Glen Mulready
Melinda Domzalski-Hansen
National Association of Insurance Commissioners
444 North Capitol Street NW
Suite 701
Washington, DC 20001

Re: Accident and Sickness Insurance Model 171

Dear Commissioner Mulready and Ms. Domzalski-Hansen:

I am heartened by the stated willingness of this Subgroup to mandate disclosures for the short-term health and supplementary insurance products governed by Model 171. These products have historically offered low value to consumers, but NAIC could improve the market through a well-designed disclosure regime.

While I have no objection to the Subgroup proceeding to a line-by-line markup of the existing model, it is important that Subgroup members, either collectively or individually, contemporaneously conduct an environmental scan of the markets for these products. As I reported at the Consumer Liaison meeting in San Francisco, loss ratios for supplemental products governed by Model 171 have steadily declined over the past decade, and the products have lost literally hundreds of millions of dollars in value over that time. We know of at least one issuer of supplemental products that spends only 30% of premium dollars earned on benefits, but 36% on commissions. Industrywide, loss ratios for specified disease products are below 50% and for Accidental Death & Disability, around 40%.

An environmental scan could be formal, as by holding a hearing; or informal, with members of the Subgroup reporting information on market conditions for these products in their states. But at the very least, the Subgroup should order NAIC staff to compile data on "group" short-term health insurance products in the same format that data on individual short-term health insurance is reported in the annual NAIC annual Experience Reports. Because short-term health insurance products have migrated to the "group" market (I put the word group in quotes because these groups are entirely artificial) NAIC no longer compiles data for the companies issuing these policies. Data is also missing for "Other Medical" products in the group category and this should be compiled for the Subgroup as well.

I would call the Subgroup's attention to the "Monroney Sticker" that for six decades has served as the disclosure regime in the market for new automobiles. The Monroney Sticker's uniform format permits and expedites comparison shopping among vehicles and dealers. NAIC should

devise an analogue to this sticker to be embedded in the shopping process—e.g., displayed in search results online when the products are sold on the web, and handed to consumers by brokers when sold in-person, before the consumer enrolls—to promote price competition and increased value for these products.

Finally, I would urge the Subgroup to bear in mind, as we see the first warning signs of a recession that may hit as the 171 revisions are completed: The primary tool of economic stimulus, under both Republican and Democratic administrations, has been to withhold less money from workers' paychecks. Most of the supplemental insurance products are purchased through paycheck deductions. Unlike the withholding for Social Security, which ultimately returns much more to workers than the amounts withheld, these products always return less than was deducted. Money deducted for these products is money not spent at local retailers, restaurants, car dealers, etc. If you can lower the spending on these products you can tell your governor that you did your part to stimulate the economy in your state.

I. Disclosure of indicia of product value.

In order to facilitate comparison shopping based upon product value, and create a competitive dynamic favoring increased value, the regulation should require disclosure of some indicator of value. It might be possible to create an actuarial value equivalent for short-term health insurance, but it would be difficult for supplementary products such as specified disease. The simplest value indicator to determine and disclose would be loss ratios.

I would direct the Subgroup's attention to two current statutory provisions that mandate loss ratio disclosures for major medical insurance. It goes without saying that disclosures are far more warranted for limited-benefit products for which there is no mandated loss ratio floor, but these statutes demonstrate that loss ratio disclosures at the point of sale have been successfully implemented by your peers.

> **Connecticut: Sec. 38a-477c. Disclosure of medical loss ratio with each health insurance application.** An insurer or health care center shall include a written notice with each application for individual or group health insurance coverage that discloses such insurer's or health care center's medical loss ratio, as defined in subsection (b) of section 38a-478l, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut, to an applicant at the time of application for coverage.
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> **District of Columbia: § 31–3311.03. Loss ratio disclosure.** Policies, certificates, and marketing materials shall prominently display medical loss ratio disclosure, as defined by rule.

Recommendation 1: The Model Regulation should provide for prominent, pre-sale disclosure of product loss ratios.

II. **Prescribing uniformity and clarity to rationalize the shopping experience.**

The impression among consumer advocates who have spent time exploring the two leading aggregator websites on which short term products are sold is that these products are represented online in confusing and misleading ways.

Health insurance is already confusing to consumers. As we have found from focus groups of consumers, the concept of insurance that lacks ACA protections adds to this confusion.

