DC Health Benefit Exchange Authority

September 11, 2023

Submitted via www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS–9904–P
P.O. Box 8016
Baltimore, MD 21244–8010

Re: Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance -- CMS-9904-P

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments in support of the proposed rule.

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling residents and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Since we opened for business, we have cut the uninsured rate by 50% and now more than 96% of District residents have health coverage.

We strongly support the proposed rule on short-term limited duration insurance (STLDI) and indemnity insurance and appreciate the reminders of current federal requirements related to these products. We also appreciate the Departments seeking additional information on level-funded plans.

The Departments' efforts to improve consumer protections are especially timely now as millions of people will no longer qualify for Medicaid coverage. In an August 2023 "secret shopper" study, researchers from Georgetown University documented some of the misleading tactics promoters of limited benefit plans are using to induce people who are losing Medicaid coverage to sign up for limited benefit plans.[1] The Departments should act quickly to finalize the proposed consumer protections.

[1] "The Perfect Storm: Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage," Georgetown University, Center for Health Insurance Reforms (August 2023). (https://georgetown.app.box.com/v/the-perfect-storm-august-2023)

Short-Term, Limited-Duration Insurance

HBX strongly supports the Departments' STLDI proposals to curb junk insurance nationwide, protect consumers from medical and financial harm, and promote stability in individual and small group insurance markets.

Unlike health insurance subject to the ACA, short-term plans are exempt from the consumer protections now required in the individual health insurance markets. For example, these plans can still impose pre-existing condition exclusions, use medical underwriting, apply annual and lifetime dollar caps on benefits, and exclude coverage for essential health benefits (EHB) such as prescription drugs, maternity, and mental health. We have seen firsthand the devastating impact on consumers who enroll, falsely believing they are enrolling in major medical coverage. For example, one resident was diagnosed with a life-threatening condition and learned too late that he purchased a STLDI policy that did not cover treatment. The resident told our staff that he thought he was signing up for comprehensive coverage and would have signed up for real coverage during open enrollment had he understood the true nature of the policy he bought.

Lower premiums established under the ACA and expanded most recently under the Inflation Reduction Act, allows residents to buy comprehensive health insurance for as little as $11/month on DC Health Link. District residents buying junk insurance are forgoing savings available for ACA plans, and not getting the financial protection or the medical care that comprehensive health insurance provides.

The proposed new standards to limit STLDI to no more than 3 months, with a total maximum coverage period of no more than 4 months, stacking restrictions, new notice requirements, and reminders about selling STLDI through associations – to name a few – will help protect consumers, help keep health insurance affordable, and will help keep insurance markets for consumers stable.

Stable Markets

HBX supports the Departments' proposal, which bolsters the stability of the individual market by limiting STLDI. SLTDI is exempt from ACA consumer protections like guaranteed-issue requirements. STLDI is "underwritten" -- specifically designed to attract and cover healthy people. People with medical needs can enroll in ACA plans. However, "cherry picking" by STLDI of healthy people out of ACA plans, makes ACA pools more expensive for all people who need comprehensive health insurance. Also, ACA market stabilization standards like single risk pool and risk-adjustment do not apply to STLDI. Therefore, strong standards for STLDI are necessary to ensure stability of ACA comprehensive coverage.

In 2018, the Trump Administration expanded STLDI market by allowing such products to last up to 12 months with renewals up to 36 months. Our external actuaries estimated that, based on the characteristics of the District's individual market, the 2018 standards would:

- Increase claims costs by as much as 3.1% in the District's individual market (note that if the District did not adopt a local individual responsibility requirement, then we could see as much as a 21.4% increase in claims cost); and

- Result in as many as 5.3% of covered lives,[2] leaving the individual market (note that if the District had not adopted a local individual responsibility requirement, then we could see approximately 35.9% of covered lives leaving the individual market).

