NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – OCTOBER 6, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee held an interim meeting via Zoom on Friday, October 6, 2023 at 12:00 P.M. (EST)

Delegate Steve Westfall of West Virginia, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Tim Grayson (CA)
Rep. Camille Lilly (IL)
Rep. Rachel Roberts (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Asm. Jarett Gandolfo (NY)
Sen. Bob Hackett (OH)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Lezzah Sun (AZ)
Rep. Jim Gooch (KY)
Rep. Poppy Arford (ME)
Sen. Walter Michel (MS)
Rep. Forrest Bennett (OK)
Rep. Carl Perry (SD)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Manager, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Sen. Bob Hackett (OH) and seconded by Sen. Paul Utke (MN), NCOIL Secretary, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

INTRODUCTORY REMARKS: CHAIR WESTFALL

Del. Westfall thanked everyone for joining the meeting and stated that while there are only two items on our agenda, I anticipate that each will generate a lot of discussion. We'll begin with a continued discussion on what I refer to as the NCOIL Dental Loss Ration (DLR) Model Act, a Model which I am sponsoring and Rep. Rita Mayfield (IL) is co-sponsoring. There won't be any votes on the Model today. Rather, we'll be discussing some alternative language that has been circulated and we'll be hearing from some new perspectives on this issue today. We'll then discuss a proposed federal rule that deals with certain issues such as short-term limit duration insurance and excepted benefits coverage.

CONTINUED DISCUSSION ON NCOIL DLR MODEL ACT

First, we'll continue discussion on the NCOIL DLR Model. I know Rep. Deborah Ferguson, DDS (AR), NCOIL President, has been working with some interested parties and staff trying to develop a compromise for all sides to accept - or at least something that leaves everyone sullen but not rebellious. I hope we can see the language within the next week. Rep. Ferguson stated that I look forward to working towards a compromise with something that's not just the Colorado law but somewhat of a "Colorado plus" with additional provisions.

Del. Westfall stated that as you can see in the meeting materials, there's a revised version of the Model that has been posted and it generally follows the approach Colorado took when dealing with this issue. Instead of requiring a DLR and setting forth specific percentages, Colorado took the approach of requiring carriers to submit DLR information to the Commissioner. And after two years, the Commissioner is required to issue rules to calculate an average DLR, verify any carriers that significantly deviate from the average DLR, and investigate the cause of the deviation. I'm not necessarily committed to replacing the current version of the Model with this version, but I'd like to at least hear what the speakers today have to say as well as my fellow committee members. After today's discussion I will discuss with staff how I'd like to proceed with our next meeting in November.

Mary Watanabe, Director of the California Department of Managed Health Care, thanked the Committee for the opportunity to speak and stated that her colleague, Pritika Dutt, Deputy Director for our Office of Financial Review which reviews our DLR filings, is also present. It's an honor to be with you today to provide an overview of our requirements here in California for DLR reporting and to share a summary of the data that was submitted in 2021. We just received and are reviewing our 2022 data so that will be available publicly early next year. So, just a quick overview of who we are in California. We actually have two regulators: myself at the Department of Managed Healthcare and then we also have the Department of Insurance. We license 143 health plans, including full service and specialized plans. We have nearly 30 million of California's 39 to 40 million consumers under our jurisdiction. That's about 96% of state regulated commercial and public health plan enrollment in the state. So it's a big responsibility that I have.

So, our Department has been collecting DLR information since 2015. AB 1962 was signed by the Governor in 2014 and it required commercial dental plans to file their DLR information with us by September 30th, starting in 2015. To develop the template for reporting, we worked with our dental plans, associations, the Department of Insurance, and other stakeholders. The legislation was really intended to bring transparency. Prior to this bill, we really didn't know how much of premiums were being spent on dental services. And so it didn't establish a DLR requirement but was really around transparency. It was intended to be considered by the legislature in adopting a DLR standard that would take effect no later than January 1st, 2018. However, to date, the legislature has not adopted a DLR. We do produce an annual report that we organize by product type. So, you'll hear me talk a little bit about dental health maintenance organization (HMO's) and dental preferred provider organizations (PPO's) and we also look at the information by market type in the individual market small group and the large group market. We post this information on our website and we present it to our Financial Solvency Standards Board which meets quarterly to advise me on financial matters.

