To: Commissioner Glen Mulready and Melinda Domzalski-Hansen, co-chairs of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, to the members of the Subgroup, and Jolie Matthews

From: Justin Giovannelli, Sarah Lueck, Anna Schwamlein Howard, Jackson Williams, and Silvia Yee, NAIC Consumer Representatives

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Thank you for the opportunity to comment on issues related to the definition of "pre-existing condition" in Model #171, the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act. The Subgroup's work to revise this Model Regulation is critical to protecting consumers. Ensuring the definition of "pre-existing condition" is clear and consistent would help reduce the harm consumers may face from plans that can exclude coverage, charge higher rates, or rescind coverage of a condition deemed "pre-existing."

As a threshold matter, it is surely within the purview of the Subgroup to revise the pre-existing condition definition in Model #171, including by adopting the modifications we have proposed. Section 7 of Model Law #170 does not purport to define the term "pre-existing condition," nor otherwise establish a framework for the application of pre-existing condition exclusions that is somehow inconsistent with our recommendations. In short, Section 7 does not limit, expressly or impliedly, the authority of the Subgroup to consider the revisions to the "pre-existing condition" definition that it has been discussing for weeks and to adopt such changes at its members consider appropriate.

The changes we propose to this definition, as further explained below, would have three main effects: ensuring the definition is based on receipt of medical advice or care instead of a "prudent person" standard, shortening the "look-back" period, and modifying the drafting note to increase transparency for consumers about how an insurer plans to use information about the pre-existing conditions identified in the underwriting process. If the Subgroup finalizes a definition that appropriately identifies conditions that truly pre-date the effective date of a given plan, then people enrolling in short-term, indemnity, and other forms of insurance covered by this model can more accurately answer the health questions they are asked and hopefully avoid situations where their coverage is rescinded or cancelled after they receive expensive medical care.

Below, please find a re-statement (with slight modifications to our summer 2019 comments) to the consumer representatives' proposed definition of "preexisting condition" in this model.

> L. "Preexisting condition" shall not be defined more restrictively (for the insured or prospective insured person) 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~~ a specified condition for which medical advice, diagnosis, care, or treatment was recommended by a physician or received from a physician within a [~~two~~6-] ~~year~~ month period preceding the effective date of the coverage of the insured person."
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> **Drafting Note:** This definition does not prohibit an insurer, using an application or enrollment form, including a simplified application form, designed to elicit the health history of a

prospective insured and on the basis of the answers on that application or enrollment form, from underwriting in accordance with that insurer's established standards and in accordance with state and federal law. It is assumed that an insurer that elicits a health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition and/or deny payment of a claim related to a condition, the policy or certificate will be endorsed or amended by including the specific exclusion and giving notice to the prospective insured about the condition or conditions for which related claims will not be paid. This same requirement of notice to the prospective insured of the specific exclusion or exclusions will also apply to insurers that elect to use simplified application or enrollment forms containing questions relating to the prospective insured's health. This definition does, however, prohibit an insurer that elects to use a simplified application or enrollment form, with or without a question as to the proposed insured's health at the time of application or enrollment, from reducing or denying a claim on the basis of the existence of a preexisting condition that is defined more restrictively than above.

Under this modified definition, a condition would be deemed to be "pre-existing" when a consumer had received medical advice, diagnosis, care, or treatment within the specified "look-back" period.[1] (We recommend the "for the insured or prospective insured" parenthetical to clarify the meaning of "more restrictively.") However, the definition would not apply in cases where a consumer experiences sensations that later turn out to be symptoms of an illness, or in situations when a doctor makes a note in a person's medical record regarding potential conditions that the doctor is not diagnosing, treating, or perhaps even discussing with the person. We recommend shortening the look-back period to six months because we believe consumers will be more likely to remember and provide accurate information about medical care and treatment they received during that period. Again, we seek to limit situations where consumers are caught off guard by coverage decisions regarding a health issue that they weren't aware of or did not remember. Finally, our proposed changes to the drafting note are intended to clarify how insurers are likely to use information about a person's pre-existing conditions (i.e., to deny claims related to a pre-existing condition as well as to exclude the condition from coverage). To promote transparency during the application process, the drafting note also adds an expectation that the insurer will notify the prospective enrollee about the impact of any pre-existing conditions that are identified.

Taken together, our recommended changes would reduce the burden on the consumer to identify what a "prudent person" might have considered an early symptom of a condition that has not even been diagnosed and to remember the past two years of their health issues and medical details, while also mitigating the risk that people will face medical bills that are unexpectedly not covered. Ensuring this process occurs ahead of time, rather than after a plan enrollee has received expensive medical care, would reduce ambiguity and better prepare people to make an informed choice about their health coverage.

[1] Kaiser Family Foundation, Individual Market Portability, https://www.kff.org/other/state-indicator/individual-market-portability-rules/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Maximum%20Look-Back%20Period%20(months)%22,%22sort%22:%22asc%22%7D The standard based on actual receipt of medical advice, diagnosis, care, or treatment is sometimes referred to as an "objective" standard as in the source cited here.