The District of Columbia acted to protect District residents through passage of the *Health Insurance Marketplace Improvement Amendment Act of 2018* in response to the 2018 Trump Administration Rule. Proposed by Mayor Bowser, and unanimously passed by the DC Council, our law limits STLDI to 3 months, requires coverage of pre-existing conditions for which an applicant sought treatment over the last 12 months, and limits underwriting for these preexisting conditions. These consumer protection standards have worked well to protect consumers.

While DC policymakers acted to protect consumers and ACA pools in DC, the Departments' new standards are necessary to help protect the stability of the ACA risk pools everywhere, ensuring that people continue to have access to affordable quality coverage no matter where they live. The Departments' proposed approach will establish a strong federal floor to protect consumers everywhere and importantly those who live in states that have not enacted strong consumer protections.

Applicability to Entities in Same Control Group (addressing "stacking" and efforts to circumvent durational standards)

The Departments ask whether the proposed standards should apply to STLDI offered by entities within the same control group, not merely the "same issuer." The District prohibits renewal of a policy and prohibits issuance of a new policy directly or indirectly through an "affiliate" to someone who has had a policy in the last 9 months. District law defines "affiliate" as, with respect to an individual or business entity, another individual or business entity that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person. This covers issuers in corporate families that operate in the same market under two separate licenses. DC's standards have worked well to address "stacking" and efforts to circumventing standards applicable to STLDI. We recommend that Departments apply STLDI standards to entities in the same control group.

Consumer Notice

HBX supports the Departments' proposal to improve how, when, and the type of information provided to consumers. Providing improved notices for newly issued and existing STLDI is an important way to empower consumers to make more informed decisions.

[2] The actuaries assumed an individual market enrollment volume prior to the changes of approximately 17,000 covered lives. Oliver Wyman, "Potential Impact of Short-Term Limited Duration Plans", April 11, 2018, available at: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/OWReview%20of%20Impact%20of%20Short%20Term%20Duration%20Plans%204.11.2018%20%28002%29.pdf

As a state-based marketplace, we've conducted one-on-one testing with consumers using our website, held focus groups, and surveyed our customers. Our experience is consistent with what independent research shows. Simplifying the information presented, e.g., by removing unnecessary text, helps consumers make better choices. Some studies have shown that people make better choices when information is presented graphically (as opposed to using text or numbers), such as through charts.[3]

In addition, we have found in our consumer testing:

- The term "comprehensive" is not a well understood term and some consumers believe that it means the best or most expensive "Cadillac" coverage. In other words, some believe that "regular" health insurance is fine and that they don't need "comprehensive" health insurance.
- Terms like "may" and "might" are not concrete and therefore not meaningful to a consumer.
- Terms like "financial help" and "financial assistance" are viewed negatively by both African-American and Latino residents, while the term "lower premiums" is viewed positively by communities of color and white residents.

We recommend the following changes to the model notice:

> **WARNING:** This is **short-term, limited duration insurance** that will only last [insert duration] month.
>
> - This **isn't health insurance**.
> - To enroll in **health insurance** visit [insert healthcare.gov OR state-based marketplace website] or call [insert federal or state-based marketplace call center number].
> - At [insert healthcare.gov OR state-based marketplace website] you can get health insurance for as low as $11/month [insert different amount depending on state] if you qualify for lower premiums.
> - If you enroll in this short-term, limited duration insurance, you will have to wait until the next open enrollment period to enroll in health insurance.
> - If you enroll in this short-term, limited duration insurance, it will not pay for care and medication you need for your existing medical conditions (preexisting conditions).
> - This policy does not cover [insert which essential health benefits are excluded].
> - This policy limits the total amount it will cover for [insert which essential health benefits are limited].

[3] *See e.g.*, Erin Taylor, Katherine Carman, Andrea Lopez, Ashley N. Muchow, Parisa Roshan, and Christine Eibner. RAND Corporation. "Consumer Decision-making in the Healthcare Marketplace," (2016), available at: https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1567/RAND_RR1567.pdf.; *see also* Sabrina Corlette *et. al*, Urban Institute. "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses." (Jan. 2019), available at: https://www.urban.org/sites/default/files/publication/99708/moni_stldi_final_0.pdf.

