HEALTH BENEFITS INSTITUTE

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January 8, 2020
Commissioner Glen Mulready and Ms. Melinda Domzalski-Hansen
Accident and Sickness Minimum Standards Subgroup
National Association of Insurance Commissioners
444 North Capitol Street NW
Suite 700
Washington, DC 20001
Attention: Jolie Matthews, J.D., Senior Health and Life Policy Counsel

Dear Commissioner Mulready and Ms. Domzalski-Hansen

Thank you for soliciting comments on the definition and use of the term pre-existing condition. The Health Benefits Institute continues to support including a single definition in the proposed Model 171.

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 applies to numerous product types including some excepted benefits policies, disability policies, and short-term limited duration health policies. In general, the insurers do not require the policies to be issued during an open enrollment time frame leading to significant adverse selection issues. And while some policies, like disability and short-term limited duration coverage, may be subject to underwriting other policies like dental and vision may not. In all cases, adverse selection is a problem. Many consumers act rationally when offered the option to buy coverage for a pre-existing condition and have another party pay for their expenses, and subsequently dropping coverage when treatment is complete.

As a result, the many policies covered under this model regulation use the pre-existing definition similarly, and there should be no consumer confusion by using the single common definition that is contained in this model. As a minimum standard, a universal definition is easier for consumers to understand when applied to multiple types policies. Crafting separate definitions for each policy type would be time consuming and provide little benefit. We support a single definition.

The subgroup has also been focused on the prudent layperson standard currently contained in the definition. In the experience of our member companies, this provision has been used rarely by insurers. In general, the provision is only used in the most egregious cases in which a consumer has avoided seeking treatment knowingly in an attempt to secure coverage. Despite the concern, we understand a number of states have limited the use of this subjective standard and believe the instances of consumer dishonesty are rare enough to support movement to an objective standard.

We would like to emphasize the point that this objective standard has to cut both ways. If the medical records indicate that a medical professional has diagnosed an insured person with a medical condition, the insurer should not be required to prove that an insured person "knew" they had a medical condition. This undue burden puts the insurer in an untenable position.

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
JP Wieske
Executive Director