Descriptions on the aggregator websites often create inflated impressions of the products' protections:

- We see some products described as a "PPO" when in fact, the products promise to pay fixed indemnities for certain occurrences. Consumers generally understand a PPO to connote agreement by providers to accept a negotiated sum and refrain from balance billing; that is certainly the definition that was in front of Justice Breyer when he upheld the legality of the PPO business model in 1984.

- We have also seen policies prominently advertised as offering "36 months of coverage" when fine print—visible only when an icon is clicked—indicates that three policies of 12-month duration are being offered. Because the pre-existing condition exclusion re-sets after 12 months, it cannot be accurately said that these products offer 36 months of coverage.

- Some insurers are advertising an out-of-pocket maximum that does not account for the deductible, while others do. This situation is confusing, makes comparison shopping difficult, and invites a race-to-the-bottom.

- We also see products advertised as having policy limits of as much as $2 million, even for products with 3-month terms. It's doubtful that any of these products have come close to paying out these amounts, and extremely unlikely, if not impossible, that they could, even under the most unusual circumstances. Consumers' expectations, from their experience with life and P&C products, is that policy limits are a meaningful gauge of a product's value. It appears that insurers are exploiting this dynamic by advertising policy limits more with an eye to puffing up the apparent value of a product than with limiting the insurer's liability.

To be clear, I think that some of the circumstances described above are already in violation of existing legal prohibitions on deceptive practices, and are better candidates for enforcement action than for new rulemaking. But it could be worthwhile for Model 171 to explicitly restate the illegality of such practices.

> *Recommendation 2: The Model Regulation should provide for clear, understandable, realistic, and uniform descriptions and definitions of product attributes, including duration, type of product, out-of-pocket maximums, and policy limits. Please note that this recommendation is not the same as recommending substantive minimum*

standards for the sale of products, but a less restrictive option relating to how products may be described, which I ask to be considered if analogous, substantive restrictions are rejected. This option should extend to prescribing a uniform format for display of products in online search results.

III. Regulating nomenclature to warn consumers about limited benefit products.

The presentation of insurance products on the two key aggregator websites understates the key differences between "short term" products and real health insurance. "Short-Term Health Insurance" is in most cases a misnomer, because the duration is only one difference, often dwarfed by other differences. "Limited benefit" is a better descriptor of products that fail to meet consumers' reasonable expectations of what constitutes "health insurance," even when the product is medically underwritten and has a pre-existing condition exclusion.

Many products include limitations for the most common conditions likely to escape any pre-existing condition exclusion. We find that products carve out from coverage the incidence of gallbladder removal, kidney stones, appendicitis, knee injuries, and joint or tendon surgery. Such incidents share two traits: first, they come without warning or prior symptoms, thereby avoiding the pre-existing existing condition exclusion; and second, they are the most common operating room procedures for the non-elderly population. In short, the products have been designed to deny coverage for precisely those emergencies for which buyers expect protection.

Recommendation 3: The Model Regulation should set some minimal standard of comprehensiveness to be met if products are to be marketed as "Short-Term Health Insurance." The phrase "health insurance" should be reserved for products with coverage that healthy buyers reasonably expect that phrase to connote. Please note that this recommendation is not the same as recommending substantive minimum standards for the sale of products, but a less restrictive option relating to how products may be described, which I ask to be considered if analogous, substantive restrictions are rejected.

IV. Prescribing uniform coverage examples.

Because there is no explicit regulation of coverage examples, we find insurers are including unrealistic depictions of the costs of medical care in order to overstate the value of their products. For instance, one seller of a hospitalization-only product, which pays a $4,500 benefit, indicates that the hospital facility fee for hernia surgery is $5,784. One large hospital system in Pennsylvania which has a cost-lookup feature on its website states its price for hernia surgery—exclusive of professional fees—at $16,200. The coverage example thus understates the buyer's out-of-pocket costs by at least $10,000.

Recommendation 4: The Model Regulation should require uniform coverage examples for illness episodes involving asymptomatic conditions.

My suggestion is that the Subgroup take an early "impression vote," either formally or informally, on whether there is support for these concepts. If the Subgroup is receptive, the

consumer representatives can work on black-letter language for the Model as well as wording and formatting of disclosure documents in language accessible to consumers. We would also be willing to sit down with industry to try to reach agreement on a package if we were so directed.

Respectfully submitted,

Jackson Williams
Funded Consumer Representative