If the Departments choose to use the table as the model notice, we suggest the following simplified language and format:

	This Short-term Limited Duration Insurance	**Health Insurance on [Healthcare.gov/State-based Marketplace]**
Does this insurance cover primary care and specialists, pediatric, hospital, emergency, maternity, mental health, substance abuse, prescription drugs, labs, and preventive care?	**NO**	**YES**
Does this insurance cover all pre-existing conditions?	**NO**	**YES**
Are there limits on what I pay out of pocket?	**NO**	**YES**
Can I qualify for lower premiums and lower out of pocket costs?	**NO**	**YES**

We strongly support including state-based marketplace information in the required notice. For example, a DC Health Link customer was convinced to enroll in a bundled package of non-ACA products for $474.85/month. She was induced into believing that she was paying for a change to her existing ACA plan. Had the proposed model notice been required – stating that the plan is not health insurance and referring consumers directly to our state-based marketplace, our customer would have known that she was about to enroll in a non-ACA plan. We also support requiring these notices for short-term limited duration insurance sold through associations.

Finally, the Departments should test model notices either through focus groups or surveys to ensure that the notices are understandable. Doing so aligns with the Departments' approach in developing the Summaries of Benefits and Coverage and Uniform Glossary. In the proposed and final rules on SBCs, the Departments discussed the AHIP and Consumer's Union focus group testing that informed the NAIC recommendations the Departments adopted.[4] This testing supported key changes that NAIC incorporated into its recommendations. For example, some recommendations from the Consumers Union study provided to the NAIC working group included (but were not limited to):

- Revisiting formatting for key definitions (highlighting and placement) because consumers failed to notice these decision aids.
- Adding numeric examples to cost sharing definitions in the glossary, and glossary terms that clarify covered services.[5]

[4] IRS, EBSA, CMS, "Summary of Benefits and Coverage and Uniform Glossary," Final Rule, 77 Fed. Reg. 8667, 8678 (Feb. 14, 2012); IRS, EBSA, CMS, "Summary of Benefits and Coverage and the Uniform Glossary," Proposed Rule, 76 Fed. Reg. 52441, 52443-44 (Aug. 22, 2011).

[5] Issue Brief: "Making Health Insurance Cost-Sharing Clear to Consumers: Challenges in Implementing Health Reform's Insurance Disclosure Requirements," Lynn Quincy, Consumer's Union, Commonwealth Fund Issue Brief (2011), available at:

In adopting NAIC recommendations, the Departments also highlighted that the "[c]onsumer testing performed on behalf of the NAIC demonstrated that the coverage examples facilitated individuals' understanding of the benefits and limitations of a plan or policy and helped them make more informed choices about their options. Such testing also showed that individuals were able to comprehend that the examples were only illustrative."[6]

The history of the development of the SBCs shows the importance of consumer testing. Without subjecting the proposed STDLI notice language to similar testing, there is no guarantee that consumers will benefit as intended. Further, such testing should include consideration of culturally appropriate materials in translation.

Our own experience (as with the case of the consumer we described above) shows the serious consequences that can result when consumers do not receive appropriate notices.

Applicability Dates

HBX supports the Departments' thoughtful approach to winding down the use of STDLI for those currently covered under STDLI plans. This approach is consistent with how the Departments have implemented the ACA – grandfathering and providing time to transition from underwritten products.

Associations and Out-Of-State Trusts

We appreciate the Departments' reminder that selling short-term limited duration plans through associations or trusts does not get them out of federal requirements applicable to the individual market and small group market depending on who the STLDI is covering. This reminder is important and as the Departments state, this type of coverage is typically sold through out of state associations/trusts designed to circumvent state-based protections for consumers. The Departments' reminder in itself is a helpful tool that can help address the pushback that states face when asserting jurisdiction over out of state associations or trusts covering state residents.

