To: Chair of the Regulatory Framework (B) Task Force, Task Force members, and Ms. Jolie Matthews

From: NAIC Consumer Representatives

Date: August 27, 2018

Re: Comments on Model #170 Draft, Dated July 23, 2018

Dear Mr. Wieske, Ms. Matthews, and the members of the Regulatory Framework (B) Task Force,

We appreciate the opportunity to comment on the latest version of the revisions to Model #170, as well as the time and effort the Accident and Sickness Insurance Minimum Standards (B) Subgroup has put in to these issues.

Since the draft was adopted by the Accident and Sickness Insurance Minimum Standards (B) Subgroup in late July, new federal rule changes affecting short-term limited-duration health insurance have been finalized. Under the rules, which take effect in early October, the federal government now permits a short-term health plan to last less than 12 months, instead of less than three months. In addition, a short-term plan can be renewed or extended for up to 36 months, if states allow it. In other words, federal rules no longer set either a short term or a limited duration for short-term plans, nor do they protect against “stacking” of multiple different policies, allowing this type of coverage to effectively last far longer than the timeframes set in the rules.

As the federal rules made clear, states have broad authority to regulate and set standards for short-term health plans, including by prohibiting them altogether or by establishing a three-month limit with no renewals or “stacking.” We urge states to protect health insurance consumers and insurance markets from an expansion of short-term plans that now, in most states, will be able to grow into a parallel market for health insurance (for healthy people) even though these plans fail to meet the benefit standards, consumer protections, and market rules that apply in the traditional individual market. Premiums for regular individual market health insurance will rise, and middle-income people with pre-existing conditions will be the ones most affected. Plus, some people who enroll in short-term plans will end up needing medical care but will be hit with high costs because, for example, these plans often lack coverage of important benefits such as maternity and mental health and deny claims that can be linked even tenuously to a pre-existing medical condition, even one that has not been diagnosed. The fact that insurance agents and brokers may be able to earn higher commissions for selling short-term health plans and other ancillary benefits than they do for plans that meet individual-market standards will only fuel aggressive sales tactics, consumer confusion, and greater enrollment in skimpier plans – especially during this fall’s open enrollment period for individual-market coverage.
As we have said in prior discussions of the Subgroup, the model law on ancillary coverage should define short-term, limited-duration health insurance in a more specific manner (i.e., a three-month term including any extensions or renewals). But we understand some states may allow short-term plans to be sold more broadly and for longer terms, as permitted under the final federal rule published August 3rd, in spite of the harms to individuals and the traditional individual health insurance market. We believe the definition of short-term, limited-duration insurance, as written in the latest draft at Subsection J, accommodates states that will defer to the federal definition as well as those that choose to be more protective of their consumers and markets. In the interest of time and progress, we therefore support the definition and recommend the modest changes detailed below. Thank you very much for your consideration.

Sincerely,

Sarah Lueck
JoAnn Volk
Betsy Imholz
Ashley Blackburn
James Roberts
Amy Killelea
Debra Judy
Laura Colbert
Lincoln Nehring
Birny Birnbaum
Peter Kochenburger
Andrew Sperling
Deborah Darcy
Lorri Unumb
Claire McAndrew
Michelle Lilienfeld
Silvia Yee
Anna Howard
Lucy Culp
Harper Jean Tobin
Marguerite Herman
Carl Schmid
Dave Chandrasekaran
Eric Ellsworth
Matthew Smith
Brendan Riley
Bonnie Burns

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In the drafting note at Section 3, Subjection J:

Drafting Note: Subsection J does not include a potential maximum length of coverage for short-term, limited duration insurance. States have established different terms and durations of coverage for short-term, limited-duration insurance, if such coverage is permitted to be sold. Some states have barred the sale of such products while others have set the maximum duration of coverage at less than 12 months, while others have such as by establishing a three-month maximum. In addition, some states provide that such coverage may not be renewed or extended beyond the established term, or have otherwise limited total duration, while other states have no such provisions regarding renewal or extension. The current federal regulations limit short-term, limited-duration insurance contracts to less than three

months, including renewals or extensions that may be elected with or without the insurer’s consent. For policies sold on or after October 2, 2018, federal rules (The proposed federal regulations, as published in the Federal Register on August 3, 2018) limit short-term, limited-duration contracts to terms of less than 12 months and a total duration of no more than 36 months. Feb. 21, 2018, propose a maximum duration of coverage of less than 12 months. States should carefully examine their health insurance markets in order to: determine the appropriate maximum term and duration for short-term, limited-duration health plans (—including whether renewability or extension of such coverage is appropriate and consistent with federal law); protect against the issuance of multiple policies as a way of avoiding term and/or duration limits; and appropriately regulate the sale of so-called “renewal guarantees” of health plans to consumers.

In the final sentence of the drafting note at Section 5, Subsection B:

States may want to consider developing regulations on combination products and the potential for such products to confuse consumers, especially by leaving the impression that the combination coverage is equivalent to comprehensive, major medical coverage.

In the Section 6, Subsection K:

K. For ancillary health insurance providing short-term, limited-duration coverage, an insurer shall display prominently in the application materials provided in connection with enrollment a notice providing information that this coverage is not required to comply with federal requirements for health insurance, principally the requirements in the federal Affordable Care Act (ACA). The notice also shall provide information advising the consumer to review and check the policy to understand what the policy covers and does not cover (including limitations and exclusions related to pre-existing conditions or health benefits such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services. The notice shall also state that and the possibility that if coverage expires or eligibility for coverage under the policy is lost, the consumer may have to wait until an open enrollment period to obtain other health insurance coverage.

Drafting Note: Because states may have different statutory requirements for short-term, limited duration insurance coverage, states should carefully review the language in Subsection K to ensure it accurately reflects a state’s specific requirements. States should also be aware that federal regulations, effective October 2, 2018, include specific notice requirements for short-term, limited-duration coverage, and recognize that the notice may also need to contain additional information as required by applicable state law, rules, or guidance. Please see Federal Register Vol. 83, No. 150, p. 38243 for the changes to federal rules at 45 CFR §144.103. A state also may need to require disclosure alter the language to reflect any additional requirements a state may have, such as requirements regarding minimum essential coverage or special enrollment periods for expiration or loss of eligibility for this coverage. States also may have to consider including language to alert consumers to potential issues to consider prior to enrollment when the consumer is purchasing coverage under a policy using funds from a health reimbursement account (HRA).