September 16, 2014

Ms. Jolie Matthews
NAIC Senior Health and Life Policy Counsel
Regulatory Framework (B) Task Force
444 North Capitol Street NW Suite 701
Washington, DC 20001

RE: Further AHIP Comments on ACA Potential Revisions to the Minimum Standards Model Act (#170)

Dear Ms. Matthews,

AHIP provides the following additional comments to the Regulatory Framework Task Force regarding some of the potential revisions suggested to the Minimum Standards for Accident and Sickness Insurance Model Act (#170). America’s Health Insurance Plans (AHIP) is the national trade association representing the health insurance industry. AHIP’s members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health insurance to all Americans through a competitive marketplace that fosters choice, quality and innovation. Our comments and recommendations on specific proposals that were brought forward in the first comment period follow:

The recommendation that the product categories of Hospital Medical Expense, Medical Surgical Expense, Hospital-Medical-Surgical Expense Individual Major Medical Expense and Individual Basic Medical Expense be removed from the model: Based on recent updates to the NAIC Individual Market Health Insurance Coverage Model Act and Regulation, it may be appropriate to remove basic hospital expense coverage, basic medical surgical expense coverage, basic hospital-medical-surgical expense coverage, individual major medical expense coverage, and individual basic medical expense coverage from Model 170.

We recommend that Task Force members carefully analyze the model to determine whether removal of these provisions would be appropriate. If these expense-based coverage categories are removed from the model, we suggest that since consumers continue to maintain grandfathered products, a drafting note reflecting this point be added to remind states that grandfathered products should continue to be reflected in state laws and regulations.

Should the above-mentioned expense-based product categories be removed, Model 170 will no longer apply to any form of group medical expense coverage. As such, a separate definition of “group supplemental health insurance” would no longer be needed and should also be deleted.
The recommendation to substantially modify the provisions governing specified disease, hospital confinement indemnity, and other indemnity insurance: The commenter states as rationale for this recommendation that these forms of coverage are illegal under the ACA as individual medical coverage. This assertion is incorrect. These benefits can be sold as individual or group insurance as long as they are sold as independent, non-coordinated benefits that can be used to cover non-medical expenses and/or expenses outside of actual medical claims coverage such as for copayments or deductibles. The federal rule published on May 27, 2014 (45 C.F.R.§148.220(b)(4)) only changed the conditions under which the specific category of excepted benefits known as "hospital indemnity or other fixed indemnity insurance" are considered a HIPAA excepted benefit. HHS was very careful to draft the rule so that its scope was not extended to other excepted benefits products that may or may not have fixed indemnity features. The federal rule amendments have no application to any other type or category of insurance that is listed separately as an excepted benefit in the federal Public Health Service Act regardless of whether benefits under such coverage are paid as a fixed dollar amount per day or other fixed period, and/or per service.

As we noted in our previous comment letter, with the exception of reflecting the required federal regulatory change related to hospital indemnity or other fixed indemnity insurance found in 45 C.F.R.§148.220(b)(4), no other changes to the model law or rule related to excepted benefits products are necessary or appropriate. States have regulated, and will continue to regulate these products appropriately and there are no changes to the model required.

The recommendation that Disability Income Protection coverage be removed from Model 170 with creation of a separate Disability Income model: The rationale for this recommendation is that Disability Income Protection is not health insurance and therefore doesn't belong in the minimum standards model. We strongly disagree with this assertion. States have always regulated disability income coverage as a form of accident and sickness insurance. To exclude disability income insurance from the minimum standards model could create confusion and regulatory uncertainty. As with all of the other HIPAA excepted benefit products named in this model, this category of coverage is a form of financial protection for the unexpected costs and losses associated with a health condition, disease, or injury. It is accident and sickness insurance in exactly the same sense that the other categories of HIPAA excepted benefits such as specified disease, or accident-only coverage are accident and sickness insurance. There is no legitimate reason to distinguish this category of coverage from the others in terms of minimum standards requirements.

The recommendation that Model #170 be rewritten to redefine specified disease and indemnity forms of coverage, and the conditions under which they can be sold: The rationale for this recommendation is that the promulgation of the new hospital indemnity or other fixed indemnity product rule (§148.220(b)(4)) requires that the model be updated. As stated above, HHS specifically applied this new rule only to "hospital indemnity or other fixed
indemnity insurance" and carefully distinguished these products from other HIPAA excepted benefits that may or may not have fixed indemnity payment features. We agree that the definition of "hospital confinement indemnity" should be renamed to "hospital indemnity or other fixed indemnity insurance" and also redefined to reflect that it includes hospital confinement indemnity, and that benefits in the individual market may be paid on the basis of per day or other fixed time period and/or per service triggers. With the exception of redefining and updating the conditions for the sale of individual "hospital indemnity or other fixed indemnity insurance" coverage, there are no other changes required to this model that relate directly or indirectly to the ACA. We emphasize again that the federal rule changes in (§148.220(b)(4)) apply only to "hospital indemnity or other fixed indemnity insurance" sold in the individual market and have no application to any other type or category of insurance that is listed separately as an excepted benefit in the federal Public Health Service Act.

The recommendation that Model #170 mandate the carrier to use the Summary of Benefits and Coverage for approved for coverage under §2715 of the ACA: AHIP supports consumer disclosure to allow for informed consumer decisions, however because these products are by design and function much simpler to understand, and not major medical coverage, a much simpler disclosure is needed. The current minimum standards require a disclosure on the face of the policy and an outline of coverage which are extremely effective in communicating the coverage for these products. Thus AHIP strongly disagrees with the recommendation to require a Summary of Benefits and Coverage (SBC) for a non-ACA product. SBCs are specifically used for ACA regulated products. To require SBCs for HIPAA excepted benefits would create consumer confusion rather than clarification, would create a new mandate, and would place significant new administrative burdens and costs that would affect consumer premiums of these non-ACA products. This recommendation is inappropriate for these products and this model.

The recommendation that Short Term Medical Expense Coverage be added to Model #170: Short Term Medical Expense coverage is a very specific type of medical expense coverage. It is not a HIPAA excepted benefit, nor is it an ACA regulated program. We suggest that a drafting note clarifying its special status would be most appropriate in this model.

We appreciate the opportunity to comment on revisions to the Minimum Standards Model Act. If you have questions or would like to discuss any of these recommendations, please do not hesitate to contact me at cgallaher@ahip.org or (202) 778-8487, or my colleague Cindy Goff at cgoff@ahip.org.

Sincerely,

C.M. (Candy) Gallaher
Senior Vice President - State Policy