Fixed Indemnity Excepted Benefits

HBX supports the Departments' proposed new standards to help reduce abusive marketing practices misrepresenting fixed indemnity products as comprehensive health insurance coverage, and consumer confusion related to such insurance.

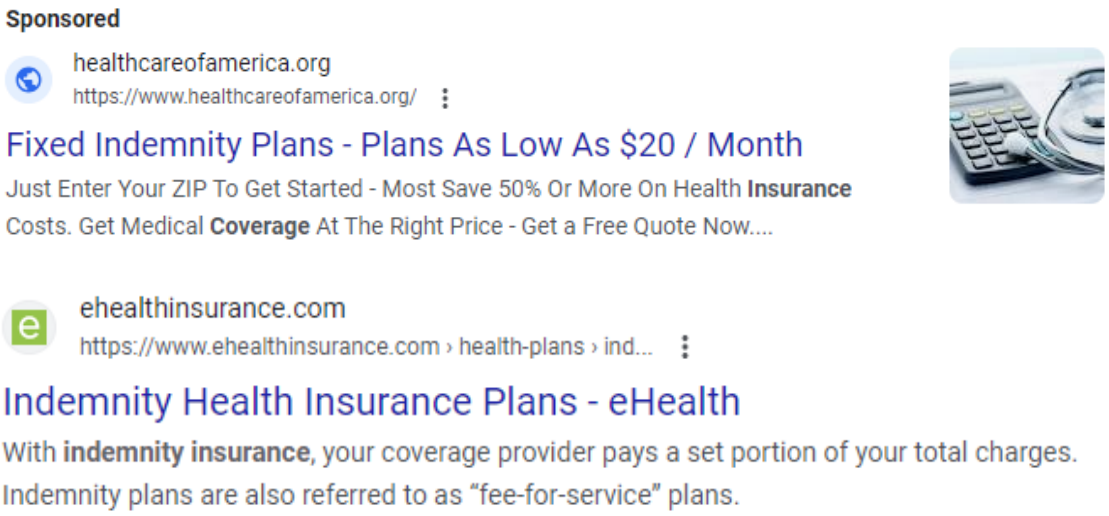
Despite state and federal standards, problems with fixed indemnity exist today. A simple web search conducted in July 2023 on Google for "fixed indemnity" shows:

https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2011_feb_1480_quincy_making_hlt_ins_costsharing_clear_consumers_ib.pdf

[6] 77 Fed. Reg. at 8674.

"Is fixed indemnity worth it?

If you struggle to get approved for medical health insurance, fixed indemnity insurance may be a good solution. It can also act as a supplement to major medical insurance to help cover specific illnesses and injuries."



The Departments' proposed new standards and notice requirements are necessary especially because prior efforts have not stopped abusive marketing tactics. Confusing, predatory, misleading, and fraudulent practices induce consumers to buy fixed indemnity. We have seen cases where residents falsely believed they were enrolling in major medical health insurance. For example, a resident that was paying $184.95 in monthly premiums contacted us for help. The resident was enrolled in a "bundled" package, which included excepted benefits, made to look like comprehensive major medical insurance. After contacting us, we were able to qualify the resident for lower premiums and enroll them into a Silver-level individual marketplace health plan for less than $34 per month.

Consequently, there is a need for a model consumer notice that is succinct, clear, and prominent. We strongly support notice in the application and marketing websites and other materials as proposed by the Departments, in addition to the policy documents. And we support applying the notice requirement in both the group and individual markets. We suggest clarifying that when fixed indemnity is sold as part of a bundled package, e.g. fixed indemnity, accident only, discount cards, and specified disease (some, any combination, on with other products), the notice must be displaced on the front page of the bundled package not just on the first page of fixed indemnity material. This will help consumers see the notice instead of having it be embedded in a package that's bundled - where a consumer may not see it among many pages of material. Insurers must be responsible for monitoring their brokers and downstream promoters to ensure compliance.

