



July 2, 2021

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 on Section 1 through 7 for 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.

First, we'd like to acknowledge the consistently detailed and excellent work Jolie Matthews has done in documenting the subgroups efforts on completing this model.

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.

Unlike major medical insurance, most of these products provide direct financial assistance to the consumer. The products generally do not limit the consumer's use of the money which can help fill the gap for high cost sharing in their major medical plan, cover travel expenses, or help replace lost wages.

It is important to note that 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 created just such an issue.

As a minimum standards model, this model differs significantly from many other NAIC models. The insurers offering this coverage may offer coverage that meets the minimum standard for consumers requesting low cost policies, but most also offer policies that exceed these standards. These coverages allow consumers to fill their particular needs. Our members support consumer choice, strong consumer-friendly disclosures, and consistent minimum standards that will protect consumers and will not limit the availability of coverage to people who can least afford it.

Specific Section by Section Comments

Section 1

No changes

Section 2

No changes

Section 3

The original draft of the model law included Limited Long-Term Care and those sections have been moved to NAIC Model #642 and Model #643. This section may want to include language that specifically excludes Limited Long-Term Care from the model.

Section 4

The current draft includes bracketed language suggesting a minimum standard of 120 days for implementation. While we agree with the existing language, we would note for regulators that the timeline should be no less than 120 days, and insurers may need flexibility if new product filings are necessary. .

Section 5

As stated above, this model is different that most other NAIC models for a variety of reasons. Two key issues intertwine in this section making it important for regulators to pay close attention. Unlike, most NAIC models, the language in this product applies to multiple products offered for sale. The definitions may or may not be used by particular line of insurance depending on type of coverage. The other issue in this section is that the definitions are “minimum standard definitions” meaning that the definitions are to be used by the insurer as a minimum standard definition in the policy. As a result, the definitions used in this section are to be used by the insurer in governing coverage and would typically be filed with the insurance policy. It is important to note that many insurance policies – depending on the type of coverage – may use more generous terms of coverage.

In general, we support common definitions to be included in this section rather moved under specific products in Section 7.

Pre-Existing Conditions

One of the key definitional issues the subgroup was in the process of discussing was the pre-existing condition language:

L. “Preexisting condition” shall not be defined more restrictively than the following: “Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a [two] year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a [two-] year period preceding the effective date of the coverage of the insured person.

We continue to support the existing language and would note the following from our prior letter:

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.

In short, we do not advocate for but would not oppose removing the “prudent layperson standard” provided the use of objective data like medical records continue to be supported. The existing language already has shortened the look back time frame from the many insurance policies and prior version of the model. We also support keeping a single definition that would apply to all products as a minimum standard.

One Period of Confinement

This definition potentially has multiple impacts based on type of policy. In some cases, benefits are limited if the incident is treated as a single incident. In other policies benefits may only apply to a single incident. A common definition ensures all policies treat the policyholder fairly.

Disability Definitions

As you know, the disability definitions may be used in multiple ways depending on the specifics of the product. In the staff prepared draft, Ms. Matthews has noted a couple of issues. The definitions in this section apply when a consumer becomes disabled under an insurable event. Someone who does not receive monetary compensation may not have an insurable event – indeed a regulator might find that benefit illusory. It is also important to note that these are definitions used in short term and long-term disability policies, they do not apply consumers who are already disabled from separate event and should not limit employment in an alternative field.

Section 6

Policy Dividends

The section on policy dividends may be confusing for many legislators and regulators since the policy provisions are rare in the products offered. In essence, the below section requires insurers to offer consumers the cash value of any dividend as an alternative to a policy extension. Our members are not aware, based on the policies covered by this proposed model, if this provision would generally apply. We would recommend deletion with an insertion of a drafting note since states will likely already have these provisions in their life insurance laws and regulations.

~~B. (1) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months.~~

~~(2) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.~~

Drafting Note: Rarely, insurers may offer consumers policy dividends as a benefit. These provisions are more common in life insurance policies. If policy dividends are available on

policies covered by this model in your state, you should look to the treatment of dividends in life insurance. Generally, consumers should be allowed to take the policy dividend as a cash payment but insurers may offer the consumer additional policy benefits in lieu of a cash payment at the option of the consumer.

Exclusions

This section delineates what insurers are allowed to exclude from coverage. Consumers have a strong interest in genetic testing, as the success of companies like 23andMe indicate. While these commercial genetic tests can help some consumers to understand their risks for certain conditions, it is not medical treatment. This generalized testing does not typically qualify as a medical expense and is not covered under most insurance plans. We would suggest the addition of the following exclusion to allow insurers to limit coverage when genetic tests are medically necessary:

A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(13) Genetic testing not ordered by a medical provider, and not used to diagnose or treat a disease.

Section 7

B. Hospital Indemnity or Other Fixed Indemnity Coverage

We would suggest one minor change to this section. In the current model the minimum amount is bracketed but the number of days is not. HBI suggests that adding brackets to the minimum number of days adds to state flexibility and therefore should be included in this model.

(1) “Hospital confinement indemnity or other fixed indemnity coverage” is a policy of 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.

H. 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. Presuming no extensions, after August 15th, anyone who has not secured coverage will be ineligible to buy ACA qualified coverage unless qualified for an SEP. Short-term limited duration coverage is necessary to fill that gap.

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 meet 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



JP Wieske
Executive Director