From:	Sandy Wood
To:	OIC Rules Coordinator
Subject:	WAC 284-43-XXX comments
Date:	Tuesday, June 26, 2018 3:40:33 PM
Attachments:	Stakeholder Draft WAC 284-43-XXX- comments-Sandra Wood.docx

Hello – I am including a comment letter with regards to the Short-term limited duration medical plans Stakeholder Draft.
Please let me know if you have any questions. Thank you for your attention.

- Sandy

Sandra Wood, CEBS | President

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TO: **rulescoordinator@oic.wa.gov**

RE: **Short-term limited duration medical plans**
WAC 284-43-XXX
Stakeholder draft comments

To Whom It May Concern:

I am writing to provide comments on the stakeholder draft outlining short-term limited duration medical plan rulemaking. If you have any questions about my comments, I can be reached directly at 206-669-3345 or via email at sandy@thebenefitsacademy.com.

Sincerely,

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Under the definition of "Short-Term Limited Duration Medical Plan" (hereafter called "STM" in this comment letter), item (1)(a), the stakeholder draft includes reference to WAC 284-50-350. This area of the WAC is very outdated and many of its provisions would not apply to future STMs. In addition, WAC 284-50-350 references in-hospital medical services as defined in WAC 284-50-340(3). Again, this is an outdated WAC and specifically contradicts some of the provisions outlined in WAC 284-50-350. I would recommend that item (1)(a) remove the reference to WAC 284-50-350 and instead include the following, or similar, wording:

a. Provides major medical coverage
    i. "Major medical coverage" is a disability insurance policy which provides hospital, medical and surgical expense coverage, and includes
        1. An aggregate maximum of not less than $XXXXXX [I would recommend at least $100,000]
        2. Copayment by the covered person not to exceed XX% of covered charges [I would recommend not to exceed 50%]
        3. A deductible stated on a per person basis with a stated duration per benefit period not to exceed $XXXX [I would recommend not to exceed $5000]
    ii. The coverage for each covered person shall be for at least:
        1. [List the items here that the OIC is requiring under these plans]

Under the definition of STM item (1)(b), the stakeholder draft denotes that there can be a look-back period for pre-existing conditions of no more than 24 months prior to the date of application. I would recommend that two definitions be added to this section:

- A Pre-existing conditions shall include any condition for which the patient has already received medical advice or treatment, including taking a prescribed medication, prior to the date of application for the short-term limited duration medical plan.
- The date of application for purposes of this section is the later of the signature date on the application or the date the short-term limited duration medical plan takes effect.

Under the definition of STM item (1)(c), the stakeholder draft denotes the policy expiration. An enrollee typically will enroll under an STM due to one of several factors, including, but not limited to: missing the Annual Open Enrollment window, missing a Special Enrollment Period deadline, and missing a payment of regular insurance coverage which does not constitute a SEP. Due to this, I would recommend that (1)(c) be changed to extend the duration:

> (c) If the policy, contract, or agreement begins on the first of a month, the expiration date will be no longer than 6 calendar months after and including the original effective date of the policy, contract or agreement. If the policy, contract, or agreement begins in the middle of a calendar month, the expiration date will be no longer than the enrollment month plus 5 full calendar months past the original effective date of the policy, contract, or agreement.

Others have expressed that they would like to continue to have "up to 3 months" of coverage, and provide one additional 3 month policy within a 12 month period. However, based on current and prior practice of STM programs, each 3-month policy will have its own deductible and out of pocket maximum. Plus, when enrolling on the second 3-month policy, the pre-existing condition limitations start new with the 24 month lookback starting as of the date of that new second plan's effective date. A consumer could purchase their first 3-month plan and not have any pre-existing conditions, then, for example, be placed on heart medication during that 3 months. Upon needing to sign up for an additional 3-month policy, the person either may not be accepted due to their new pre-existing condition or, if accepted, not have any heart-related services and drugs covered under the second 3-month policy. Because of the confusion that would be caused by the double-deductible, double-out of pocket, and new pre-existing condition lookback, I feel it would be in the best interest of the consumer to have a longer 6-month period STM rather than have an option to enroll in a second 3-month STM.

If the 3-month time period is retained, I would recommend that the wording be changed, as noted in the above example. This will clear up any confusion, since "less than three months" could imply one day less than 90 days or one less day than 3 calendar months.

> (c) If the policy, contract, or agreement begins on the first of a month, the expiration date will be no longer than 3 calendar months after and including the original effective date of the policy, contract or agreement. If the policy, contract, or agreement begins in the middle of a calendar month, the expiration date will be no longer than the enrollment month plus 2 full calendar months past the original effective date of the policy, contract, or agreement.

In keeping with my recommendation to change the time period under (1)(c) to 6 months, if this were changed there would also need to be a change to the wording in section (2):

(2) A short term limited duration medical plan shall be nonrenewable. A carrier shall not issue a short-term limited duration medical plan to any person if the issuance would result in the

person being covered by a short-term limited duration medical plan for more than is allowed under (1)(c).

