September 11, 2023

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

To Whom It May Concern,

On behalf of the Individual and Small Group Markets Committee, Risk Sharing Subcommittee, and Active Benefits Committee of the American Academy of Actuaries[1] (the Committees), we appreciate the opportunity to provide comments in response to the notice of proposed rulemaking (NPRM), *Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance* released on July 12, 2023.[2] The Committees are commenting on several provisions of the proposed rule including short-term limited duration insurance (STLDI), fixed indemnity (FI) coverage, level-funded coverage, and critical illness / specified disease coverage.

The market for health coverage in the United States is diverse, with a wide range of insurance products focused on various consumers and their needs. While federal and state health programs address a large segment of the population, the private market is the largest and most varied source of coverage for medical, pharmacy, and other health care needs.

The most prominent type of coverage for health needs is major medical coverage, which typically provides comprehensive coverage for chronic and acute health-related needs. This market is split into individual / direct purchase coverage and employment-based / employer-sponsored coverage. Employment-based coverage is further divided along two different dimensions—the size of the employer and the way in which the employer funds coverage (coverage purchased from an insurer that assumes risk vs. self-funded coverage where the employer holds some or all the risk). Self-funded small group coverage often uses level-funded arrangements discussed in the proposed rule and later in this letter.

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

[2] "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance"; *Federal Register*; July 12, 2023.

One challenge of employment-based coverage is that coverage is not portable. Certain individuals and their families leaving employment or experiencing a qualifying life event have the right to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage for a specified time. However, qualified individuals and their families may have to pay the entire premium for coverage, up to 102% of the costs of the plan. For some households, the costs of premiums could be unaffordable. Individuals gaining new employment often face a waiting period before becoming eligible to enroll in coverage. Current statutes limit waiting periods to 90 days, but this can result in households being in a coverage gap. This dynamic creates the need for a coverage solution to bridge that gap—a need that has been filled by STLDI.

A second challenge associated with employment-based coverage, particularly for very small employers with 10 or fewer employees, is the difficulty of maintaining robust health benefits with limited resources. This challenge is a key driver in the development of association-based coverage, wherein multiple smaller organizations pool their resources to provide more robust and / or flexible benefits to their employees and families.

A third challenge associated with employment-based coverage is that the scope of services under major medical insurance is typically focused on chronic and acute medical needs. When unforeseen events result in an employee being unable to work, two notable challenges emerge for the insured. First, the employee may exhaust many or all sources of income, or—particularly in the hospital setting—and have significant out-of-pocket (OOP) costs associated with the hospital stay. This is the primary driver of the creation of FI insurance, which historically replaces lost income in the event of certain predefined events, and hospital indemnity plans, which provide payments when an individual has a hospital visit. Second, the employee may need care and income beyond that typically provided under major medical health coverage—most notably for disability. This need drives the short-term and long-term disability insurance market.

As the prior paragraph notes, health needs may exceed the scope of major medical coverage. Certain high-cost conditions (such as cancer) may create long-term health coverage and financial needs that exceed available major medical insurance coverage. The market has responded with critical illness / specified disease coverage. These coverages are limited to specific identifiable conditions, and do not provide for preventive care and other more routine medical needs.

This segmentation of health coverage (into major medical coverage, short-term coverage, critical illness coverage, etc.) helps the market address the full scope of consumer coverage needs while maintaining actuarially appropriate risk pools. When coverage types with different rules overlap, consumers can select the coverage with the rules most favorable to them. This flexibility benefits consumers for whom lower-cost coverage is preferable, thus increasing costs for consumers insured in the remainder of the market. If the higher-cost market cannot find a stable risk pool, this member selection dynamic results in an actuarial death spiral, as consumers leave the higher-cost risk pool until only the most expensive risks remain. To ensure market stability, regulators should consider this balance when approving overlapping coverages that compete for the same consumers.

Comments on Short-Term Limited-Duration and Fixed Indemnity Coverage in the Individual Market

In 2018, the Academy's Individual and Small Group Markets Committee provided comments regarding "CMS-9924-P, Short Term Limited Duration Insurance." The 2018 provisions lengthened the maximum duration from three months to less than 12 months. Additional provisions included a renewability provision for a maximum duration of 36 months. The recently released NPRM rule proposes to limit the length of the initial contract to no more than three months, with a maximum coverage period of four months, and prohibit the same issuer from issuing multiple consecutive STLDI policies to the same member.

