

Limited Benefit Plan Update

REGULATORY AND LITIGATION DEVELOPMENTS

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Limited Benefit Plans Under Increased Scrutiny

The limited benefit medical plans product area is under enhanced scrutiny by state insurance regulators. Most recently, at the National Association of Insurance Commissioners (NAIC) meeting in Seattle there was a Joint Meeting of the Antifraud (D) Task Force and ERISA (B) Subgroup on August 12. The goals of the meeting were as follows:

- Understand how limited benefit policies are marketed
- Assess the disclosures that are made with respect to covered benefits
- Evaluate the advantages of these types of policies
- Determine the need for additional regulation
- Discuss the impact of the Patient Protection and Affordable Care Act (PPACA) on these policies

Testimony was received in person and in writing from numerous consumer and industry groups, as well as a number of state insurance regulators. Some of the testimony attempted to define limited benefit plans and explain how they fit within the established NAIC Model Accident and Sickness Minimum Standards Regulations, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and PPACA.

Most of the industry testimony focused on concerns regarding the impact of PPACA on limited benefit policies. Industry testimony was provided by America's Health Insurance Plans (AHIP), The Council of Insurance Agents & Brokers, the National Association of Health Underwriters (NAHU) and Aetna.

AHIP discussed the role of mini-med plans and stated that around 2.5 million consumers are covered by such plans in the individual and group markets. AHIP indicated that mini-med policies allow individuals to budget for preventive and routine medical services, at a relatively affordable price, while maintaining credible coverage. The Council of Insurance Agents & Brokers expressed concern that if health care reform did not provide an exception for limited benefit medical plans during the transition period up until 2014, when subsidized coverage becomes available, more than one million individuals' coverage could be jeopardized.

NAHU said that two million Americans are covered under limited benefit plans that provide credible coverage and access to medical services at an affordable price. Per NAHU, most beneficiaries receive this coverage through employers and are part-time, seasonal, or temporary workers who are ineligible for comprehensive coverage options or cannot afford such coverage.

Aetna stated that many major employers and charitable organizations provided coverage to their employees through limited benefit plans, and provided information regarding the cost of these programs in comparison to comprehensive major medical plans. Aetna then provided information regarding the cost impact of eliminating limited benefit plans for many part-time, hourly and seasonal workers or if such plans were forced to comply with the new annual limit requirements. Aetna also described some additional benefits provided by limited benefit plans and made some recommendations with respect to the HHS waiver process.

State insurance regulators also addressed the marketing of limited benefit plans. Mila Kaufman, the Superintendent of Insurance in Maine, who has written several articles addressing the marketing and regulation of association group insurance coverage, spoke at the Joint Meeting. Additionally, Bob Lisson, Deputy Commissioner of the North Carolina Department of Insurance, spoke primarily about how limited benefit coverage is being sold through group policies issued to discretionary membership associations. Deputy Commissioner Lisson indicated that there tends to be little disclosure regarding association membership. He believed that consumers were harmed by misrepresented coverage, bundled payments and association dues/fees that may far exceed the premium. He stated that advance disclosure should be provided of premiums vs. dues and other non-insurance fees and there should be a thorough regulatory review of prospective association group policyholders for compliance.

A few consumer representatives also spoke at the Joint Meeting, primarily with respect to whether limited benefit plans offer consumers any benefit. For example, Bonnie Burns, from the California Health Advocates, stated that many policyholders "are convinced that their coverage is better than it is, only to discover its limitations when serious illness strikes." She pointed out that these policies are often sold with a disclosure, per the Accident and Health Model Regulation, that states the coverage is "supplemental and not intended to cover all medical expenses," despite her position that the

policies are frequently sold as primary coverage, which is sometimes encouraged by states "in a misguided attempt to reduce the number of uninsured citizens in their state."

On August 14, 2010, the NAIC issued a news release summarizing the outcome of the Joint Meeting. The news release stated:

"The hearing was precipitated by a growing number of instances where health plans sold were misrepresented as comprehensive coverage, and consumers were left without medical insurance and often with significant debt. The NAIC heard testimony from representatives of insurance industry and consumer groups. Regulators stressed the importance of clarifying disclosures at the point of sale that address what the plan specifically covers."