The next bill that impacted dental reporting was Senate Bill 1008 that was signed in 2018 and it requires plans that cover dental services to use a uniform benefits and coverage disclosure matrix starting in January of 2021. This was really intended to bring transparency to consumers to compare plans and see what benefits were covered to see what they're getting for sometimes a very low premium or more costly premium. Again, we worked with our Department of Insurance and other stakeholders to develop this matrix. We promulgated regulations. The bill did also require plans to continue reporting the DLR information but it moved the deadline from September 30th to July 31st of each year to align with the federal medical loss ratio (MLR) reporting requirements.

Okay, so now I'm going to go over the results from 2021 and again, we'll start with the dental HMO products. So, you can see here that in the individual market the DLR ranged from a really low 5% to 81%. The weighted average was 61%. We had 14 plans in the individual market, 18 overall that offered dental HMO products. In the small group market it ranged from 37% to 88% with an average of 50%. And then in our large group market you see there are 38% to 75% with an average of 63%. This next slide just shows kind of our trends since we started collecting the information in 2014. There hasn't been a whole lot of movement. You can see some slight changes, particularly on the small group market but overall, it's remained pretty consistent. And then this is the slide I think that's always the most interesting. It shows the weighted average premium in our dental HMO market. In 2021 in the individual market the average is around $11 and small group was $14. And then the large group was about $14.50. So, these are fairly low premiums in the dental HMO market.

So, next we'll go to our dental PPO plans. You can see here we have a smaller number of plans. So, three plans that offered dental PPO products. The two plans in the individual market had DLR's of 62% and 69% for an average of 64%. In the small group market it ranged from 55% to 65% with an average of 57%. And then in the large group market, DLR ranged from 57% to 88% with an average of 88%. There was very little change. I think on the next slide we'll show you the trends we did. I will just note we had some outliers when we first started to collect this information. I think the transparency helped to kind of move everybody to a little more consistency. So, we didn't have as many outliers, which you can kind of see here on this chart, but overall, pretty consistent year over year.

And then here, of course, the premiums in our PPO. The individual market was a $48 average. Small group was an average premium of $50. Large group was $42. So, quite a bit difference from the smaller $14 to about $18 that we see in the HMO market. So that concludes our presentation. I hope it was helpful to kind of see some of the data. I will just note we don't have a position on setting a DLR. I think the transparency has been really helpful to us. I think overall we can all agree on the importance of oral health in overall health and we want to make sure consumers understand what they're getting even for those lowest premiums. The transparency has been very helpful. I'm sure you'll hear from plans and providers of kind of the pros and cons of setting a DLR. As we've had these conversations with our board and in public forums I think one of the fundamental questions that comes up is just what is the value of these very low cost dental plans? And is there value to having some dental coverage versus employers, particularly small group employers or individuals, just not offering coverage. What does that mean for potential consolidation in the market? As you're well aware, unlike on the medical benefits side we don't have a standard benefit design or mandated benefits so

it’s different and it's complicated. I think we've had a lot of conversations with our board of just where to set a DLR. Is DLR the right measurement? So again, I think the transparency has been very helpful because prior to this reporting we just didn't know how much of the premium dollar was spent on dental services.

Chad Olson, Director of State Gov’t Affairs at the American Dental Association (ADA), thanked the Committee for the opportunity to speak and thanked the speakers from California for bringing that information to us. It reflects some of the previous comments I've made about things staying very similarly in terms of the DLR's that are reported. And that's I think the question before the committee as we keep considering the Model is do we look at this as an opportunity to change the value structure of the plans which is something that DLR has the opportunity to do. We are also pleased to be working with several legislators and interested persons on concepts beyond just the Colorado language.