Additionally, we recommend the following changes to the proposed consumer notice to further simplify and strengthen the notice:

- Based on our experience, we have found that consumers read and understand bullet style information better than paragraphs and therefore we recommend a model notice to be bullet style.
- Using terms like "doesn't have to" is not concrete and therefore not meaningful to a consumer. When an unscrupulous promoter tells a consumer the insurance policy has protections, the proposed model language "doesn't have to" will not help a consumer identify the conflicting information.
- We've found in our consumer testing that the term "comprehensive" is not a well understood term and some consumers believe that it means the best/most expensive coverage. In other words, some believe that regular health insurance is fine and that they don't need "comprehensive" health insurance.
- We recommend the following model notice language for the individual market, which can be modified for group coverage:

  IMPORTANT: This **isn't** health insurance.
  - To enroll in **health insurance**, visit [insert healthcare.gov OR state-based marketplace website] or call [insert federal or state-based marketplace call center number]
  - This **fixed indemnity insurance** does not pay your doctors and hospitals.
  - This policy provides you with income and will be taxed as income by the IRS.

Prior to finalizing the model notice, the Departments should test it either through focus groups or surveys to ensure that consumers understand the notice.

In addition to the updated notice, it is important for the Departments' to finalize the proposed stronger standards for what qualifies as fixed indemnity insurance excepted benefits. Problems related to non-major medical health insurance, such as fixed indemnity plans, are not new. State insurance regulators tried to address those during development of health insurance reform model laws.

As the Departments indicate, HIPAA established the excepted benefits category recognizing that there are insurance products that existed in the private market in the mid-1990s – at the time of enactment of HIPAA private market reforms – that were not generally considered comprehensive ("medical") insurance, e.g. hospital indemnity (paid $100/day in the hospital). Hence, such products were carved out of consumer protections applicable to major medical insurance.

HIPAA's approach was largely based on existing health insurance reform models for the small group market developed by the National Association of Insurance Commissioners (NAIC), which excluded specified disease, hospital confinement indemnity, and "limited benefit plans"[7] (called "excepted benefits" under HIPAA) from market reforms and consumer protections applicable to major medical insurance. Neither HIPAA nor the ACA standards apply to excepted benefits. According to a 2022 NAIC Report, loss ratios – defined by the NAIC as "Loss Ratio = (Incurred Claims Amount + Change in Contract Reserves) / Premiums Earned" – for fixed

[7] National Association of Insurance Commissioners NAIC Small Employer Health Insurance Availability Model Act, April 1995, available at: https://naic.soutronglobal.net/Portal/Public/en-US/DownloadImageFile.ashx?objectId=7971&ownerType=0&ownerId=25171

indemnity in the individual market were 38.85% compared to an MLR of 86.69% for individual market health insurance.[8] Loss ratios show value of an insurance product. Fixed indemnity insurance low loss ratios show little payout for claims (and perhaps significant overpricing for what consumers get). Even back in the early 90's, state regulators questioned whether limited benefit products had a place in reformed insurance markets and the level of scrutiny – suitability analysis – that regulators may have to engage in to protect insurance consumers. In fact, during development of the Small Employer Health Insurance Availability Model Act in 1992, insurance regulators expressed concerns:

> … about the dangers of limited benefit plans being sold as substitutes for health insurance coverage to circumvent the model reforms.[9]

Regulators continued to express concerns and in the 1995 model, the NAIC's drafting note states:

> It may be desirable to provide the commissioner with discretion to implement regulations to delineate the suitability of these products in the health insurance market reformed pursuant to this Act. For example, the commissioner might conclude <u>that the sale of certain specified disease or other policies is inappropriate in the context of a reformed health insurance market</u>. (emphasis added).[10]

The proposed standards and improved model notice are necessary to respond to on-going problems consumers experience with fixed indemnity insurance.