The press release went on to state that the NAIC would further look into how health care reform will affect limited benefit plans and how regulators could address "the current rise of scams related to these health care plans."

We are going to continue monitoring the NAIC's review and treatment of limited benefit plans, such as its recommendations involving health care reform, any revisions to the Model laws or regulations, or the issuance of any new consumer alerts. We will also follow any trends indicating any apparent decision to take concerted action against the limited benefit plan industry.

Health Care Reform Ramifications Still Unclear for Limited Benefit Plans

Until further direction is given by the Department of Health and Human Services (HHS), it is unclear how limited benefit plans are going to be handled under the Patient Protection and Affordable Care Act (PPACA or commonly referred to as health care reform). Some limited benefit plans will qualify as "excepted benefits" under the HIPAA definitions, such that they will not be subject to the requirements of health care reform. These types of plans will generally be limited to accident-only plans, hospital indemnity plans, and other fixed indemnity plans under

federal law, although some states will impose additional requirements on the types of plans that will qualify as limited benefit plans.

Those limited benefit plans that do not qualify as an excepted benefit under the HIPAA definitions do appear subject to the PPACA requirements, except for those plans that are grandfathered. In particular, for the next three years, this means that they must comply with the phased-in annual limit restrictions imposed by the new regulations promulgated by the HHS on June 28, 2010. (Grandfathered individual policies are exempt from this provision). The dollar value of benefits may not be less than \$750,000 for policy years beginning on or after September 23, 2010; \$1.25 million on or after September 23, 2011; and \$2 million on or after September 23, 2012 but before January 1, 2014.

HHS appears to have recognized that many consumers may be adversely affected by these annual limit restrictions, which will have a much greater impact on limited benefit plans. The Overview of the Regulations states:

"So that individuals with certain coverage, including coverage under a limited benefit plan or so-called 'mini-med' plans, would not be denied access to needed services or experience more than a minimal impact on premiums, these interim final regulations provide for the Secretary of Health and Human Services to establish a program under which the requirements relating to restricted annual limits may be waived if compliance with these interim final regulations would result in significant decrease in access to benefits or a significant increase in premiums. Guidance from the Secretary of Health and Human Services regarding the scope and process for applying for a waiver is expected to be issued in the near future."

As this newsletter went to press, HHS had not released any guidance with respect to the waiver process for limited benefit plans. However, certain large employer and trade groups have written HHS and indicated that if the annual cap limit is strictly enforced, then many low-wage, seasonal or temporary workers who are covered by limited benefit plans are likely to lose their coverage. We are monitoring this situation and intend to provide further information as it develops.

The National Association of Insurance Commissioners (NAIC) provided some additional information with respect to the treatment of limited benefit plans under health care reform. On the NAIC's website under "Special Section: Health Care Reform," there is a form titled, "PPACA Uniform Compliance Summary." This document is apparently being used as a filing checklist in the states with respect to health care reform filings. The first paragraph of the form states:

"This form filing compliance summary is to be submitted with your [endorsement] [contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage."

We contacted the NAIC in order to clarify why this statement seemed to exclude other types of coverage, such as limited benefit plans were not accepted benefits under HIPAA, and which HHS indicated was subject to the PPACA's requirements under health care reform. The NAIC indicated that when it used the term "major medical," it was actually referring to lines of business codes on the NAIC's "Uniform Life, Accident & Health, Annuity and Credit Product Coding Matrix." Those limited benefit plans that would qualify as excepted benefits under HIPAA were classified as lines of business on this matrix that were not subject to health care reform requirements, whereas other types of plans, even if not "major medical," such as hospital, medical, surgical plans or "other plans," did qualify as health care reform-eligible.

FTC and States Crack Down on Improper Marketing Practices

At a joint news conference on August 11, officials from the Federal Trade Commission (FTC), New York Department of Insurance and attorneys general offices from several states, announced their intent to aggressively target what the officials claim are misleading marketing practices by medical discount plan companies. However, a review of some of the lawsuits

filed by the FTC indicates that officials are concerned with misleading marketing practices by companies selling products that include limited benefit plans bundled with medical discount benefits.