Brianna Pittman-Spencer, Senior Director of Gov’t Affairs at the California Dental Association (CDA), thanked the Committee for the opportunity to speak and stated we have been looking at and thinking about and talking about MLR since 2014 when we worked on AB1962 and put that in place. And then sort of watching the MLR and trying to understand what it all meant. And I really agree that the MLR data has been really helpful from sort of a policy perspective in understanding the market and it has given us a lot of insight. A lot of times we look at things like those weighted averages and they seem fairly reasonable 65% but that really does hide that sort of huge spread. I think what you saw in the slides is that some of the trends seem to be that sort of the larger the plan or the larger the group the higher the number. So larger large group products tend to have a higher MLR than small groups which tend to have a higher MLR than individual. But when you look at them individually they are products and plans that have similar size that have very different MLRs, and there are high MLRs. So, it is very clear that you can provide that value at a smaller scale.

And I think we have some of the same concerns and CDA would really like to see a high threshold. We know that the medical MLR threshold is set at 80%/85% and we sort of remain unconvinced that dental plans can't meet that. And we think that would be a good thing for patients but those really low MLR plans are really concerning. What is that? Is that actually a benefit? Is that of value? If five cents of every dollar is going to patient care, is that a good use of somebody's dollars? When you get more into what's the right threshold – is it 50%? Is it 60%? Again, CDA would like to see it higher but I think even an MLR below 50%, that seems pretty low. How do we rationalize allowing consumers to spend money when they're only getting less than 50 cents of every dollar back in value? And I think that there's a wide range just really shows sort of the Wild West of dental plans. There isn't a standardized benefit. As much as I think we all should know how to use our dental plan, there really is this wide range. There's no standardized benefits. There's no cap on out of pocket expenses. There's a very low annual max and not really meeting people's needs. There's been a lot of studies to show out of pocket expenses are rising. We know that people skip dental visits because dental care is really expensive, even when they have dental insurance. So for us, the MLR reporting has been really helpful in understanding and thinking through what our dental plans offer and what value do we think they should provide to consumers. It hasn't really at least in California, moved the needle. We haven't seen sort of this rise in MLR over time. Because of the way it's reported, it's not something consumers can use to make decisions about their healthcare dollars.

So it's not driving competition. That's not to say it's not good, but I think for us it's useful and in California I think it was the very start of the conversation around MLR. So, I guess my message would just be don't make that the end. I think it's really helpful to look at and understand and think about dental plans but I really believe that we need to be raising the floor on dental products and that includes an MLR but probably some other conversations around what the value is? Is there a standardized benefit? What do we think people should be getting to make sure they can take care of their dental health? And I would really encourage MLR to be part of that conversation. I don't think reporting alone is going to get anybody where they want and it's definitely not going to be pushing greater value.

Mike Adelberg, Executive Director of the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and stated that in considering this issue I want to note that NADP is prepared to support a Colorado type approach. And we view Colorado as a significant concession but there aren't very many industries that step forward and say please regulate me more. We also note that while the Colorado approach is characterized as transparency or reporting, it's also reporting plus remediation. And so to Ms. Pittman's comments, they're appreciated, but if there are 5% plans and the regulator wishes to remediate them this is a lever to do that. With respect to the Massachusetts approach and whether there should be an MLR imposed on a much lower premium product, I just note that the news coming out of Massachusetts I think is concerning. The Department is late in finalizing its regulation. It was released a couple of days ago and we think the Department is struggling and doing its best to ameliorate a difficult situation. But nonetheless, we think there are going to be some bad outcomes on January 1st and today I do want to announce and inform NCOIL that there are now three dental plans that will be leaving the small group market in Massachusetts. Guardian had previously made this announcement. Today I can inform you that both Ameritas and Principal will also be leaving the Massachusetts market and other exits are quite possible as dental plans look at the regulation and run the numbers and see whether they can in fact do business with a medical level MLR - a loss ratio devised for a high premium product and applying that to a low premium product like dental. Regrettably, I think things are going to be tough in Massachusetts next year. We just wanted to make sure that NCOIL is aware of that. And we continue to be happy to engage in constructive dialogue but do want NCOIL to understand that we think the Colorado approach is already a significant concession on our part.

