
- Employers or employees, or a combination of both normally pay the premium
- Premiums ranges from \$25 to \$500 per month based on income level and duration of coverage purchased
- Typical benefits
 - Usually has a 90-day elimination period, often covered by short term disability income insurance
 - Benefit period usually sold in year increments, usually 5-year, 10-year, 20-year, or even until retirement age.
 - 50 – 70% of wages replaced (depends on coverage selected)
 - Trained medical and vocational experts to monitor progress and assure recovery resources are available
 - Assistance in transitioning to different types of leave (e.g. permanent disability status with SSA)
 - Return-to-work programs (e.g. vocational training for new careers, special accommodations, workspace modifications, work re-entry plans, etc.)

NON-HIPAA EXCEPTED BENEFITS

Short-term Limited Duration Insurance

- Temporary primary coverage for people in transition
- Defined in HIPAA as “not health insurance”
- Nor is it an excepted benefit under HIPAA
- The ACA did not mention STLDI so exempt from most ACA requirements
- Key Features:
 - Temporary coverage (usually 3 – 9 months)
 - Underwritten; pre-exes allowed
 - Annual limits allowed
 - Usually not network-based coverage; sometimes crafted with indemnity-type benefits rather than expense-based
 - Variation in which ACA essential benefits they cover
- Obama Administration limited their duration to 3 months; Trump returned limit to 364 days, allowing two renewals; Biden ?

QUESTIONS?