Specifically, the FTC announced that it had filed three lawsuits in early August charging several companies with deceptive practices and asking the courts to order the companies to halt their business operations. The FTC lawsuits are based on its jurisdiction over fraudulent telemarketing and broadcast advertisements and include allegations that these companies misrepresented various items about the plans, including refund policies. The FTC also claims that the companies were selling plans disguised as major medical health insurance.

State officials announced during the conference that 24 states have taken recent enforcement actions against various entities, which include allegations of sham insurance, illegal robocalls and fax blasting, and licensing violations.

One of the states that recently took action against a company selling limited benefit plans was New York, which assessed a \$700,000 monetary penalty against American Medical Life Insurance Company for allegedly marketing limited benefit health insurance policies through misleading advertisements. Other states have also become concerned regarding the manner in which limited benefit plans have been advertised. For example, Florida insurance regulators filed a complaint alleging deceptive advertising against one marketer of limited benefit health insurance. Following Florida's lead, Arkansas temporarily suspended the license of the marketer, and an investigation of the marketer is underway in California.

The fact that many of the cited enforcement actions involve the marketing of medical discount plan products bundled with limited health benefit insurance suggest that the joint federal and state effort to target misleading marketing practices may have been triggered by regulator's concerns that certain companies are allegedly attempting to take advantage of consumers in the wake of the new health care reform laws. Several states have issued guidance regarding the minimum marketing requirements for bundled discount and insurance products, many of which are duplicative of the regulations that already apply to the insurance products.

Some examples of the special marketing requirements applicable to bundled products are identified below, though this should by no means be considered an exhaustive list.

- Medical discount plan components should be clearly identified separately from the insurance product components
- Insurance products must be underwritten by an insurer that is licensed in the consumer's state of residence
- Licensed insurers that underwrite each insurance product must be identified
- Specific insurance policy form number for each insurance product must be disclosed
- Insurance product must be in compliance with the policy form filing and rate filing requirements under the insurance laws in the consumer's state of residence
- Business entity or natural person who sells, solicits, or negotiates the bundled product must be a licensed insurance agent in the consumer's state of residence
- Health insurance advertising regulations requirements and all applicable disclosure requirements must be complied with in the consumer's state of residence

We will continue tracking litigation and regulatory activity by the FTC, state attorneys general offices and state insurance departments with respect to limited benefit plans and bundled products.

NAIC Consumer Alert

The NAIC issued a consumer alert in January 2010 regarding limited benefit plans that warned consumers to be mindful of the limitations of coverage inherent in such plans. This alert tells consumers that if they watch late night television, they may have seen the ads offering health insurance at a low, affordable price. The NAIC alert states that these ads are often for limited benefit plans, described as "bare bones policies that cover specific expenses and have many more limitations than a comprehensive medical plan." The NAIC alert warns that limited benefit plans may not be a consumer's only option and tells consumers that it's important to educate themselves before purchasing a policy. The NAIC alert then describes limited benefit policies and items that should be considered before purchasing such a plan.

Limited Benefit Plan Compliance & Regulatory Services

Our Limited Benefit Plan Compliance Program can assist your company with its compliance needs and provide the following services to insurance companies, insurance agents and brokers, third party administrators (TPA's) and medical discount plan companies:

- Review sales and marketing materials, advertisements, websites, brochures and scripts for compliance with state insurance laws and regulations
- Assist insurance companies, insurance agents, brokers, TPA's and medical discount plan companies respond to regulatory investigations or regulatory actions
- License insurance companies, insurance agencies and brokers, TPA's and medical discount plan companies
- Review insurance policy forms and outlines of coverage for compliance with state insurance laws and regulations
- Assist with association due diligence to confirm associations are in compliance with state insurance laws
- Audit insurance agencies, insurance producers, marketers, and TPA's; and draft attorney/client privileged reports regarding the audits
- Assist with drafting and negotiating agreements between insurance companies, insurance agencies, TPA's and/or medical discount plan companies

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