Jeff Album, VP of Public & Gov't Affairs at Delta Dental of California thanked the Committee for the opportunity to speak and stated that as one of the dental plans that is heavily weighted in those figures that were spoken about earlier I simply wanted to explain that the reason you do not see over time the loss ratio changing very much is because the market pushes us to reduce our administration as low as we possibly can and reduce the premium as low as we possibly can to reach the marketplace, especially in the small group and individual market. So on these individual products specifically what we have is that a loss ratio not actually measuring the savings that has generated to a customer because they are paying lower premium. In fact, you are penalized. The MLR penalizes your plan for lowering the premium to the customer because as you lower the premium the administration has to take a higher percentage of that premium. So, if you really want to measure savings, and I did make this point last Spring, a higher MLR dental plan can actually deliver higher savings to a customer than a lower MLR plan. The MLR is perverse when you apply it to a low premium product like dental. If you're only spending less than $200 a year on your dental plan, if you show up and get

two dental services cleanings and X-rays all at 100% coverage and a 50% MLR dental plan, you're going to get $400 worth of services. You've already got your premium back plus some. And then if you actually need a filling or something else the savings are more. So again, the MLR threshold is a perverse measurement that has nothing to do with the value of the product and I would strongly encourage you to go with transparency. As you heard earlier, the transparency provides some value and the remediation element of the Colorado model gives the regulator room to act when these outliers occur and there is some other aspect to the story.

Mr. Olson thanked everyone for their comments and stated that he wanted to point out a couple of things. One is that what Mr. Album has just said is an admission that the value of dental plans is almost fully based on the discounts they demand through providers. It is not about paying for care. The true customers of these plans in many cases are employers, and not the patients themselves. Just to remind everyone that Massachusetts passed with 72% of the vote because when patients heard the true value of the plan and how much is being paid for their care, they voted overwhelmingly for this policy. But keeping costs low for employers as the only gauge on whether plans are providing value is not proper and so I would push back on the idea that Mr. Album presented that this is a perverse policy. It is working on the major medical side and it can definitely work on the dental side.

Rep. Camille Lilly (IL) asked if information could be shared on the rollout in states that passed dental MLR policy and what was learned there. Ms. Watanabe stated that probably the biggest challenge to the rollout was just developing the templates and the guidance for the reporting. So again, it wasn't a DLR requirement, it was just a reporting requirement. So we had a robust stakeholder process to make sure all of our dental plans and provider associations work with the us and the Department of Insurance just so we could make sure we captured the information that would be helpful to just provide that transparency. So, I think robust stakeholder engagement to make sure everybody has a voice at the table is really important. Publicly sharing the information is important too. Anytime you start something new, sometimes you need to tweak things and so sharing that in public settings and allowing for that dialogue I think it's been really helpful. Again, we haven't set a DLR in California but I think just having that stakeholder engagement and transparency has been helpful.

Ms. Pittman-Spencer stated that I agree with everything that Ms. Watanabe said and really appreciated the engagement in California. I think because we were the first state that did this we didn't quite know what we were doing and one of the things I think looking back there's probably ways that we could have made the data more accessible. I know Ms. Watanabe's department does a really great job of putting together the slide deck and the charts that you have just seen that they share at their regular quarterly meeting. But when you actually get down into what does this particular plan or this particular product ratio have - it's really hard to access. The CDA spends a lot of time and energy every year so we have sort of historical information on that but I don't know that anybody else outside of us and the departments and maybe some of the plans is doing that. So, I do think if you're looking at either a reporting, reporting plus or setting an MLR threshold I really do think that thinking through how do you want to present the information and what do you want it to do is important. Again, it's not something that your average consumer is going to be able to access and really do anything with. So, that might be something to think through - are you just doing reporting? Are you trying to have it be something that pushes consumer dollars? How do you want to display that

information? Those are things definitely worth thinking about. And I think if we knew then what we know now, we might have moved a little bit differently.

Owen Urech, Director of State Gov't Affairs at NADP thanked the Committee for the opportunity to speak and stated that the California experience has been very informative in other states. In Colorado we're currently going through the rule making process. There was a listening session yesterday on the implementation of the law that passed last year. And Maine recently wrapped up that process and is finalizing those requirements and that built on a lot of the work that was done in California from 2014 and after about making that information accessible but then also knowing that the regulators had kind of a robust framework to jump off on when they're implementing those outlier requirements.