Tax Treatment

We support the proposed clarification that a payout under fixed indemnity insurance is considered taxable income and offer additional information to help educate consumers about the taxability of such payouts and APTC.

When we built DC Health Link in 2013, we based the online application on the model Insurance Affordability Program application that CMS developed when state-based marketplaces were being established. Although the model application identifies types of payments that are considered "income", it does not specify that payments from fixed indemnity insurance are a type of income that should be included to project income for APTC purposes.[11] CMS may want to consider updating the information in the model application to help consumers more accurately project their income to avoid having to owe the IRS. Additionally, it is difficult to anticipate having such payouts in a future year, so we ask the IRS for some accommodation if a taxpayer doesn't accurately predict such payouts in a future year for APTC calculation purposes.

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[8] National Association of Insurance Commissioners. "2022 Accident and Health Policy Experience Report". 2023, available at: https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf.
[9] NAIC proceedings at page 41, available at https://content.naic.org/sites/default/files/inline-files/MDL-118.pdf.
[10] *Supra* n.7
[11] There is a catch-all question for "other taxable income", but such broad language is unlikely to prompt a consumer to list or be able to project future payments from an indemnity plan.

We are committed to providing our customers new information on taxability of benefits paid by fixed indemnity insurance and we will be making the necessary IT changes. Note that such changes to our online application would not be ready for open enrollment this year even if the final regulation is published this year. Therefore, we request that the applicability of the taxable income clarification for APTC purposes become effective for 2025 instead of the proposed 2024 to give us and, if they choose to, other state-based marketplaces and the federal marketplace time to update information on the online application.

Level-Funded Plan Arrangements

HBX applauds the Departments for examining the issue of level-funded plans because such plans pose a threat to the long-term viability of ACA-compliant small group markets. Such plans also circumvent the ACA health insurance reforms applicable in small group markets and put small businesses and their employees at risk.

Promoters of level-funded plans target employers with younger and healthier employees because younger and healthier employees have fewer claims. As an example, a recent web search for level funded plans showed the following on a promoter's website:

> ….The advantage is that you are not paying premiums based on community rates. This can be a major financial advantage if you have a healthy population of employees.[12] (emphasis added)

The refence to "healthy population of employees" directly targets employers with healthy employees – cherry picking that segments the market and destabilizes the ACA small group market. This cherry picking of healthier employers leaves older and sicker groups in the ACA-compliant small group market, increasing the premiums for employers who need coverage in the small group market. Groups covered through level-funded arrangements will eventually need a stable and affordable small group market to come back to as those groups get older and their claims experience gets worse. Long-term, ACA markets cannot survive insuring only sick people.

In DC, the Department of Insurance, Securities, and Banking (DISB) led legislative changes, advocating for rules to protect our small group market against cherry-picking. HBX supported and assisted our insurance regulators to enact protections against cherry-picking. Our policymakers enacted stop-loss insurance laws which include a prohibition on issuing stop-loss to small businesses unless the employer has a fully-insured employee health benefit plan. 31 D.C. Code § 31–3822(a).

As a result, DC has been able to protect the integrity of our small group market from the cherry picking and risk segmentation problems posed by stop-loss insurance and level-funded plan arrangements. Our ACA single risk pool ensures a risk mix of healthy and sick people in one large insurance pool and helps to keep premiums down for all employers.

[12] https://www.thehortongroup.com/employee/solutions/alternative-funding/level-funded-health-plans/ last visited August 2, 2023.

Protecting our market against cherry picking has been essential in helping our small group market continue to grow and be competitive. Indeed, DC has one the strongest, most robust, and competitive small group markets in the country. For 2023, three United Health Care companies, two Aetna companies, CareFirst Blue Cross Blue Shield, and Kaiser Permanente offer 211 health plans and compete for small businesses based on price and benefits. In 2022, we had 157 small group options. In addition to 54 new plans, 5 small group plans have lower premiums in 2023 compared to 2022. Our small group market continues to grow and as of August 1, 2023 covers 87,276 people and 5,321 District small businesses compared to five years ago covering 77,070 people and 4,944 employers – a 13% increase in covered lives in the small group market.