The proposed changes outlined above are consistent with how STLDI was historically used by healthy people who know they will have a short gap in medical coverage, for instance between jobs. In general, members enrolled in STLDI plans are healthier than the Affordable Care Act (ACA) population, as STLDI plans are underwritten while ACA plans are guaranteed issue. If current STLDI members move into the ACA market, we would expect the ACA risk pool to improve over time (all else equal), putting downward pressure on rates / rate changes. In addition, members enrolling in ACA-compliant plans have more robust benefits than typical STLDI, including the 10 essential health benefits (EHB) requirements (e.g., maternity, prescription drugs, behavioral health), maximum) and certain consumer protections including maximum OOP limits, and prohibitions on lifetime maximums, most of which are not provided by STLDI plans unless mandated by state law.

The proposals in this rule largely align STLDI coverage with its initial purpose and current timing rules regarding enrollment in employer-sponsored coverage with a new employer. However, we are concerned that the current rules may not sufficiently address all reasonable scenarios related to loss of coverage under the proposed rules. For example, if an individual changes employment, determines that the new employer was not an appropriate fit for their skills or needs, and then seeks to change employment again, the individual may not yet be enrolled in the new employer coverage, nor would the individual necessarily have sufficient time remaining on a purchased short-term limited-duration policy to cover the additional time to secure employment coverage from a different employer. This could leave the individual without access to an Exchange special enrollment period (SEP) or additional short-term coverage prior to their ability to effectuate new employment-based coverage.

This potential gap in coverage availability could be addressed either by extending the maximum term of a short-term policy to the beginning of the next calendar year to align with the annual open enrollment period, clarifying that an existing SEP would allow the individual access to coverage, or creating a new SEP that explicitly allows for entrance into the Exchange upon the termination of a short-term limited-duration policy. This latter option should consider limiting the potential for abuse, such as by limiting availability of the SEP to situations where the individual elected short-term coverage following loss of employment-based coverage due to a job transition or to provide temporary coverage during an employer's waiting period.

We note that similar considerations also apply to FI products that are designed to provide a benefit similar to the mini-med market segment—the population that enrolls in these plans generally prioritizes cost over coverage and therefore is expected to be healthier.

STLDI in the Group Market

The comments related to group STLDI are consistent with the Committees understanding of the regulations surrounding STLDI, and we believe appropriately serve to avoid the hazard associated with risk segmentation overlap as discussed in the previous section of this letter.

Level-Funded Coverage

As noted previously, level-funded products are prominent in small and mid-sized employer self-funded coverage segments of the market. The proposed rule mentions an extremely limited set of available data points related to level-funded products. The lack of data for this market segment is a common challenge for employers and self-funded service providers seeking to better understand this segment, and we are not aware of any robust data on these employers. We note that the proposed rule addresses the potential limitations of the reinsurance arrangements that are perhaps the key defining characteristic of level-funded coverage. While these challenges certainly exist on a theoretical basis, it is our understanding that most major benefit administrators providing services for level-funded plans do not incorporate lasering (the practice of excluding an otherwise eligible member from coverage due to an existing health condition), as these risks are specifically the risks that smaller employers are hoping to protect against. These benefit limitations may be more likely when using a benefit administrator unfamiliar with the market's needs or solely focused on providing a low-cost product. We are not aware of any data addressing the prevalence of limited reinsurance coverage in the level-funded market.

As the departments have noted in the proposed rule, level-funded products have a similar dynamic to some STLDI and FI coverages, as they create two markets for small employers—a market with guaranteed coverage under the rules of the ACA, and a market with the ability to rate for health status and / or limit the availability of coverage for higher risk groups through level funding. This creates the opportunity for healthier, lower-cost groups to select against the insured ACA small group market and is likely one of the reasons for the lack of growth in the small group market in many states, as well as overall nationally.

Specified Disease

We note that the general parameters surrounding critical illness / specified disease coverage do not appear to create a clear avenue for these products to be marketed as a replacement for major medical coverage. However, should the proposals in the rule be adopted, state and /or federal monitoring may be appropriate.

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The Committees appreciate the opportunity to provide comments on the short-term limited-duration insurance NPRM and welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments. If you have any questions or would like to discuss further, please contact Matthew Williams, the American Academy of Actuaries' senior health policy analyst, at williams@actuary.org.

Sincerely,

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