Del. Westfall thanked everyone for speaking and stated that if anyone has any thoughts or comments, please contact me or the NCOIL staff. I look forward to continuing discussion in November and depending on how things go between now and then, we could vote on the Model.

DISCUSSION ON NOTICE OF PROPOSED RULEMAKING "SHORT TERM LIMITED DURATION INSURANCE; INDEPENDENT NON-COORDINATED EXCEPTED BENEFITS COVERAGE; LEVEL-FUNDED PLAN ARRANGEMENTS; AND TAX TREATMENT OF CERTAIN ACCIDENT AND HEALTH INSURANCE

Del. Westfall stated that next up is a discussion on the proposed federal rule issued by the federal tri-agencies (Labor, Health & Human Services, and Treasury). Included in the meeting materials is a comment letter that NCOIL submitted on the proposed rule. NCOIL CEO, Cmsr. Tom Considine, will speak briefly about the letter.

Cmsr. Considine thanked Del. Westfall and stated that without regard to anyone's substantive position on the underlying proposals, the rule is essentially an attempt at a second bite at the apple by the Biden Administration to try and do something that the Obama-Biden Administration was not able to do some years ago back in 2016. And so it would be a significant encroachment into state jurisdiction of insurance and that was the basis for our objection. I understand that reasonable minds can differ on issues such as short term limited duration insurance and other things covered in the rule, but some of the items covered in the rule were considered during the Affordable Care Act (ACA), and Congress expressly decided to exempt them. The McCarran-Ferguson Act did give Congress the ability to regulate the business of insurance in certain instances but it didn't give any agencies to the federal government the ability to regulate the business of insurance. So, without going into the underlying issues, NCOIL really protects the turf of state regulation of insurance and that was the basis for our letter.

JoAnn Volk, Research Professor at the Georgetown University Center on Health Insurance Reforms, thanked the Committee for the opportunity to speak and to share some of our research on short term plans. We've long done research on these plans and the risks they pose for consumers and I'm pleased that I can share some of that research with you today. Just a little bit about the Center before I jump into the plans. We are part of the McCourt School of Public Policy at Georgetown University and we're a team of about 15 people who study the legal and policy framework for private health insurance that is regulated by the states as well as federally regulated plans. We track

market trends, also and publish reports, studies, blog posts, and provide technical assistance to consumer and patient groups and to state officials on private insurance. I'm going to talk about the short term plans and the research on them and the benefit limits that they have and the risks for the enrollees. And then I want to share some recent research looking at the sales of one of the benefit plans during the public health emergency unwinding. We conducted a secret shopper study earlier this year.
So as I'm sure you know, the limited benefit products universe out there is a multitude of products that don't have to comply with the ACA marketplace rules. They include short term limited duration plans, which I'll call short term plans, fixed indemnity plans, but also healthcare sharing ministries which I know you all looked at before. Importantly, they don't have to comply with key ACA protections including coverage of the ten essential health benefits such as: prohibition on dollar limits on benefits, requirement to cover pre-existing conditions, requirement to cover people and renew that coverage when it ends, and to meet a minimum loss ratio which is a measure of how much of an enrollee's premium goes towards healthcare versus overhead costs.

So short term plans is one of those limited benefit plans. When the 2018 rule came out there were predictions that sellers of the policies would make coverage more robust to make it seem more comprehensive than it had previously been. But that didn't happen. Instead, it just erased the line between short term plans and comprehensive coverage so that it was nearly impossible to distinguish between a plan that stopped just short of 12 months and another that could go for a full year. And it often appears cheaper for enrollees who are considering these products. But the gaps and exclusions leave patients with very high out of pocket costs. And of course, they're medically underwritten, meaning that applicants with health conditions can be turned down, charged more or have benefits excluded for their pre-existing conditions. Typically, for all enrollees these plans exclude key services such as maternity, mental health and substance abuse disorder treatments and prescription drugs. Some of these can be added with a costly rider but they are not in the benefit plan. They can impose dollar limits on benefits. They don't have to be renewed at the plans end. And they can in fact be rescinded during the policy if a claim is submitted and the insurer can use the substantial documentation of health conditions that was part of the application process to show that there was some basis for knowing that there was a condition there even if the enrollee didn't recognize it as such. There are five states that have banned recissions and I show that here. In a number of areas, here are states that have gone beyond the federal floor.

So, I want to talk particularly about the end of the continuous Medicaid coverage. As you all know, Congress established a continuous Medicaid coverage policy during the COVID public health emergency in which states were not allowed to do Medicaid redeterminations and Medicaid enrollment reached a record high. That policy ended in March and states have now resumed their redeterminations and by one estimate more than 15 million people are expected to lose Medicaid coverage before the end of this year. The ACA marketplace is a source of comprehensive affordable coverage for those coming off of Medicaid but former Medicaid enrollees may not know about this option. There's been a number of studies of deceptive and aggressive marketing tactics used to sell limited benefit products including short term plans and we've done some at Georgetown. The Government Accountability Office did a secret shopper study and others have too. I include links to a lot of this research at the end of my presentation. So, we wondered earlier this year with 15 million people coming off Medicaid, the marketplace open with a special enrollment period, and enhanced premium tax credits

making coverage more affordable for individuals at $10 dollars or less for four out of five people - we wondered whether or not people that went online to shop for coverage would be directed to the marketplaces and subsidies for which they are eligible.

This actually adopts the same process we used in previous Georgetown secret shopper studies. We created two profiles for hypothetical consumers losing Medicaid in Texas. They had one who had no pre-existing conditions and the other who was older and had a pre-existing condition. So, when asked they indicated that they took a prescription drug for high cholesterol. But otherwise they were the same. Both were females about to lose Medicaid in their state and had the same annual income and the household size of two. So, with that income for their household size, we knew that they were eligible for $0 silver plans, including plans with no deductibles, and they were also eligible for marketplace special enrollment period. So, with those profiles, we went online to search with Google for terms that people might use when looking for coverage including health, Obamacare plans, and affordable health insurance, and healthcare.gov. After entering the information for the consumer profiles on websites that came up with that search, we spoke to 20 sales representatives, 10 for each profile. The results are as follows - in no case was a federal marketplace healthcare.gov the top result. It was sites promoting limited benefit products with usually paid advertisements and promoted well above other results. And the first results were often lead generating sites in which you enter your information and calls are generated and outreach from brokers from those sites. One of our consumers received over 100 voicemails in one week in response to entering her information into one website.

Out of the 20 sales representatives, 11 tried to sell a limited benefit product. At least two are fixed indemnity products. In one case there was information shared that we could use to actually determine what the plan was. So, it might have been short term, could have been fixed indemnity. In two cases information was shared sufficient to identify them as fixed indemnity plans. But the premiums ranged from $109 to $271. Even though they were eligible for a $0 premium plan in the marketplace with a $0 deductible. In no case did a representative direct the shoppers to that plan. For one thing, they misrepresented the products and I think this is important with short term plans. I know there's an argument that they are a gap filler and as long as people understand the limits they should be entitled to buy what they want to buy. And I think the substantial challenge here is they do not have enough information to understand what they are buying and often don't find out until too late the benefits limits that there are.

So just to describe this process, the brokers or people who reached out to the consumers gave false or deceptive information about the level of coverage these products offered. They made misleading comparisons to major medical plans and then refused to provide written plan information when asked. That was a part of the protocol, was in all cases to ask for information before making a decision. And it was only shared in one case. And in another case it was a screen shared to look at some quick three pages of planned documents. They also misrepresented the marketplace plan, saying that the marketplace was closed and not open to enrollment and that subsidies are only available during open enrollment and hat they were more costly and had higher deductibles than what could be had with the plans the brokers were selling. And there was substantial pressure on the shoppers to buy immediately, urging them to commit to the plan over the phone without information about the underlying plan and discouraging them from taking time to look at options or even consider their budget with a premium amount and telling them that if they came back later the plans would fill up or be

unavailable. And these high-pressure sales tactics were more common among representatives selling limited benefit plans.