Although DC has protected and helped grow a competitive small group market for District employers to ensure comprehensive coverage at affordable premiums and choice of insurer, unfortunately cherry picking and destabilization of ACA small group markets are a problem in other areas. In addition to putting ACA markets at risk, level funded plans put employers and their workers at risk.

A feature of "level-funded plans" is for an employer to "self-fund" claims up to a pre-determined level and have a stop-loss insurance policy triggered when claims exceed individual and/or aggregate attachment points. Stop-loss insurance is not subject to ACA and state-based protections applicable to health insurance. Stop-loss is an underwritten product where the insurer determines who to accept for coverage. In the small group market, this means that promoters target healthier and younger groups and if there are claims against the stop-loss policy, carriers either do not renew the policy, engage in retroactive underwriting to avoid paying the claims, or raise the premiums substantially to force the employer to drop the policy. When such policies are issued, the insurer can exclude covering claims for employees with preexisting conditions, making the small business responsible for such claims. The ACA made all of these tactics illegal for health insurance but not for stop-loss insurance. The so called "level-funded" feature means that the employer is at risk for medical claims during a plan year and at risk of huge increases at renewal. ERISA applies to group health plans (benefits sponsored by an employer). Having a "level-funded plan" does not remove ERISA requirements. Small businesses targeted for this coverage are put at risk of being out-of-compliance with the ACA requirements in ERISA or on the hook for significant claims. Furthermore, some promoters of "level-funded plans" sold to small businesses falsely claim that such plans offer full protection of fully-insured plans – where the employer is not responsible for medical claims. As an example, a recent web search for level funded plans showed the following on a promoter's website:

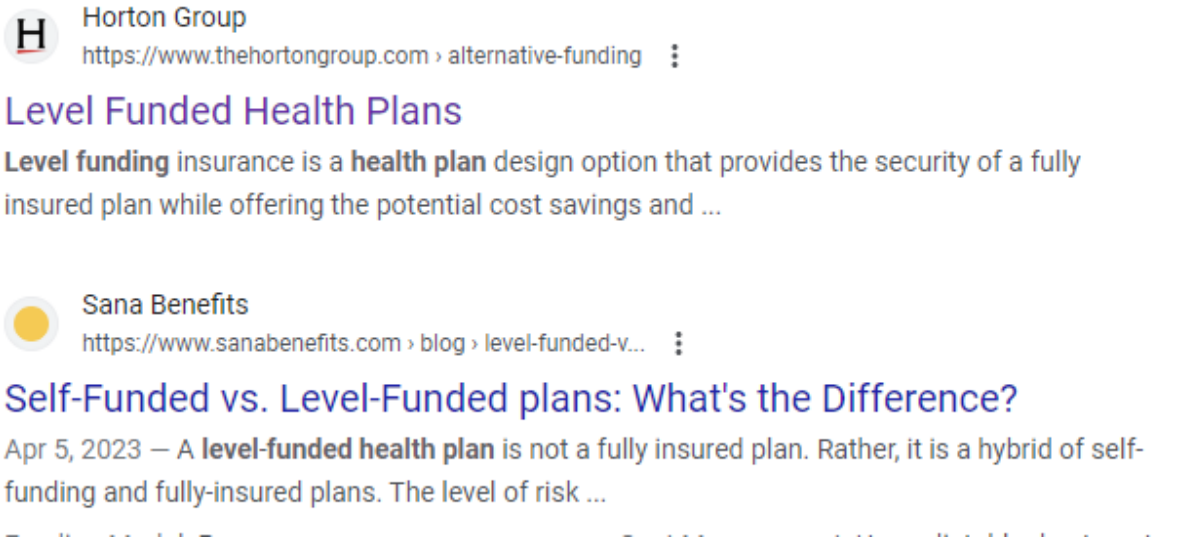
> Just like with a fully insured medical plan, the company pays a set monthly insurance premium throughout the policy period.[13] (emphasis added)

Small businesses and their workers are put at financial risk by this misleading (and fraudulent) marketing.