Alternatively, if (1)(c) retains the three month maximum, I would recommend that the commissioner allow an additional 3-month STM policy. This would require a change to the wording under section (2). Below is an illustration of a possible change to this section:

a) A carrier shall be allowed to issue a short-term limited duration medical plan to any consumer that has not been covered under such a plan for more than 180 calendar days. The maximum coverage duration allowed to a consumer in a 12 month period would be no longer than 6 full calendar months (of 180 calendar days if coverage began or ended midmonth. The consumer's 12 month period will be calculated from the date the consumer is seeking to begin a short-term limited duration medical plan, with any months/days of coverage under a short-term limited duration medical plan being applied to the consumer's maximum allowable duration.

Under the definition of STM item (3), the stakeholder draft adopts the definition of the annual open enrollment period as outlined under WAC 284-43-1080. That WAC does not include "annual" in the naming of the definition item. In addition, only item (1) of that WAC is applicable here. Therefore, I recommend changing (3) to:

b) A carrier must not issue a short-term limited duration medical plan for coverage beginning in the upcoming year during an open enrollment period, as defined in WAC 284-43-1080(1).

The disclosure form that will be required for each plan looks to be fairly extensive. There are a few areas that I would recommend additions or strengthening of the language. These include:

- In the CAUTION box, I would recommend the following language:
    - CAUTION: This plan does not cover pre-existing medical or behavioral health conditions for which you have already received medical advice or treatment, including taking prescribed medications, during the 24 months prior to enrolling in this plan.

      This plan provides limited benefits, is temporary, and may not cover your costs for certain hospital or other medical services, prescriptions, or some essential health benefits. Benefits disclosures are provided in this document.

      If applicable, carrier should enter information about provider network limitations, for example: "This plan provides coverage for in-network provider services only. Services received outside the network will not be covered. "

- Under "Does this policy cover pre-existing conditions?", if the plan does not, I would recommend that the example to the carrier include additional language for transparency, such as:
    - … or *"No, it limits/excludes coverage for pre-existing medical or behavioral health conditions for which you have already received medical advice or treatment, including taking prescribed medications, during the 24 months prior to enrolling in this plan. See policy for details."*

- Under "Can the policy be renewed", I would recommend:
    - If a 6 month maximum plan is allowed, change to:
        - No, a person cannot be covered by a short-term limited duration medical plan for more than six calendar months in any twelve-month period.
    - If a 3 month maximum plan with one additional 3-month policy is allowed, change to:
        - Possibly. A person cannot be covered by a short-term duration medical plan for more than a combined six calendar months in any twelve-month period. In addition, enrollment onto a short-term limited duration plan is not allowed to begin during the individual open enrollment period that occurs annually.
    - If no change is made to the rules outlined
        - No, a person cannot be covered by a short-term limited duration medical plan for more than 3 calendar months in any twelve-month period.
- Under "Plan coinsurance (amount member must pay per service)", I would recommend adding language that the maximum denoted is the patient's cost maximum, not the total amount paid by the plan and the patient for care.
    - "__ % *(Must be expressed in terms of the percentage to be paid by the member. If coinsurance applies to a maximum amount, provide that information here. Example: "This policy has a 50% coinsurance up to $10,000 maximum in patient out-of-pocket costs, after which covered benefits are paid at 100%."*
- Under "the maximum amount a member will pay out-of-pocket for cost-sharing for the term of the plan…", I would recommend that the types of payments by members that will count toward the deductible should be denoted, for example:
    - "…$____ *(If there is an out of pocket maximum, clearly state which member payments are applied to this maximum, such as the deductible, coinsurance, and/or copays. …*"
- Under the list of services, I would recommend adding the following services to this outline:
    - Ambulance Services:
    - Lab & X-ray:
    - Alternative Care (acupuncture/chiropractic/massage):
    - Physical Therapy:
- Add a question & answer:
    - Do I need to use a specific network of providers or a specific list of pharmacies?
- Two paragraphs above the consumer signature area, I would recommend adding "individual plan" to the sentence:
    - "…you may have to wait until the next individual plan open enrollment to buy…"
- One paragraph above the consumer signature area, I would recommend adding to the start of the last sentence"
    - "… If you are using the services of a producer, your producer …"
- On the consumer acknowledgement, I would recommend changing the wording prior to the signature to:
    - I have reviewed the content of this disclosure form.
      If I have used the services of a producer (also referred to as insurance agent), the benefits, limitations, and costs of this short term limited duration medical plan have been fully explained to me by _____ (insert name of producer).

I have one comment about the “Commissioner’s approval required” area. Will there be any required Loss Ratio standards? If not, what would be possible grounds for disapproving a rate?

Under the Cancellation and Rescission area, I do not agree with the current segmentation of what can be rescinded (i.e. terminated retroactive to the start of the policy) versus cancelled.

I recommend that the contract be allowed to be rescinded for:

a) Non-payment of initial premium payment
b) Cause, such as making a fraudulent claim
c) Providing fraudulent information to the carrier, including enrollment information
d) An intentional misrepresentation of material fact

As for terminations, I would recommend defining termination timelines for items listed. For example:

a) Nonpayment of premium other than initial premium – cancellation would be effective the 1st of the month of coverage for which payment is not received by the 10th of that coverage month
b) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage – cancellation would be effective the last day of the month in which such law becomes effective, or at the end date of the member’s specific short-term limited duration medical plan contract if sooner.

Under the Cancellation and Rescission area, item (5), I would recommend that the carrier only be required to provide a ten day notice of cancellation to the member regardless of the reason for the cancellation, not just the items the rule denotes in item (1).