In terms of the policy implications, despite some enforcement efforts deceptive marketing on limited benefit products persists putting millions of people at risk. We of course have this proposed rule that you all commented on that would limit the short-term plans to three months. And states can of course go above whatever federal floor is set. And many have. And I think it's important to raise awareness about marketplace plans and investing in enrollment assistance so people can really take their time and understand their plan options. Again, one of the big risks for short term plans is you do not get the information about the risks and find out too late what was excluded. Or, that coverage can be canceled. And I think while there's a hope and expectation that providing disclosures can help consumers know what they're buying, importantly from the Secret Shopper study that moment never happened in that sales transaction that they could understand exactly what they would have been buying. And there was substantial pressure to buy on the spot. So, I've concluded links to the Secret Shopper study here along with previous Secret Shopper studies and the research that has been done at Georgetown and other centers or researchers about the limits and risks of short-term plans.

JP Wieske, Executive Director of the Health Benefits Institute (HBI), thanked the Committee for the opportunity to speak and thanked NCOIL for protecting the state's ability to be able to regulate these plans. First it is frustrating to conflate short term limited benefits and healthcare sharing ministries because the issues are very different between them and as a former regulator myself I can tell the regulatory issues are very different as well. So, that is a frustrating sort of conversation to be able to have. And that's by design by a lot of folks and that's concerning. We are very concerned, similar to Georgetown, with improper marketing. So we've actually done work around this with the National Association of Insurance Commissioners (NAIC). We are members of an NAIC subgroup which is dealing with a model regulation around all of these products except for healthcare sharing ministries. Also, I'm the former chair of the NAIC working group that developed the NAIC Model Law related to these products. I would note that from a state perspective, states license the insurers and they license the agents. They take the forms and the rates on the insurers and they review those. They respond to complaints. They actually have data on these plans and the federal government has none of this. If you read through the rule it's anecdotes and blog posts around this. And while there are problems and there are concerns, there's a 94% satisfaction rate in the fixed indemnity market and the thought of the federal government taking these products away is going to be a big problem I think for consumers across the country and your consumers as we look at it.

I would note that states are continuing to look and gather data on this. Short term limited duration has a market conduct annual statement process that is currently ongoing. So they're collecting data on the number of plans. I would note the number of individuals who have purchased short term limited duration plans has plummeted in the last few years. So, the sense that there's significant problems is very different. Certainly, the issues around marketing, especially around improper marketing of healthcare broadly, part of which has been exacerbated by the federal government's involvement and removing the states from Medicare Advantage, are significant. And the NAIC has added lead generation models into the Unfair Trade Practices Act as a proposal to help deal with this issue. We also strongly support disclosure. The simple reality is if an individual

misses the open enrollment deadline and does not have a special enrollment period, they literally cannot buy private market coverage except for short term limited duration coverage in the market. And the idea of a four month time limit is going to be extremely problematic. We had some discussions around aligning those incentives around the ACA open enrollment period to ensure consumers have access over the whole time frame that they will be uninsured but the solution that the federal government has proposed is forcing consumers who missed the open enrollment deadline and do not have a special enrollment period to consistently change plans and have new rules and be subject to underwriting time and again throughout the process. We are concerned with that.

The fixed indemnity market is going to be an existential crisis if it's done as it is written. As Cmsr. Considine indicated, the federal law creates a section which includes fixed indemnity that excepts them from federal regulation. The rules are counter to the existing statute. We do support broadly the idea that there should be broad consumer disclosure. We support states taking action. As Ms. Volk noted, there are a number of states that have banned short term plans or a number of states that have limited access to short term plans. They've limited time frames and they've expanded disclosures. Same thing with fixed indemnity. So, the idea that the states are not acting on this is just simply not correct . I would encourage each of you to reach out to your departments, a number of whom have issued letters in opposition to the federal rule, and chat with them about what they're seeing and whether or not there are laws that should be changed in your states.

In closing, there are very different solutions around short term and fixed indemnity insofar as marketing issues go. And I will also note, a Secret Shopper survey in one state speaking to sales representatives and not agents creates an issue. I acknowledge the issue that Ms. Volk has highlighted and it comports with others that have seen similar issues when you go through sales representatives, rather than using licensed agents. And I think that has been part of the marketing problem - the use of non-licensed agents, which has been exacerbated by the lack of federal action on a number of things. So, states have been forced to act and trying to figure it out without federal help on a number of these things.

Ronnell Nolan, President of Health Agents for America, thanked the Committee for the opportunity to speak and stated that there are a couple of concerns about the Georgetown report. Number one, we know that Congressman Smith from Missouri just came out and said 1.6 million folks would be affected if short term medical plans were taken away. And I agree that 20 representatives is not a good way to determine what's actually going on in the market. Short-term medical plays a huge role for those not only that are not in a special enrollment period but for those that do not get a tax credit. So, if they do not get a tax credit they can choose the plan they want that has all the bells and whistles that a marketplace plan has. But it's their choice. We all know the ACA is not affordable. Premiums are not affordable. If you look at premiums for an individual without a tax subsidy you would probably be blown away. People can't afford it. So these plans play a role and we appreciate transparency as agents.

Michael Hickey, Regional Director of Gov't Relations at Aflac, thanked the Committee for the opportunity to speak and thanked NCOIL for the letter that was sent to the agencies. It's great when we hear from the state legislatures. I also want to thank Mr. Wieske. He actually said a lot of what I wanted to say and part of our problem is at Aflac we don't

offer short term limited duration policies. We offer fixed indemnity plans, hospital indemnity, cancer, specified disease. And they often get lumped together and considered short term limited duration. And the way we look at this federal rule right now is that it would put a lot of our products out of business. I won't get into the tax problems because this isn't the forum for that but I did want to thank Mr. Wieske and NCOIL for their comments.

Ms. Volk stated that I do want to point out that for the people that were shopping, the tax credits at this moment are available to all. There is no longer a 400% poverty cut off. And the particular consumers we were using were eligible for the greatest subsidies for their premiums and out of pocket cost. So they would have gotten a plan with a $) deductible, 94% AV coverage, $0 premium. And I should add to that they all seem to be being sold through an association. There was a reference to a one time fee that would lock in your rates for three years if you paid it. So, we took that to be a reference to association plans and I know and I know Mr. Wiekse knows about the challenges of capturing sales through associations for state regulators and getting that count in the market conduct annual statement at the NAIC. This is not to disparage reputable brokers, but we took the path that I think most people would take to shop for anything whether it's health insurance or TV, we go to Google. And we even used healthcare.gov and it didn't come up as the first option. So, I'm just trying to make folks aware of what many people will use as their shopping mechanism will unfortunately not only not lead them to the the optimal plan in the marketplace with $0 premium and $0 deductible, it will mischaracterize what that coverage is and mischaracterize the coverage that they're being sold.

Miranda Motter, Senior VP of State Affairs at America's Health Insurance Plans, thanked the Committee for the opportunity to speak and stated that I would just reiterate a couple of the things that Mr. Wieske and others said just in terms of how important fixed indemnity products are. We know that Americans need to be protected from a few bad actors who certainly commit fraud and abuse. But we want to be really clear and make sure that we don't throw the baby out with the bathwater, because we do know that Americans do agree that these kinds of plans are an important choice for them and those Americans do have these plans and are satisfied with that coverage. And so we just want to ensure that the personal choice, control, and financial security through these products remains.

John Ashenfelter, Associate General Counsel at State Farm, thanked the Committee for the opportunity to speak and thanked for the letter it sent to the tri-agencies. We agree with the statements from Mr. Wieske and from Aflac and others related to the fixed indemnity issue. It is very important that it stays in line with the federal statute which actually exempts these products, so we would appreciate the continued focus of the states in terms of that exemption and protection of a very important and quite frankly, essential policy in the fixed indemnity products.

ADJOURNMENT

Heating no further business, upon a Motion made by Sen. Utke and seconded by Rep. Ferguson, the Committee adjourned at 1:00 p.m.