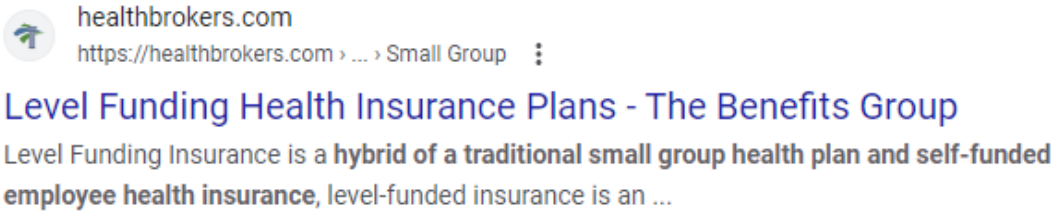
[13] https://www.thehortongroup.com/employee/solutions/alternative-funding/level-funded-health-plans/ last visited August 2, 2023.

Promoters of level-funded plans also claim exemption under ERISA from state regulation. Such claims make it difficult for states to assert jurisdiction to figure out if there is actual self-funding or just a subterfuge designed to circumvent state insurance and ACA protections.

A search for "level funded health insurance" on August 2, 2023 on Google, showed:



A search for "level funded plans" on August 2, 2023 on Google, had similar results on first page of the search:



In the first result, the statement "security of a fully insured plan…" tells an employer that they are not at risk for claims, which is not accurate for level-funded plans. If the employer has risk ("shares risk"), then it is not a fully insured plan and the employer does not get the protections of a fully insured plan. The reference to a fully insured medical plan leads employers to believe that what they are purchasing is ACA compliant and that the employer will not be at risk if the stop-loss policy under the level-funded arrangement denies payment or excludes preexisting conditions from the policy. Using language of "security of a fully insured plan" is misleading. On the other hand, in the above case if an employer has zero risk and all the risk is transferred to the insurer, then this is a full insured group health plan and should be regulated as such. In the third link above, referring to "hybrid" could be interpreted as a way to attempt to avoid both federal and state oversight.

In addition to establishing standards for level-funded plans, the Departments should consider providing additional guidance for level funded plans similar to the Department of Labor's "Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act

(ERISA): A Guide to Federal and State Regulation." This is to help determine when a plan is actually a level-funded plan (also known as self-funded or self-insured). Such additional guidance will help shut down promoters trying to circumvent state consumer protections – where an employer has no risk yet promoters assert ERISA to avoid state oversight and "hybrid" plans where an employer is at risk but also has a stop-loss policy subject to state insurance regulation.

Federal standards are necessary and should be designed to help states when ERISA is used as a shield against state regulation, to protect employers and their workers in actual "self-funded" plans, and to ensure long-term stability of ACA compliant small group markets. Absent federal standards, level-funded plans and similar arrangements will:

1. continue to cherry pick and segment markets – eroding ACA small group markets,
2. continue to put small businesses and their workers at risk for unpaid claims in cases of stop-loss insurance claim denial, and
3. continue to allow promoters to evade state oversight by claiming ERISA preemption.

For these reasons, we support the Departments' efforts to develop consumer protection standards and clear delineation for federal, state, and overlapping authority for level-funded plans.

Conclusion

Thank you for considering our comments on issues that will directly impact District residents and the continued operations of our marketplace. We appreciate CMS's continued support for state flexibility, consumer protections, and working to ensure a more equitable future. We look forward to working with you on these issues.

Sincerely,

Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority